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The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2018/19

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The Rotherham NHS Foundation Trust

Annual Report and Accounts 2018/19

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paragraph 25 (4) (a) of the National Health Service Act 2006

Contents


NHS

Welcome from the Chairman

Welcome to The Rotherham NHS Foundation Trust's Annual Report and Accounts for 2018/19. This document sets out how the Trust performed over the year including details of some key achievements and ongoing challenges.

The last year has been another demanding one for the NHS, although we also had the opportunity to celebrate the 70th birthday of the founding of the NHS, providing an opportunity to take stock of the incredible achievements and advancements made in healthcare over the last seven decades.

In addition, we also celebrated 40 years since the doors of Rotherham Hospital first opened to patients and the positive impact its services have had on the town since then.

As I see it, there are three key challenges for the Trust going forward. The first is guaranteeing and raising our service quality, ensuring all of us in the Trust – from boardroom to frontline – play a part in driving forward continuous improvements.

The second, is continuing to develop an open, innovative and supportive culture that encourages our colleagues to develop their potential to the benefit of the Trust and the community we serve.

The third key aspect of our approach is to ensure we are on a sound financial footing, ensuring the viability and sustainability of the Trust and its services.

Let me begin with finance. Many NHS Trusts across the country continue to face serious financial challenges, however our performance was better than predicted, achieving a £19.9 million deficit, (£0.4 million favourable to plan), which included the successful delivery of our stretching £9.7 million Cost Improvement Programme. This helped the Trust to successfully deliver its financial plan.

I am also pleased that we secured £3.4 million in external funding, enabling us to invest in improvements like the co-location and enhancement of our assessment and ambulatory facilities. Also, we invested £2.1 million in developing our Acute Surgical Unit. Funding was also awarded for improvements in our digital equipment and systems, including £750,000 for the implementation of electronic prescribing (ePMA).

Our workforce continues to be our greatest asset and, in addition to their caring nature being commended by the Care Quality Commission (CQC), we have seen a number of colleagues receiving national recognition. Three of our community nurses have been awarded the prestigious title of Queen's Nurse for their ongoing commitment to the profession and dedication to patients.

I was also delighted to see the hard work of our apprentices being praised as well, with one of our Therapy Support Workers being awarded the Silver Medal at the 2018 World Skills Competition.

Collaboration has continued to be a central theme in much of our work over the last 12 months and this will only increase as we move forward, working closely with our partner organisations in Rotherham and across the wider South Yorkshire and Bassetlaw Integrated Care System. These improved ways of working are helping us all build sustainable services for the populations we serve.

Finally, let me say a few words about quality. In January 2019, the CQC published its inspection report into our services following visits in September and October 2018. While the overall rating remained at 'Requires Improvement' it did show a number of our services were getting better.

However, despite a fantastic effort from colleagues, we were rated as 'Inadequate' for Urgent and Emergency Care. An immediate response from our teams addressed some of the concerns raised and we will continue to drive improvements in this area.

The four-hour waiting time target remains highly challenging, but the Trust is working hard to drive improvements and is one of just 14 sites across the country chosen to field test a set of new national performance standards for NHS urgent and emergency care, during 2019/20.

The CQC report does, however, present the Trust with considerable challenges and I am clear we will use this as an opportunity to redouble our efforts. Already, we have a new Quality Improvement Plan and the launch of our 'Safe and Sound' framework to drive quality improvements at a granular level, combined with an approach to listening and engaging with patients in a spirit of 'no decision about me, without me.'

Thank you once again to all of our colleagues, governors, partner organisations and members of the public for your ongoing support throughout the year. We are continuing to make good progress on our improvement journey as we aim to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital.

Martin Havenhand
Chairman

Performance Report

Overview of Performance

The purpose of this Overview of Performance section is to provide a short summary with sufficient information to enable the reader to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Introduction to The Rotherham NHS Foundation Trust

The Rotherham NHS Foundation Trust (TRFT) was established in 2005 pursuant to Section 6 of the Health and Social Care (Community Health Standards) Act 2003, and was formerly the Rotherham General Hospitals NHS Trust. As an NHS Foundation Trust, the Trust is regulated by the sector regulator, NHS Improvement, and standards of health care are overseen by the Care Quality Commission.

In 2011, the Trust acquired Rotherham Community Health Services to become a combined acute and community Trust, with the aim to be a leading healthcare provider to patients in the hospital, community and home settings.

The Trust serves a population of around 263,400 of which 25% is aged 60 and over and around 22% are aged 0 to 17[1]. It is projected that the number of people aged over 65 will increase by 17% between 2017 to 2027 with the majority of this increase in people aged over 75.

The Black and Minority Ethnic (BME) population in Rotherham constitutes a relatively small percentage, although it has grown and become increasingly diverse, more than doubling between 2001 and 2011. In 2011 8.1% (20,842) of the population belonged to Black and Minority Ethnic (BME) groups, which was significantly below the English average of 20.2%.[1]

Within the BME groups, the largest included those identifying as Pakistani & Kashmiri at 3.1% of total population compared to the 2.1% average across England. The second largest BME group was Other White at 1.3%, which includes people from European countries such as Poland and Slovakia. 91.9% of Rotherham residents were White British.[2]

The health of people in Rotherham is varied compared with the England average. The number of people in Rotherham with a limiting long-term illness in 2011 was 56,588 (21.9% of the population) meaning that the borough had a higher rate than the national average of 17.6%. Of these individuals, over half (51%) considered that their day to day activities were limited 'a lot' by their long term illness. Compared to the national average, 3% more people in Rotherham experienced this impact on their day to day activities.

16.4% of the Rotherham population aged 16 to 64 was living with a limiting long-term illness compared to the national average of 12.7%. In addition, the rate at which the local population is registered on the blind / partially sighted register is almost double the English average with over 65% aged over 75.

In the 2011 census 12% of the population provided unpaid care, compared to 10% for England. In fact, 3.4% of Rotherham's population provided 50 hours or more of unpaid care per week, a figure higher than the English average of 2.4%.

Deprivation is higher than average with Rotherham ranked as the 52nd most deprived district out of 326 English districts as defined by the 2015 Index of Multiple Deprivation. Almost a third of the population (31.5%) live in areas which are among the most deprived 20% in England, a statistic which has barely changed since 2004. In fact, the years between 2007 and 2015 saw the greatest increase in deprivation across the most deprived areas of the borough. The main factors leading to deprivation locally are health and disability; education and skills; and employment.

Conversely, the proportion of Rotherham residents living in the least deprived 30% of England doubled from 8% in 2004 to 16% in 2015 illustrating the polarisation of deprivation across the area.

The latest figures (August 2014) show that almost a quarter (24.1%) of children in Rotherham were living in poverty which equates to just over 14,000 children. This was lower than the average across South Yorkshire of 24.3% but higher than the England average of 19.9%.[3]

Life expectancy for both men and women is lower than the England average although it is improving. Rotherham residents are more likely to die from circulatory disease and cancer than the national average, however when compared with similar areas their risk of dying from these diseases is actually lower.

Life expectancy is 9.8 years lower for men and 7.6 years lower for women in the most deprived areas of Rotherham than in the least deprived areas. [4]

The Trust has 396 inpatient beds, and circa 4,000 members of staff providing a comprehensive range of services to the population of Rotherham, as well as specialist services across the South Yorkshire region and nationally.

[1] Source: Rotherham Joint Strategic Needs Assessment (Resident Population) located at: https://www.rotherham.gov.uk/jsna/info/23/people/48/resident_population last accessed 19 February 2019.

[2] Source Rotherham Joint Strategic Needs Assessment (Demographic Profile 2017/18) located at: https://www.rotherham.gov.uk/jsna/downloads/file/139/rotherham_demographic_profile_2017-18 last accessed 19 February 2019.

[3] Source Rotherham Joint Strategic Needs Assessment (Children & Young People) located at: https://www.rotherham.gov.uk/jsna/info/23/people/55/children_and_young_people/8 last accessed 19 February 2019.

[4] Source Rotherham Joint Strategic Needs Assessment (Rotherham Health Profile 2017) located at https://www.rotherham.gov.uk/jsna/.../id/.../health_profile_for_rotherham_2017.pdf last accessed 19 February 2019.

Purpose and Activities of The Rotherham NHS Foundation Trust

The Trust is registered with the Care Quality Commission ('CQC') to provide the following services:

- Assessment or medical treatment for persons detained under the1983 Act
- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

The majority of acute services are provided at the Trust's Moorgate Road site (Rotherham General Hospital), however the Trust also provides services at Breathing Space, Park Rehabilitation Centre, Rotherham Community Health Centre, Rotherham Intermediate Care Centre, New Street Health Centre in Barnsley and at The Flying Scotsman Centre in Doncaster.

The Rotherham NHS Foundation Trust has a divisional management structure to coordinate and deliver healthcare services. This is done through 4 clinical Divisions: Integrated Medicine, Family Health, Surgery and Clinical Support Services supplemented by Urgent and Emergency Care, a fifth division introduced from 01 April 2019. Additional services covering Health informatics, Estates and Facilities, Workforce and Finance functions are considered to be provided through a corporate divisional structure.

The Trust provides care in partnership with Rotherham, Doncaster and South Humber NHS Foundation Trust through a 12-bedded ward to support patients living with dementia, within the Woodlands hospital which is based upon the main hospital site.

The Trust also sits within a sub-regional strategic context, which continues to evolve. The development of the South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS) continues to support wider system working, with the Hospital Services Review being a key work stream for acute providers. One of the developments of this work is the proposed establishment of five 'hosted networks', with the Trust being successful in being selected to lead the Maternity network. This work will develop through 2019/20 as the role of hosted networks matures.

As an organisation, the Trust continues to play a leading role in the development of Place-based working with partners across the Rotherham Integrated Care Partnership (ICP), and this has led to a number of national case studies published which recognise the progress the organisation has made with partners across health and social care. The Rotherham Integrated Health & Social Care Place Plan ('Place Plan') has been refreshed and updated during the year and has reinforced a number of the key priorities which are being focused on with Place partners.

National Healthcare Strategies

The future ambitions for the NHS have been set out in the *NHS Long Term Plan* published in January 2019. It focuses on the ambition to improve care for patients over the next ten years whilst also tackling some of the key concerns such as funding, staffing, increasing inequalities and pressures from a growing and ageing population.

The NHS plan outlines how these ambitions will be addressed through 6 broad approaches and the Trust has assessed its overall strategy against the 6 approaches to ensure alignment. It is critical that the organisational objectives and future plans continue to dovetail with the *NHS Long Term Plan* vision to deliver against its objectives, and this will be addressed through the ongoing application of the business planning cycle.


Our Vision, Mission and Values are underpinned by five strategic themes
Strategic the

Chief Executive's Statement

In 2018/19 the Trust has continued to deliver strong performance in a number of areas. This has included consistently strong performance against the 18-week Referral to Treatment standard; upper quartile performance for cancelled operations; very low CDifficile infection rates (among the lowest rates nationally) and sustained strong performance for length of stay. We have also had nationally recognised performance for our Friends & Family Inpatient score.

We have also seen significant improvements in a number of areas, including the trauma pathway demonstrated by our performance improving to be within the top 5 nationally each month from September 2018, compliance against the Hip Fracture Best Practice standards and by our Delayed Transfers of Care performance which has achieved compliance against the national standards in most months, despite a challenging winter period. Performance in a number of areas has been achieved as a result of the ongoing partnership working across Rotherham through the Rotherham Integrated Health & Social Care Place Plan, which is bringing partners together across health and social care to improve the health and wellbeing of the population we serve, delivering more joined up integrated services across Rotherham.

We also continue to develop and build upon our Trust 5-year strategy, which was further refreshed during the year. We continue to drive change across the Trust, across Rotherham Place and across the South Yorkshire & Bassetlaw Integrated Care System.

This programme has seen the reconfiguration of our assessment floor and the opening of a new Acute Surgical Unit, the development of an Integrated Discharge Team with Rotherham Metropolitan Borough Council and the development of an enhanced Integrated Rapid Response team. We have equally ambitious plans for 2019/20 which will see us continue our collaboration with partners across health and social care and will include a reconfiguration of the Intermediate Care bed base and investment in additional community capacity to provide care closer to home, the further development of the integrated locality model and in particular how this will align with the new Primary Care Networks as well as a review of the Out-of-Hours provision of care across Rotherham, to deliver a more joined-up model of care across partners.

It is also positive to note that the Trust has delivered its financial plan resulting in a year end deficit of £19.9M, £0.4M better than plan and the Trust achieved its Cost Improvement Programme of £9.8M. However, whilst achieving this plan the Trust continues to take actions to address the underlying financial deficit which was £22.3M at 31 March 2019 compared with £25.0M at 31 March 2018, with the aim of improving financial sustainability over the coming years.

Despite positive progress in many areas, a number of key performance standards have remained challenging this year in particular performance against the 4-hour access standard. The Trust ended the year 85.7%, which represents a slight improvement in overall performance of 0.65% compared with 2017/18 but still requires significant improvement to ensure all patients are seen in a timely way.

The Trust has taken significant steps to address this position including a number of the transformation programmes outlined above, in particular focusing on assessment, ambulatory and frailty pathways to support more timely and effective care for patients. However, the new model of care within the Urgent & Emergency Care Centre (UECC) is not yet fully embedded with a number of challenges as identified in the recent CQC inspection report which rated Urgent & Emergency Care services as 'Inadequate' at the time of the inspection. Significant improvements have been made since that time and the Trust is striving to ensure that the services are rated positively for patients at the next inspection.

The Trust has an improvement plan in place and in addition, will be field testing the proposed new Urgent and Emergency Care access standards, ensuring patient safety and experience are at the heart of our approach. Therefore, considerable focus will continue to further improve the quality and performance of Urgent and Emergency services for patients over the coming year.

In terms of cancer, a standard against which we have traditionally performed well, the Trust consistently achieved the national standard for patients being treated within 31 days of diagnosis throughout 2018/19. However, the Trust did not consistently achieve the 62-day cancer standard throughout 2018/19. Whilst, the Trust did recover performance in quarter 2 as planned, unfortunately this was not sustained during quarter 3 and quarter 4. Therefore, further actions are being taken to improve performance during 2019/20.

Whilst the Trust has a generally very strong track record in delivering against the 6-week diagnostic standard, as a result of some workforce challenges performance was not achieved from November 2018 to January 2019. Appropriate actions were taken and as a result the standard was achieved from February 2019 onwards, we anticipate this to continue to deliver through 2019/20 whilst recognising that workforce challenges will remain an ongoing risk.

A number of core services were inspected by the CQC during the year with the Trust receiving an overall rating of 'Requires Improvement', with a second domain, 'Responsive', rated as 'Good' alongside 'Caring' compared with the previous inspection ratings. The Trust was rated

as 'Requires Improvement' for both the Use of Resources and Well-led inspections. This valuable feedback is being used to support the development and delivery of action plans to address key areas of concern whilst building on the good practice that exists to support the Trust to achieve its vision '*to be an outstanding Trust delivering excellent care at home, in our community and in hospital*'.

Finally, 2018/19 marked 40 years of Rotherham Hospital and the 70th anniversary of the NHS which was a fantastic opportunity to recognise and thank all our wonderful, hard-working colleagues and the many patients, families and partner organisations who support the Trust. We are looking forward to 2019/20 to build on the positive progress we have made and to continue to tackle the challenges we face to provide the very best high quality care for the population we serve.

The Key Issues and Risks that could affect the Foundation Trust in delivering its Objectives

Quality of Care:
The Trust will continue to strive to deliver high quality, compassionate, patient-centred and harm-free care. It will do so by ensuring that actions are taken to improve services following feedback received from the CQC, most recently in their inspections undertaken in September and October 2018, and by ensuring that its quality governance framework is strengthened to become as robust as possible through the launch of the new Safe & Sound Quality Framework, Quality Improvement Strategy and Quality Improvement Plan. It will also do this by ensuring that the services it provides are safe and clinically effective, supported by proactive engagement in national initiatives such as the 'Get It Right First Time' (GIRFT) programme and Model Hospital.

The Trust will also continue to focus on providing a positive experience for patients, relatives and colleagues, by improving engagement with patients and colleagues in service delivery and redesign. Furthermore, the Trust will continue to provide colleagues with leadership development and support colleagues to gain knowledge and skills in quality improvement, which in turn will empower and better enable them to drive further improvements in patient experience and outcomes, and the delivery of high-quality safe care.

A failure to deliver high-quality patient care could lead to poor patient experience and avoidable harm, and a failure to improve clinical sustainability, which could lead to financial penalties and regulatory action.

The Trust will continue to work collaboratively with stakeholders to adapt and enhance models of care in order to improve resilience and sustainability of services for patients, drawing on evidence based practice and participating in clinical audit, benchmarking, and other external reviews to continuously improve the quality of care.

Workforce:
The Trust's ambitious strategic objectives need to be delivered by a stable, experienced, flexible and highly skilled workforce with a broad range of skill sets. The context within which this is to be achieved is very challenging, with high vacancy levels in some key professions as a result of national and local skills shortages, turnover of staff and an ageing workforce profile with a potentially high proportion of staff able to retire over the next 5 years. It is generally workforce issues which create the most significant risk in the delivery of high quality care. Therefore the Trust continually seeks to develop effective strategies to attract and retain a high quality workforce, identifying risks and taking mitigating action where possible.

The gap between the available substantive workforce, vacancy levels and increasing patient and services demands is being addressed primarily through the use of additional temporary workforce supply. However, as a result the Trust incurs premium costs and is unable to provide the optimum continuity of care and flexibility of workforce to meet variations in demand at all times, creating service pressures in a number of areas. The priority over coming years is to increase the substantive staffing levels and consequently reduce reliance on temporary staffing approaches. The nature of work is also changing with increased use of technology, medical advancement and changes in societal expectations and the Trust is working with partners to develop new integrated models of care which will enhance early intervention, reducing demand on services.

The traditional workforce model reliant on skills, represented by significant market shortages is no longer sustainable, hence the Trust is developing new skill sets, roles, career opportunities and pathways to provide more cost-effective, affordable and innovative workforce solutions to deliver services required for the future which meet people's aspirations and needs and the Trust will progress overseas recruitment where appropriate.

The drivers for change and constraints facing the Trust indicate that a continuation of this journey to develop new roles and ways of working, increase skill mix and 'grow our own' workforce is likely to be the most realistic, affordable and achievable option to enable the organisation to meet its strategic aims. However, relationships with key stakeholders will also be an important factor in seeking to achieve improved shared outcomes through more collaborative approaches.


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40
years
Caring for our Community
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Finance:

The Trust set an Income and Expenditure deficit plan for 2018/19 of £20.3M.

The audited year-end position shows an actual position of a £19.9M deficit which is £0.4m favourable to the financial plan. This value also includes delivering a £9.8M cost improvement programme against a target of £9.7M.

In addition, the Trust agreed a capital programme of £7.1M to support investment in its Estate, IT infrastructure and medical equipment. In particular, the Trust invested capital in:

- New Surgical Assessment Unit (which was completed in December 2018)
- Medical equipment; and
- Maintaining environmental standards

Operational Delivery:

The achievement of the A&E 4-hour access standard has been particularly challenging throughout the year, with some performance during quarter 1 above the improvement trajectory set, but performance failing to improve through the rest of the year, which although marginally improved on 2017/18, was significantly below the national standard overall. Despite building on strong winter planning in 17/18, the Trust failed to sufficiently forecast the increase in attendances in quarter 4 and despite improved community capacity, did not have sufficient acute capacity to mitigate winter pressures. Ongoing use of scenario and capacity & demand planning will be essential in 2019/20, to optimise the reconfiguration of beds and workforce requirements.

Cancer 62 day performance has also been challenging with the Trust achieving the required standard only in quarter 2, however colleagues continue to work closely together with the Cancer Alliance to ensure improvements in this important standard. The standards for treatment within 31 days of cancer diagnosis and the 62-day target for those referred from one of the cancer screening programmes were met during the year.

The 6 week-wait diagnostic standard, has traditionally been an area of strong performance for the Trust. However, at the end of 2018, the Trust experienced specific challenges within sleep studies which resulted in failure to achieve the national standard. Following the implementation of a series of actions, performance significantly improved from February 2019 and the Trust ended the year as one of the best performing in the country against this particular standard over the 12-month period. The Trust remains sensitive to workforce pressures, however, expects to achieve this standard through 2019/20.

The Delayed Transfers of Care standard received significant focus on a national basis during 2018/19, and the Trust was a high performer nationally throughout the year. We benefit from strong partnership working with the Local Authority. Performance falls well within national target thresholds, ranking amongst the strongest performance regionally. The integrated discharge team has been central to this approach and we are proud to be finalists at the 2019 HSJ Values Awards for the work we have done jointly in this area.

Looking ahead to 2019/20:

As the Trust moves into 2019/20, as described above, it continues to face a number of challenges across the organisation. Whilst the CQC rated the Trust good for 'responsive' in addition to 'caring', the 'inadequate' rating for Urgent and Emergency Services is clearly an area of focus and, whilst immediate actions have been taken, there is significant progress still to make and sustain. The Trust welcomes the feedback from the CQC and is working hard to ensure that it embraces the findings, drawing on good practice to inform actions which will further improve the quality of care and services for our patients in hospital and community.

As described above, performance against a number of the national standards has been challenging, particularly the 4 hour access standard and cancer 62 days standard. The Trust will continue to work with stakeholders with a view to driving sustained improvement during 2019/20.

A further critical area of focus will continue to be workforce, both in terms of the development of an effective Workforce Plan but also colleague engagement. The Workforce Plan will play a central role in shaping workforce priorities and ensuring that we retain and recruit a workforce able to meet the current and future demands, and the development of the organisational development strategy will support improved colleague engagement and health and wellbeing.

One of the organisation's five strategic themes, 'Colleagues', is to develop engaged, accountable colleagues. Feedback from the NHS Staff Survey, the CQC report, pulse surveys, local engagement sessions and other actions, all identify the need for a more effective approach to communicating and engaging with colleagues across hospital and community settings. The Trust will continue to build on the positive leadership and development programmes in place to support further cohorts of colleagues to develop their potential, share their ideas and innovate, bringing improvements in services for patients. The 'Together We Can' approach will be rolled out more widely to positively support colleagues in achieving the Trust's aims and plans, in addition to a greater emphasis on individual and team recognition and sharing of achievements.

Finally, it is worth noting that there are a significant number of interdependencies between these issues. For example, building on feedback from the CQC, delivering improved performance against the 4-hour access target and strengthening quality governance through our 'Safe and Sound' approach will require effective colleague engagement across hospital and community settings to achieve the quality improvements we aim to achieve.

Fundamental to addressing the issues above is the need to drive positive change within the Trust, across the Rotherham Integrated Care Partnership (ICP) and across the South Yorkshire and Bassetlaw Integrated Care System (ICS).

As an integrated acute and community provider, the Trust also recognises the interdependency on other partners and agencies and the need for wider collaboration to support increasing resilience and sustainability of high quality services for the population it serves. The Trust remains committed to closer integration across the ICP and further collaboration across the ICS, where this is appropriate to further its strategy for the benefit of patients.

Finally, it is important to emphasise the importance of ensuring that clinical and corporate Divisions understand, recognise and embrace the Trust's Operational Plan, and that this is supported by a robust delivery framework to oversee delivery. Colleague engagement is also critical in achieving this aim, therefore plans are in place to continue to build upon the formal (and informal) mechanisms adopted during 2018/19 to communicate the plan, its priorities and the role of teams within the delivery. The aim in 2019/20 is that Divisional leadership becomes stronger in this, building on the corporate-led approach from this year, so that the Divisions engage more effectively with frontline teams, setting expectations, managing risk and valuing the amazing people the organisation is so proud of having working for it in the NHS.

External Environment:

The Trust's vision, mission and values remain unchanged. The vision is to *be an outstanding Trust delivering excellent care at home, in our community and in hospital.* The mission is *to improve the health and wellbeing of the population we serve, building a healthier future together.* The values are: *Ambitious, Caring and Together.* The Trust's aim is to achieve its vision, mission and to live our values in the way that we work every day.

Services are provided in a range of settings, with an emphasis on home, then community, highlighted ahead of hospital, in recognition of the need to encourage health promotion, self-care and early intervention to avoid hospital admission where possible.

2018/19 has also seen the Trust continue to play a leading role in both the South Yorkshire and Bassetlaw (SY&B) Integrated Care System (ICS) as well as the Rotherham Integrated Care Partnership (ICP). The organisation remains fully committed to collaborating with partners across the ICS and pursuing the closer integration of health and social care services across the ICP and both of these approaches feature strongly in the priorities for the coming year.

In order to oversee the delivery of the Rotherham Integrated Health & Social Care Place Plan, governance arrangements are in place and continue to embed, and through 2018/19 a Place Board was established which meets in public on a monthly basis, with progress reports on the jointly agreed workstreams.

Preparation of Accounts and Going Concern

NHS Foundation Trusts are required to prepare their accounts in accordance with the relevant accounting rules, which are set out in the International Financial Reporting Standards (IFRSs) and International Accounting Standards (IASs) as interpreted by Department of Health Group Annual Reporting Manual (GAM).

The requirement to prepare accounts on a going concern basis is set out in IAS 1:
Presentation of Financial Statements which states:
"An entity should prepare its financial statements on a going concern basis, unless:
(a) The entity is being liquidated or has ceased trading; or
(b) The directors have no realistic alternative but to liquidate the entity or to cease trading, in which circumstances the entity may, if appropriate, prepare its financial statements on a basis other than going concern."

"When preparing financial statements, directors should assess whether there are significant doubts about the entity's ability to continue as a going concern"

In addition to the above the Trust is also mindful of table 6.2 of the Government Financial Reporting Manual (FReM), which notes that: *"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."*

To comply with IAS 1 management must, in preparing the annual statement of accounts, undertake an assessment of the Trust's ability to continue as a going concern. In making this assessment, management should take into account all information about the future that is available at the time the judgment is made.

As a minimum, this assessment should cover at least a 12-month period from the date of approval of the accounts, although this period will need to be extended where management is aware of events and related business risks further in the future that may cast doubt on the going concern assumption.

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future, subject to additional central funding being provided by the Department of Health and Social Care to help manage working capital and maintain liquidity. For this reason, and as there is no indication from the regulators that the Trust will cease any part of its trading activities, they will continue to adopt the going concern basis in preparing the accounts.

However, the Trust recognises the challenges ahead including the existence of a material uncertainty in relation to the 2019/20 finances of the Trust, the need to take steps regarding its underlying deficit and to continue to work with partners and stakeholders to improve sustainability. The Trust has a strategic commitment to working with partners to achieve this.

Also, see note 1 of the financial statements and the report from the Audit Committee detailing the significant issues considered by the Committee in relation to the financial statements as required by the Foundation Trust Code of Governance (provision C.3.9) in the Governance and Organisational Structure section of this Annual Report.

Performance Analysis

Development and Performance of the Trust during the Year

It is critical the Trust has an appropriate framework in place to oversee the progress against key milestones and defined outcome measures. It is also important that there is a triangulation of performance across quality, workforce, operations and finance, and there are a number of elements in place to provide this.

One such element is the Trust's Integrated Performance Report (IPR). The IPR is provided on a monthly basis to the Board of Directors as well as specific performance reports going to the relevant committees of the Board. It is structured around the requirements of NHS Improvement's Single Oversight Framework to provide appropriate support in monitoring compliance with key standards/performance indicators. The IPR and its supporting monthly reports relating to clinical quality, operational performance, workforce and finance, provide the Board of Directors with a holistic view of the Trust's performance, explaining the linkages between each of the different pieces of information.

To support the IPR, the Board also uses 'soft' performance measurement feedback such as visits to service areas, patient feedback and other external stakeholder views and reports. The IPR is reviewed annually to reflect the requirements for each new financial year and ensure that any updated or 'local' requirements are reflected appropriately.

Each Division participates in an Executive Director-led monthly performance review at which the local divisional integrated performance report, structured around the Division's relevant (hard and soft) outcome measures, is reviewed.

Clinical teams have timely, relevant information to inform them of progress against their performance objectives, with feedback steps in place to see that data quality issues are addressed. In addition, the Trust has developed its own quality kite mark which ensures that the level of assurance for each key quality indicator, represented on the IPR is clear, with actions being taken to achieve future compliance and provide the assurance across all indicators.

In addition, building on progress made in 2017/18. Service Line Management (SLM) was rolled out to 10 service lines during 2018/19.

The regular review of key performance indicators (KPIs) described above as well as quarterly reviews of the corporate risk register and Board Assurance Framework at Board committees ensures a dynamic and responsive link between KPIs, risk and uncertainty.

Emergency Access

The Rotherham NHS Foundation Trust did not meet the national standard of 95% of patients being admitted, transferred or discharged within 4 hours of their arrival at the Urgent and Emergency Care Centre. The Trust achieved an end position of 85.7% and regrettably, 2 patients waited for longer than 12 hours following a decision to admit into the hospital, compared to 3 such waits in 2017/18.

Whilst the Trust was not alone in being unable to achieve this access standard and the national picture was one where performance remained significantly below the 95% standard, during 2018/19 the organisation experienced difficulties which were largely related to seasonal variations in activity and workforce, with significant process transformation work taking place during the year across medicine and the Urgent and Emergency Care Centre (UECC).

To bring context to this, the previous year had seen new teams come together from secondary care and primary care and a significantly increased department in terms of layout and size. All of this meant a period of 'bedding-in' which took longer than originally anticipated. In addition, as stated previously, the Urgent and Emergency service was rated as 'inadequate' by the CQC in the recent inspection. However, significant actions have, and continue to be taken, to ensure improvements are made and sustained to improve the safety and quality of care for our patients.

Both Trust and system-wide plans involving work undertaken with partners are ongoing to deliver change in a sustained process through to year end, and work continues on developing higher levels of performance for patients during 2019/20.

The organisation's journey of development this year has been to continue to embed effective ward rounds and discharge planning by ward teams with the development and roll out of discharge coordinators in medical wards. This work was linked to the development of the Integrated Discharge Team with staff from the Trust and Rotherham Metropolitan Borough Council (RMBC) coming together to form a single point of access for all complex discharges.

Through 2019/20 there will be a continued focus on the importance of improving flow through the medical wards and Acute Medical Unit to support the UECC. The tools used will be strengthened and oversight of the effective use of these tools will assist in this endeavour. This includes continued attention on identifying planned discharges, increasing the proportion of morning discharges and standardising the number of discharges across all seven days of the week.

In response to the increased demands placed on the health service over the winter period, the Trust led the development of a system-wide Winter Plan. This consisted of detailed modelling of the anticipated demand that would be placed upon the acute and community services and the actions that needed to be taken to meet this demand.

All partners across the borough were engaged with the plan and contributed to specific actions. This resulted in an additional, flexible 12 to 29 beds being opened within the hospital site as well as additional beds being provided by the Clinical Commissioning Group (CCG) within the nursing home sector. The Trust's elective care activity was also reduced during the busiest periods for emergency admissions.

The Trust placed significant focus on the challenges posed by winter and colleagues worked closely with partner organisations in particular to improve the quality and timeliness of transfer of patients from acute settings once they were medically fit to do so. However, as described above, despite winter planning, the failure to sufficiently mitigate acute winter pressures, contributed to the underperformance in the four-hour access standard in quarter 4.

The Rotherham NHS Foundation Trust continues to work closely with health and social care partners in Rotherham to reduce avoidable hospital admissions and avoid unnecessarily prolonged hospital stays throughout the year.

18 Week Referral to Treatment Waiting Times

During 2018/19 the 18-week Referral to Treatment performance indicator was consistently achieved. As for 2017/18, the Trust remained one of the strongest performers in the country against this standard during 2018/19 remaining above the 92% national target throughout the year. However, workforce pressures continue to be monitored and actions taken to mitigate risks, to ensure that this positive performance is sustained during 2019/20.

Cancer Waiting Times

Timely management of those patients referred onto the cancer pathway is an important focus for the Trust. The organisation has traditionally performed well against the cancer standards in previous years and is continuing to drive performance in 2 week waits and breast screening. Across 2018/19 the organisation met the national standard for patients being treated within 31 days of diagnosis.

However, during the last 12 months the Trust was compliant in Quarter 2 with the 62-day standard of patients being treated following urgent referral from their GP. This was due to a number of factors which included a significant increase in referrals into the Trust coupled with workforce challenges in a number of key areas. As would be expected for such a priority group of patients, recovery plans were put in place and enhanced oversight provided to ensure an improvement in performance. Whilst the Trust was not able to sustain this performance for 2018/19, a return to compliance with the standards is anticipated in 2019/20.

An average of 93% of the suspected cancer referrals the Trust receives a month are confirmed to not have cancer. During the year the Trust began monitoring performance against a 28-day cancer diagnosis standard, due for national implementation in April 2020. Introducing the monitoring of this standard, which requires patients to be given a confirmed diagnosis within 28 days of referral, has helped identify opportunities for faster cancer pathways and ensure more of the 93% of patients without cancer receive this confirmed diagnosis much faster.

Diagnostic Waiting Times

The performance average for 2018/19 indicates that 0.49% of patients waited no longer than six weeks for their diagnostic test. The national standard requires that no more than 1% of patients should wait longer than six weeks and therefore this was a positive achievement for the teams involved in ensuring the timeliness of these tests.

Unfortunately, during Quarter 3, diagnostic performance within the sleep studies service saw an increase in referrals and staffing shortages. However, as described above, this has been addressed and performance should be sustained throughout 2019/20.

Other Performance Indicators

In terms of the Delayed Transfers of Care indicator, the Trust remained well within the national thresholds and finished the year reporting strong performance.

The Trust's overall Length of Stay for inpatients was within the top 10 of providers nationally and the Trust saw the maintenance of complaint response times from a relatively weak position in 2017/18 to achievement of 90-100% of complaints being responded to within the agreed time frame during 2018/19.

Community services continue to see increased activity across adult and children's services. This has been particularly the case for Urgent Care, with an increase in activity of 18% and reflects the ongoing drive to provide care closer to home and away from the acute hospital setting.

Despite the pressures this increased demand brings, community teams continue to respond positively, and in a number of areas have implemented new ways of working. Within Adult services, this has been through separating the planned, routine activity from the urgent response demand, which has allowed teams to focus on providing the day-to-day care patients need, whilst also having dedicated teams to support patients who require an urgent, emergency response. As part of this development, the Care Coordination Centre and Integrated Rapid Response teams have been co-located to provide a more integrated, joined-up approach.

Within Children's services, the teams continue to work with partners and on the implementation of the new 0-19 service model, and the development of new roles to support this. A significant amount of focus has also been put into the Looked After Children service and working closely with Rotherham Metropolitan Borough Council on developing new approaches in order to deal with the changing demand that is being experienced across the Borough.

Harm-Free Care performance remained good during the year, and in terms of Hospital Acquired Infections, whilst there was one case of MRSA, the numbers of CDifficile cases were at a record low with 8 cases during 2018/19 against a trajectory of 25 cases.

Mortality performance against HSMR (Hospital Standardised Mortality Ratio) was an area of focus for much of the year, and following a significant amount of work, improvements were seen with performance in January 2019 at 102 (against a standard of 100). This will remain an area of focus for 2019/20 to ensure that such performance is sustained.

Financial Performance

The Trust did achieve the financial plan in 2018/19, which resulted in an audited year-end position of a £19.9M deficit which is £0.4m favourable to the financial plan.

The Trust set a Cost Improvement Programme (CIP) target of £9.7M and achieved £9.8M in year (101% of the target). This equated to £10.5M full year effect.

Social, Community and Anti-Bribery Issues

In 2018/19 The Rotherham NHS Foundation Trust was highlighted and recognised by a number of local and national organisations for its work across Rotherham.

This included:

- Two teams from the Trust: Rotherham Dietetic-Led Nutrition Prescribing and Occupational Therapy Single Point of Access, were shortlisted in the 2018 HSJ Value Awards
- Three community nurses were awarded the prestigious title of 'Queen's Nurse' by the Queen's Nursing Institute for their ongoing commitment to nursing
- Becoming the first Trust in the country to receive the Gold Medal in the RoSPA[5] Occupational Health and Safety Awards, recognising five consecutive years of receiving the Gold Award for its commitment to health and safety
- Five apprentices were recognised at local and national award schemes. Three won awards as part of the Rotherham Advertiser Apprenticeship Awards whilst two apprentices represented the Trust at the World Skills UK competition, with one receiving a silver medal in the finals.

The Trust's Chief Executive and Director of Finance are responsible for ensuring adherence to the NHS Counter Fraud Authority (NHSCFA) Anti-Crime Strategy for countering fraud, bribery and corruption. The Trust is obliged to safeguard NHS funds and resources through compliance with 23 standards for countering fraud, bribery and corruption.

The Trust has a nominated Counter Fraud Specialist (CFS) in place provided by 360 Assurance. The CFS is responsible for carrying out a range of activities in compliance with the above standards that are overseen by the Director of Finance and the Audit Committee. The CFS undertakes fraud, bribery and corruption risk assessments throughout the year which are used to inform the annual programme of activities that are undertaken.

During the 2018/19, counter fraud activity focussed on activities to ensure compliance with NHSCFA standards and to address areas of heightened risk for example cybercrime, bank and agency staff, declarations of interest and overseas visitors.

The Trust has a Fraud, Bribery and Corruption policy which outlines the Trust's zero tolerance approach to fraud, bribery and corruption and sends a clear message that all available sanctions will be pursued in respect of those caught committing offences against the Trust. Clear reporting procedures are included within the policy and the policy is signposted to staff within all training delivered by the CFS.

Where fraud is identified or reported, it is formally investigated in accordance with the Trust's Fraud, Bribery and Corruption policy. During 2018/19, 11 referrals of suspected fraud, bribery or corruption were made to the CFS, demonstrating a good awareness and understanding of the Fraud, Bribery and Corruption policy.

Within the entrance to Rotherham Hospital there is a 'Community Corner' which is an area for health enquiries and promotions. Community Corner hosted 260 promotions from local and national

[5] The Royal Society for the Prevention of Accidents

organisations such as South Yorkshire Police, Freedom to Speak Up Guardians, as well as a range of health awareness events.

The Rotherham Hospital and Community Charity ('the Charity') aims to enhance the experience that patients, their families and carers receive from the Trust, in our community and at Rotherham Hospital.

The Charity continued to work with fundraisers, volunteers, local business, schools and organisations to raise money to fund equipment, resources, facilities and projects which provided the added extras the Trust is unable to afford.

Colleagues and Trust volunteers continued to support the Charity enthusiastically in 2018/19. The Charity also received more support than ever before from Rotherham's schools, companies and organisations.

In order to improve engagement with local schools, companies and organisations and to gain support for events and fundraising, the Charity made valuable corporate sponsorship links in the community. In May 2018, the donation of food from Asda enabled the Trust to enjoy participating in the NHS 7Tea Party celebrations, which raised over £400.

Corporate sponsorship links also included the donation of selection boxes and treats during the festive season from Rotherham Lions, Rotherham United Football Club, Rotherham College and Brinsworth Manor Junior School. Homebase Rotherham donated real Christmas trees. A host of toys were also donated by Asda, Tesco, Smyths Toys at Parkgate, St Bernard's Catholic High School and the Hallam FM Mission Christmas Appeal.

The Mayor of Rotherham, Councillor Alan Buckley, supported the Charity's Dr Ted children's appeal during his mayoral year.

The Charity funded a number of resources and pieces of equipment during 2018/19, including:

- £11,000 for a birthing bed for the Midwifery Department. The specialist bed enhances the experience and comfort of mothers who use the Trust's birthing pool. It allows colleagues to transfer women to and from the pool smoothly and provides more supportive positions during labour.
- The Charity teamed up with the Thurcroft Cancer Fund to provide the Trust's Clinical Radiology Team with an i-STAT Alinity System, worth £6,500. The equipment means that only a few drops of blood are needed from patients at their bedside, with results available in minutes. Radiology experts are then able to proceed with potentially life-saving imaging testing, such as MRI or CT scans more quickly because patients do not need to attend a separate blood test appointment.
- Just over £6,000 funding was provided by the Charity for the Active for Health programme – a pilot project offering physical activity designed to support and encourage cancer patients to become more physically active. Thanks to the Charity, patients are offered 12 weeks of free access to the programme.
- All five bays on Ward A2 at Rotherham Hospital were furnished with a range of dementia-friendly calendars to help patients feel less anxious during their hospital stay. The calendars, which change daily to show the day, date, season and weather, cost just over £300.

Fundraisers continued to raise money for the Charity throughout the year by organising events. These included a sponsored walk in June 2018 which raised over £200 for the Labour Ward, and which enabled the Charity to purchase a 'cold cot'.

In August 2018, the Charity received £11,500 from a team of fundraisers to help raise funds for the Purple Butterfly Appeal.

In September 2018, two friends walked the route of the Camino Portuguese from Valencia in Portugal to Santiago de Compostela in Spain. The friends raised over £1,000 for the Purple Butterfly Appeal.

A daring mum and her son scaled the heights of Snowdon to also raise money for the Charity. They spent just over nine hours climbing the 3,560ft mountain raising just over £600.

Human Rights and Equality Reporting

A review of the Trust's approach to equality, across all the protected interest groups, and respecting basic human rights, was undertaken during the year and the outputs from this review shaped the work plan and renewed membership of the Diversity and Inclusion Group in 2018/19. The proposal set out to strengthen and deepen the equality, diversity and inclusion agenda and build on the previous Equality Schemes and action plans.

Workforce Race Equality Standard (WRES), Gender Pay Gap (GPG) reporting data, Public Sector Equality Duty (PSED) data, staff survey data, data from NHS jobs and census data all provide assurance in this area.

The organisation will be publishing its first report under the new Workforce Disability Equality Standard (WDES) in August 2019. Implementation of the WDES will further strengthen the Trust's approach to equality, ensuring that the organisation remains a fully inclusive one offering opportunities to all colleagues and the community as a whole, and scrutinising its practices to inform improvement work. In order to prepare for the WDES, work has been undertaken during 2018/19 to encourage colleagues to disclose disabilities, as disclosure rates in this area have been historically low.

During 2018/19, the Trust has seen improvements in WRES metrics, and a slight narrowing of the Gender Pay Gap, alongside an improvement in the equality and diversity theme data in the National Staff Survey.

Alongside WRES and WDES, the Trust continues to use the Equality and Diversity Systems (EDS2) to assist in discussions with local partners including local populations and review and improve performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, the GPG, the WDES and the WRES, the Trust is able to deliver on the Public Sector Equality Duty. During 2019/20, the Trust anticipates the introduction of EDS3, which will support further development of the organisation's approach to equality, diversity and inclusion.

All recruitment campaigns are managed in line with the Trust's policy, which has been impact assessed and identifies no immediate issues. The Trust is a Level 2 Disability Confident Employer and operates a guaranteed interview scheme for disabled applicants.

Equality and diversity training is mandatory for all colleagues and covers all protected groups. During the last two financial years, the Trust has trained a number of staff to act as Mental Health Champions. These Champions are able to provide support and signposting to colleagues who are experiencing mental ill-health and work to reduce the stigma around mental illness by encouraging open conversations.

During 2018/19, the Trust re-launched its Diversity and Inclusion Steering Group, with a refreshed membership and revised Terms of Reference. The Steering Group reports into the Trust's Operational Workforce Group (OWG) and has strong links with the Yorkshire and the Humber Equality and Diversity Leads Network.

The Trust is currently progressing the development and implementation of disability passports via the Diversity and Inclusion Steering Group. These passports are designed to further improve the support that is provided to disabled employees by working with individuals to fully understand their needs. Proposals to include black, Asian, and minority ethnic colleagues on interview panels for senior roles are also being developed.

Overseas Operations

The Trust does not have any overseas operations.

Any Important Events since the End of the Financial Year Affecting the Foundation Trust

There are no important events since the end of the 2018/19 financial year to report.

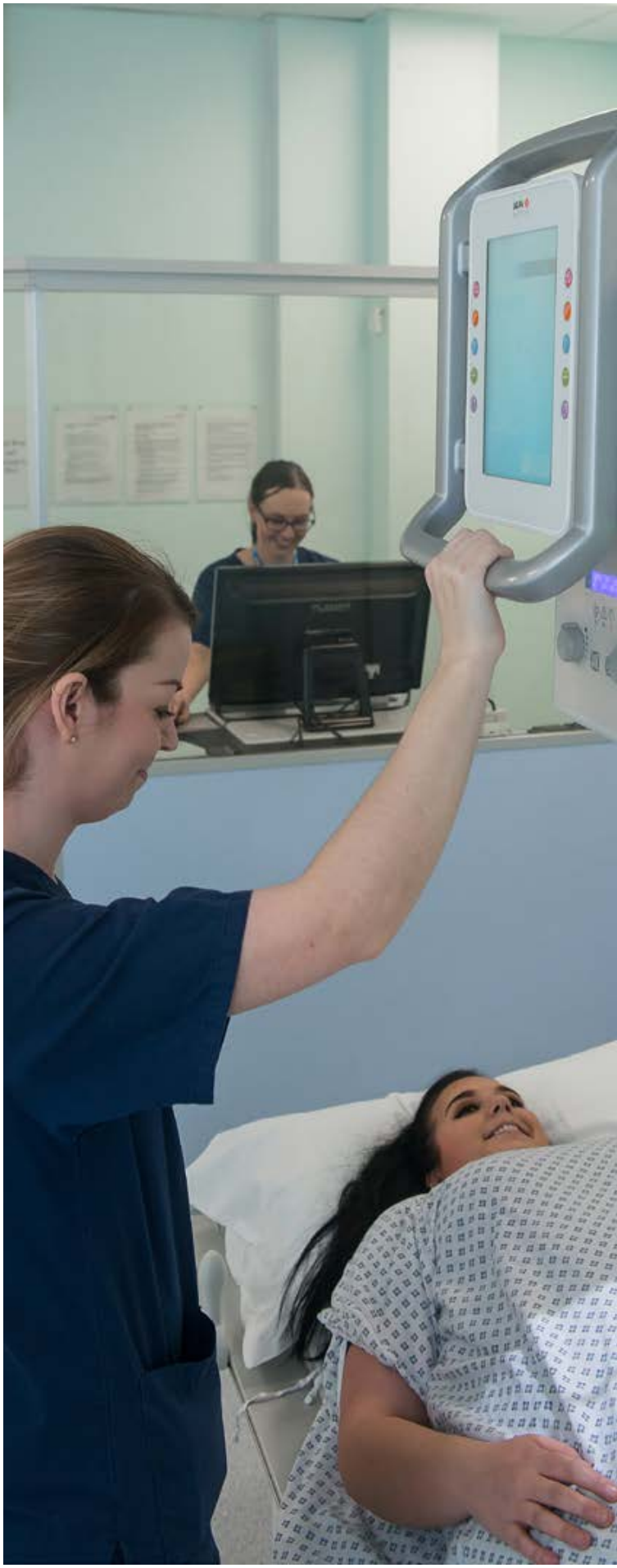
Progress against the Sustainable Development Plan

Introduction

As an NHS organisation, and as a spender of public funds, the Trust has an obligation to work in a way that has a positive effect on the communities it serves. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets it is possible to improve health both in the immediate and long term even in the context of the rising cost of natural resources. Demonstrating that consideration is given to the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

The Rotherham NHS Foundation Trust is committed to demonstrating leadership in sustainability and has produced a Sustainable Development Management Plan (SDMP) in order to set out the route to delivering a sustainable healthcare system that works within the available environmental, financial and social resources, protecting and improving health now and for future generations.

The SDMP outlines the Trust's vision and priorities for sustainable development, and ensures that it meets all applicable legislative requirements whilst embedding the principles of sustainable development for the benefit of colleagues, patients and the local community in Rotherham.




Urgent & Emergency Care Centre
Rotherham
EMERGENCY

The SDMP will embed opportunities to:

- Reduce environmental impact, associated carbon emissions and benefit from a healthier environment
- Establish local level partnerships and collaboration in order to help the local community flourish and to improve the resilience of services and the built environment in response to severe environmental and climatic changes
- Embed sustainable models of care and support the local community to be well connected, healthy, resilient, independent and manage their lives in a positive way

Policies

In order to embed sustainability within the business it is important to explain where sustainability features within the Trust's process and procedures

Area	Is sustainability considered?
Travel	Yes
Business Cases	No
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The Board of Directors approved the Trust's SDMP in 2017 so the plans for a sustainable future are now becoming well known within the organisation and are clearly laid out.

One of the ways in which the impact of the organisation on corporate social responsibility is measured is through the use of the new Sustainable Development Assessment Tool (SDAT). This is a new tool which the Trust will be working through in the forthcoming period. As an organisation that acknowledges its responsibility towards creating a sustainable future, the running of awareness campaigns that promote the benefits of sustainability to colleagues, aids in achievement of this goal.

Climate change brings new challenges to the business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has identified the need for the development of a Board-approved plan for future climate change risks affecting our area.

The social and environmental impacts for the Trust have not been assessed.

The organisation is not required to issue a statement on Modern Slavery.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for the organisation as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

No strategic partnerships are currently established. For commissioned services the sustainability comparator for local CCGs is presented below:

Organisation Name	SDMP	GCC	SD Reporting score
No commissioners identified			

More information on these measures is available here: www.sduhealth.org.uk/policystrategy/reporting/organisational-summaries.aspx

Performance

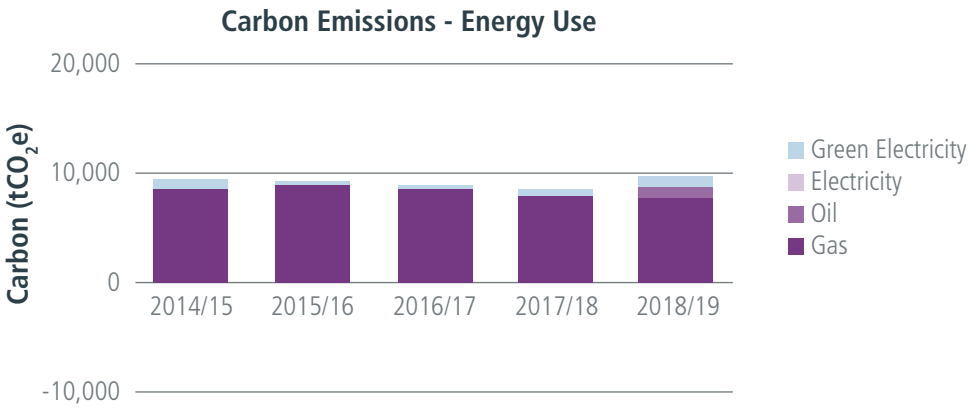
Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore, in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

Context info	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Floor Space (m^2)	69,719	69,812	70,072	70,072	79,927	80,003
Number of Staff	4,175	4,243	4,301	4,367	4,415	4,640

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. The Trust has supported this ambition as follows:

Energy

The Trust spent £1,537,401 on energy in 2018/19 which is a £44,547 (2.98%) increase on energy spend compared to the previous year.



Resource		2014/15	2015/16	2016/17	2017/18	2018/19*
Gas	Use (kWh)	36,553,450	40,577, 691	37,312,553	36,277,907	36,483,275
	tCO_2e	7,669	8,492	6,853	6,668	6,707
Oil	Use (kWh)	0	0	194,400	0	590,000
	tCO_2e	0	0	618	0	1,753
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	3,135,389	423,606	708,498	778,945	720,732
	tCO_2e	1,828	212	354	284	221
Green Electricity	Use (kWh)	348,377	1,037,104	2,306,501	4,412,514	3,486,692
	tCO_2e	0	378	841	1609	1,071
Total Energy CO_2e		10,077	9,024	8,570	8,561	10,336
Total Energy Spend		£ 1,462,708	£ 1,073,928	£1,087,629	£1,492,854	£1,537,401

*NB up to end of December 2018, figures extrapolated for full year to end of March 2019

Some of the figures re-stated in this table for the periods 2014/15 to 2017/18 have changed from those published in last year's Annual Report. The change in some of the figures is due to using averages of previous year's energy data for the quarter in question. Therefore to provide a reasonable assumption for the full12 month period, these values were used for quarter 4 in each report. As this is normally the winter quarter the assumptions are often not accurate, this is largely dependent on the type of weather experienced. Accurate usage data is available during the early part of quarter 1 the following year.

Performance
The amount of gas and electricity that is consumed at Rotherham Hospital is totally dependent upon the performance of its Combined Heat and Power plant (CHP). If the CHP achieves its target of a 90% availability then grid electricity will reduce pro rata and the waste heat will be utilised to supplement the heating and hot water systems, resulting in less gas being bought in from the supplier.

However, over the last 12 months the CHP has suffered several stoppages which resulted in it being unavailable for long periods which has impacted upon both the electricity and gas consumption on site. This is not as damaging as the previous year when the CHP was not available for 14 weeks while it underwent its 60,000 hours' refurbishment. However, the downtime still had an adverse effect upon the finances of the Trust as it resulted in more electricity being purchased from the supply grid, as well as more gas to provide heating and hot water from the site boilers. The CHP would normally generate approximately 65% of the hospital base load electricity and supplement the heating and hot water infrastructure via the waste heat that the CHP engine produces.

Over the past 4 years due to the implementation of energy saving projects and awareness training being rolled out there has been a consistent reduction in energy consumption and, even accounting for increasing tariffs and supply charges the overall spend has remained at a similar level. When taking into consideration the downtime of the CHP and site growth, then there has been a reduction in real terms.

Over the past 3 years there has been very little capital expenditure available to improve the energy performance on site and so the decision has been taken to work with a third party provider to identify and implement energy saving solutions under an Energy Performance Contract (EPC). A partner has been selected to implement this EPC beginning in summer 2019 (subject to Board of Directors' approval). The scheme will be thermally driven resulting in the replacement of 7 Low Temperature Hot Water Boilers, 2 steam raising boilers and a whole raft of other measures including a chilled water ring main, the replacing of over 7,000 light fittings for a more energy efficient option (incorporating smart controls and daylight dimming) and improved building heating controls.

All the projects identified will be funded by the energy savings made and these savings will be guaranteed. Should the targets not be met the shortfall will be made up by the partner. The aim is to replace the Trust's aging infrastructure and to remove the risk from the Trust.

Travel
The organisation recognises that colleague and visitor travel impact greatly upon the local air quality. This is an area that the Trust is actively working upon to reduce vehicle emissions. Air pollution and accidents are a major cause of health issues in the locality, whether that is through respiratory problems or attendance at our new Urgent and Emergency Care Centre on the hospital site which opened in July 2017. It is the aim of the Trust to reduce the number of cars on site and the amount of colleague travel. Business and lease car mileage information is collected on a monthly basis and the resulting carbon emissions calculated. However, over time it has proved difficult to acquire the necessary data and this leads to a certain amount of information being unavailable (see table below).

Performance
A Green Travel Plan has been developed and the Trust is committed to encouraging active and low carbon travel in order to reduce vehicle carbon emissions, reduce the demand for car parking spaces and promote health and well-being. The organisation has a long standing relationship with local bus operators, RMBC and South Yorkshire Passenger Transport Executive to maintain and possibly improve access to Rotherham Hospital by bus. Public transport incentive schemes are popular with colleagues and are aimed at encouraging bus use rather than car use. Cycle to work schemes and car share initiatives are already in place, whilst other initiatives such as the Dr Bike free cycle maintenance and health check have proved very popular with colleagues.

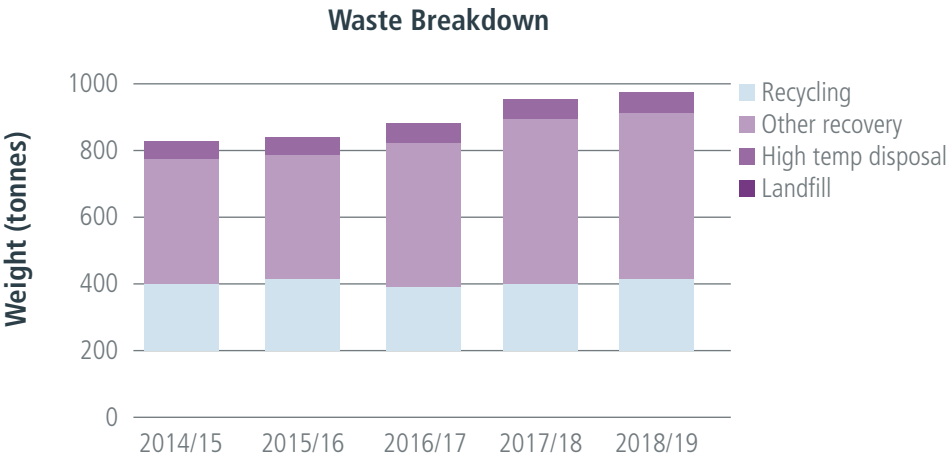
Resource		2014/15	2015/16	2016/17	2017/18	2018/19*
Business travel	miles	942,142	894,015	825,198	732,937	631,575
	tCO_2e	346	265	246	209	169.45
Fleet travel	miles	411,019	403,186	423,531	No data available	No data available
	tCO_2e	124	104	108		
Patient travel	miles	410,333	Data not collected	Data not collected	No data available	No data available
	tCO_2e	137				
Staff travel	miles	161,748	263,356	370,552	483,618	449,484
	tCO_2e	52	68	95	124	114.55

*NB up to end of November 2018. It has not been possible to obtain fuel type of vehicles so the emissions can no longer be calculated going forward.

It is no longer possible to obtain Fleet travel and Patient Transport data.

Waste

Waste		2014/15	2015/16	2016/17	2017/18	2018/19
Recycling	(tonnes)	195.00	216.00	187.00	197.00	210.03
	tCO_2e	4.10	4.32	4.07	4.29	4.57
Other recovery	(tonnes)	574.00	573.00	642.00	700.35	699.83
	tCO_2e	12.05	11.46	14.74	16.08	16.06
High Temp disposal	(tonnes)	64.00	63.00	61.00	67.68	69.08
	tCO_2e	14.08	13.80	15.51	17.21	17.57
Landfill	(tonnes)	0.00	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00	0.00
Total Waste (tonnes)		833.00	852.00	890.00	970.45	978.94
% Recycled or Re-used		23%	25%	21%	20%	21.5%
Total Waste tCO_2e		30.23	29.58	34.33	37.58	38.20



Performance

In line with legislative requirements, none of the waste from the Trust is sent to landfill. Other recovery tonnage has been maintained at the same level as 2017/18 but within this calculation, the offensive waste stream has increased by 12%, 16.80 tonnes, ahead of the KPI set for this of an increase of 2%.

Currently the orange waste stream is expected to increase by 8% on 2017/18 figures this is in the main due to a change of process which reduced 2017/18 orange bag usage. It is expected that a reduction will be seen in 2019/20 reporting.

General Waste has continued to reduce annually this is due to the increased recycling within the Trust, in 2018/19 currently an increase is predicted of 6%, the KPI has therefore not been met of a reduction of 1%.

Commentary

Plastic recycling continues to work well and the recycling tonnages have been maintained on 2017/18 figures.

There has been a further addition to the 'Recycling Family' with 'Lucy B' – an acronym for 'Let Us Crush Your Bottles'. Lucy B is our character for the plastic bottle machines that were implemented early in 2018. The machines are working well and reduce down the plastic volume in the bins. The Trust is currently reviewing the introduction of a crusher within the waste area which will further reduce the volume of the plastic bottles and perpetuate savings by the reduction of the number of bins and collections required.

The Trust is exploring the benefits of implementing two 'Big Belly' compactor bins within the hospital grounds which could reduce the number of empties required of
bins, it could also reduce the number of bins required.

In line with GDPR regulations, shredding on site commenced in early 2019, to ensure the Trust is fully compliant. This will result in a saving on carbon footprint and reduce down the storage time for confidential waste within the Trust's waste area.

Finite resource use - Water

Water		2014/15	2015/16	2016/17	2017/18	2018/19*
Water	Use (m^3)	104,971	97,450	90,224	104,822	84,257
	tCO_2e	42	34	31	36	29
Sewage	Disposal (m^3)	83,977	77,966	92,085	94,340	86,791
	tCO_2e	59	55	65	67	61

*NB up to end of December 2018, figures extrapolated for full year to March 2019

Performance

Due to diligent use and monitoring, the water usage has remained steady and even allowing for site shrinkage, there has been a reduction in real terms

Commentary

Due to diligent monitoring of usage habits and colleague awareness it has been possible to slightly reduce water / sewage disposal wastage. A colleague communication aimed at reporting dripping taps was successful and resulted in noticeable savings.

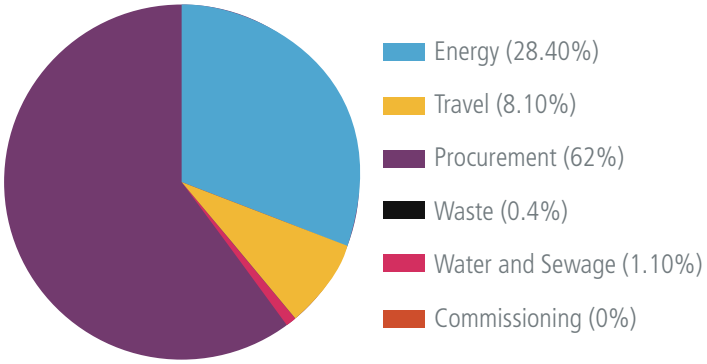
Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC (Estates Return Information Collection) returns as its data source. However, this does not reflect the organisation's entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx

Resulting in an estimated total carbon footprint of 3,634 tonnes of carbon dioxide equivalent emissions (tCO_2e), the Trust's carbon intensity per pound is 0 grams of carbon dioxide equivalent emissions per pound of operating expenditure ($gCO_2e/£$). Average emissions for service mix is 190 grams per pound.

Category	% CO_2e
Energy	28.4%
Waste	0.4%
Travel	8.1%
Water & Sewage	1.1%
Procurement	62%
Commissioning	0%

Proportions of Carbon Footprint



Modelled trajectory

In line with the NHS commitment to reduce its carbon footprint by 28% by 2020 the Trust is able to report the following progress:

Electricity - reduce electricity consumption by 10% by 2018 against a 2010 baseline **[achieved]**.

Gas - reduce gas consumption by 10% by 2018 against a 2010 baseline **[achieved]**.

Water - reduce water consumption by 15% against a 2008 baseline by 2020 **[now amended due to commissioning of the UECC, however on target]**.

Emissions - reduce building energy related greenhouse gas emissions by 10% by 2015 against a 2007 baseline [achieved]; and by 20% by 2020 against a 2008 baseline **[on target]**.

Adaptation

Events such as heat waves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that the Trust's services continue to meet the needs of the local population during such events a number of policies and protocols have been developed and implemented in partnership with other local agencies.

The Trust, as part of its operational business planning, updates its heat wave plan and winter plan annually to ensure it is able to maintain its operational services during severe weather disruption and projected increases in the demand for health care. This requires the Trust to work closely with partner agencies in ensuring it is able to fulfil its obligations in providing healthcare services. The Trust also carried out business impact assessments for all its services to ensure that they are able to respond to situations as and when they arise.

Performance Report signed by the Chief Executive in her role as Accounting Officer:

Louise Barnett
Chief Executive
22 May 2019

Quality Report 2018/19

Contents


NHS
The Rotherham
NHS Foundation Trust
NURSES' DAY
12 May
Join the UK's
BIGGEST
Nursing Party
I love being a student midwife because
I like to empower + Advocate
for women during
a time the may feel most vulnerable

Part One: Statement on Quality from the Chief Executive

In what has been another challenging year for NHS providers across the country, organisations like ours have continued to collaborate with partner organisations to transform services. As demand grows and the needs of patients change, it has never been more important to adapt to deliver and sustain high quality, sustainable services.

This Quality Report outlines the progress we continue to make, as well as the areas where we need to improve, as we strive to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital.

In 2018/19 we set nine Quality Priorities for the year which set out our biggest priorities of how we will improve the quality of care and services for our patients. These priorities are determined by stakeholder engagement and analysis of performance and data from the previous 12 months. This year's priorities include a continuation of work commenced on mortality, deteriorating patient and medicines management, alongside new priorities relating to transition of services to support children into adulthood and improving medical staff mandatory training compliance. We are committed to ensuring all of our patients have a positive experience with all of our hospital and community services and that they get the care they need, when and where they need it.

As part of our ongoing capital investment programme, a major scheme of reconfiguration and refurbishment works have taken place across the hospital site during the year. A lot of this work has focussed on our assessment and ambulatory facilities which support our urgent and emergency pathways. In February, one of the biggest aspects of the scheme, the Acute Surgical Unit, opened its doors to patients. These new and improved facilities are already making a really positive difference to the quality of our services and the overall experience of our patients.

It is important that we regularly seek the views of our patients, colleagues and members of the public so we can continue on our journey of improvement. There are a number of ways in which people can provide their feedback in both formal and informal ways.

The national Friends and Family Test continues to be one of the core ways in which we seek these views about the care our patients receive across all of our services. I am very pleased to be able to share that our results have continued to be extremely positive and above the national average, this is fantastic news.

This year our teams have also been working hard to maintain the progress we made in 2017/18 which saw almost 100% of complaints being responded to within 30 days. Whilst there have been some challenging periods during the year, we achieved 81.36% in 2018/19. (However, it should be noted that this does not include the complaints closed within agreed timescales of greater than 30 days in which we achieved 90.45%)

In September and October 2018, the Care Quality Commission (CQC) undertook a core service inspection at the Trust. This inspection covered five of the Trust's core services including:

- Urgent and Emergency Services
- Medical Care
- Maternity
- Acute services for Children and Young People
- Community services for Children and Young People

In the subsequent inspection report, published in January 2019, the overall rating for the Trust remained at 'requires improvement' with a 'good' rating for caring and responsive. However, the Trust was rated as 'inadequate' for Urgent and Emergency Services.

Since then, a significant amount of focussed work to drive quality improvements for our patients has been undertaken and progress continues to be made.

Throughout the year, our performance against our key target areas has overall been positive, however we recognise in a number of key areas, further progress is required. We are consistently among the best performing Trusts in the country for seeing and treating patients within 18-weeks and provide timely diagnostics. Despite a significant effort from our teams, we have continued to see sustained challenge in relation to the four-hour emergency access target. As outlined above, there is a significant amount of focused improvement work happening in our Urgent and Emergency Care Centre to ensure that we see improved performance and a better patient experience in 2019/20.

I would like to thank all of our colleagues, volunteers and governors for their continued hard work within the Trust. This is in addition to the ongoing support from our partner organisations, patients and members of the public as we all work together to implement sustained quality improvements for the population we serve. I declare that, to the best of my knowledge, the information in this document is accurate.

Louise Barnett
Chief Executive
22 May 2019

Part Two: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement during 2019/20

Our vision is to be an outstanding Trust, delivering excellent care at home, in our community and in hospital. To achieve this, every colleague and every team is expected to be involved in quality improvement seeing it as part of everyday business.

To embed this culture of quality improvement, the Trust creates conditions through its quality governance structures and processes to listen to and learn from the views of patients, their families, carers and colleagues. Above all, this means being open and honest even when something goes wrong.

The Trust ensures that it keeps up to date with any changes to Quality Report (Account) requirements (Chapter 2 of the Health Act 2009) through notifications from NHS Improvement and other sources. These are reviewed by those leading on developing the report where required, and the implementation of the actions are monitored by the Clinical Governance Committee.

For 2019/20, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process including a public 'showcase' where colleagues, governors, patients and members of public were able to comment on the draft proposals and shape how these priorities were delivered, along with using the findings from the recent Care Quality Commission inspection.

Delivering continuous improvement is the responsibility of all colleagues. Clinical Trust services are delivered through our five Clinical Divisions, each ultimately accountable to the Board of Directors for its contribution to the performance of the Trust as a whole. Each Division is led by a General Manager with support from a Divisional Director (a Senior Clinician), a Head of Nursing, and Finance and Human Resources Business Partners. They are responsible for maintaining the clinical governance structures that keep an overview of patient safety, patient experience, clinical effectiveness and quality of services in every clinical area and department.

Delivering Quality Improvement is a continuous process. Each year provides an opportunity to reflect on success and continuing challenges but the Trust understands that achieving and sustaining improvement requires a long-term commitment. This year's priorities therefore reflect a mix of previous areas of focus where further quality improvement are needed and additional areas identified where improvements are required.

The quality priorities for 2019/20 are:

Patient Safety

- Increase Medication Safety
- Improve the treatment of the Deteriorating patient
- Improve mandatory training compliance for medical staff

Patient Experience

- Improve End of life recognition
- Improve patient discharge
- Enhance patient feedback and public engagement

Clinical Effectiveness

- Improving the experience of patients transitioning from children to adult services
- Improve Mortality Reviews
- Improve policy and National Institute for Health and Care Excellence (NICE) guidance compliance

Domain: Patient Experience

Increase Medication Safety

Executive Lead: Medical Director
Operational Lead: Chief Pharmacist

Current position and why is it important?
Medicines optimisation is a strategic issue fundamental to the way that hospitals work and to the quality of patient care provided. The consequences of failing to deliver an effective system are significant and include: exposure of patients to unnecessary risk and harm; failure of patients to get the benefits from the medicines they are prescribed; whole system inefficiency; unnecessary expenditure and other avoidable costs; poor patient experience; and loss of reputation.

Several opportunities for improvement in governance and performance exist within the Trust with respect to medicines use. There have been some positive developments but further significant change and action is required to deliver the level of care that our patients need.

Medication Incidents	2017	2018
Medication	1,133	1,106

A fundamental requirement is to have a safe and effective system for managing medicines to ensure that all patients receive the medicines that they need, when the need them and irrespective of their location within the Trust. Medicines are complex so it should be as easy as possible for staff to do the right thing, each and every time.

The Trust wants patients to get the best out of their treatment, ensuring that they receive the information, help and support that they need and are given real input into the decisions made about the medicines they receive and the services used to provide them.

The aim and objective(s) (including the measures/metrics)
To increase the proportion of medication signed for and documented & increase the proportion of patients who receive medication in a timely & appropriate manner on discharge. This is a continued priority from 2018/19.

1) Reduce inappropriate medication omissions by 10% (9% in 2018/19)
2) Reduce critical medication omissions by 20% (11% in 2018/19)
3) Increase the appropriate prescribing and administration of antibiotics within the first hour by 10% (59.7% for the Emergency Department and 70.10% for Acute Inpatients in Quarter Four for the treatment of patients that have been identified as having sepsis)

The planned activity to achieve this

1) Roll out of Electronic Prescribing and Medicines Administration (EPMA) system
2) Undertake a review of medicines management training including Training Needs Analysis
3) Reduce the time the drug charts are off the ward
4) Undertake a pharmacy establishment review and the provision of pharmacy support to clinical areas.

How will progress be monitored and reported?

Ongoing progress reports through the Medication Safety Group which reports to the Patient Safety Group which ultimately reports to the Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve the treatment of the Deteriorating patient

Executive Lead: Medical Director
Operational Lead: Associate Medical Director for Patient Safety

Current position and why is it important?
Whilst significant improvements have been made in recognising and responding to the deteriorating patient, particularly around patients with sepsis, this remains an ongoing theme highlighted through Serious Incidents, Inquests and other quality matrices, such as complaints. It is therefore imperative that the Trust continues to give particular focus to this theme in order to improve clinical outcomes to patients and to reduce our mortality indicators.

This is a continued priority from 2018/19.

The aim and objective(s) (including the measures/metrics)
To improve the identification and treatment of deteriorating patients
1) Reduce the number of Serious Incidents relating to deteriorating patients (19 in 2018/19)
2) Reduce the Trusts Hospital Standardised Mortality Ratio (HSMR) to below 100

The planned activity to achieve this
1) Roll out of National Early Warning Score (NEWS) 2 throughout the Trust
2) Implement the Acute Response Team
3) Pilot the Clinical Sister Provision in wards

How will progress be monitored and reported?
Ongoing progress reports through the Deteriorating Patient Group which reports to Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

HSMR (Hospital Standardised Mortality Ratio) Target less than 100

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	123.4	129.2	116.2	105	91	87.4	101.5	122.5	101.2	102.1	114.7	115.2
2018/19	107.5	95.4	95.2	115.3	91.2	98.8	89.5	93.3	109.3	114.9	129.2	n/a

Data Source - Comparative Health Knowledge System (CHKS) Monthly values

Improve mandatory training compliance for medical staff

Executive Lead: Medical Director
Operational Lead: Head of Medical Workforce

Current position and why is it important?
Whilst overall mandatory training compliance across the Trust remains consistently above the national target, mandatory training compliance for medical and dental staff is not. In order to ensure that all of our staff groups are appropriately trained to do their respective roles, particular focus therefore needs to be given to improving the mandatory training compliance of medical and dental staff.

	31st March 2018	31st March 2019
	Compliance %	Compliance %
Core MaST	72.08%	70.84%
Information Governance	90.11%	79.88%

The aim and objective(s) (including the measures/metrics)
Improve clinical practice and maintain statutory requirements for completion of Mandatory and Statutory Training (MAST)

1) Increase mandatory training compliance for medical staff to 85% (with 95% for Information Governance)

This is a new priority for 2019/20.

The planned activity to achieve this
1) Review the mandatory training provision and learning culture
2) Respond to feedback from medical staff regarding access and operability of e-learning mandatory training

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Domain: Patient Experience

Improve End of life Recognition

Executive Lead: Chief Nurse
Operational Lead: Assistant Chief Nurse

Current position and why is it important?
The quality priority implemented in 2018/19 has been focused on a limited number of ward areas. It is important to continue to maintain a high focus on End of Life Care and use of the individualised care plans led by the Specialist Palliative Care Team. We need to sustain and improve leadership of areas across the Trust by providing additional support and training in relation to end of life care.

In 2017/18 there were 79 cardiac arrest calls and 4 had a DNACPR insitu and in 2018/19 there were also 79 cardiac arrest calls and 7 had a DNACPR insitu.

The aim and objective(s) (including the measures/metrics)
Improve the recognition of patients at the end of life. To increase the number of nurses trained in the use of end of life care plans and to increase the number of care plans in place for patients receiving end of life care.

This is a continued priority from 2018/19.

1) Increase positive feedback with regards to patient experience in end of life care
2) Reduce the number of cardiac arrest calls made for patients at the End of Life Care who have a Do Not Attempt Cardio-pulmonary resuscitation (DNACPR) in place.

The planned activity to achieve this
1) Improve training compliance in relation to End of Life Care (baseline to be obtained at end of quarter four)
2) Review the DNACPR policy and process
3) Reenergise and document ceilings of care
4) Implement the amber care bundle
5) Explore the identification of patients at end of life on the Meditech system
6) Introduce a combined end of life care and ceiling of care form.

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve Patient Discharge

Executive Lead: Chief Operating Officer
Operational Lead: Director of Operations

Current position and why is it important?
The NHS Improvement SAFER Patient Flow Bundle (NHS Improvement) is a practical tool to reduce delays for patients in adult inpatient wards. The SAFER Bundle blends five elements of best practice, an action is represented by each letter and when implemented together achieve cumulative benefits. SAFER also works particularly well when used in conjunction with 'Red and Green' bed days approach, which is a visual management system used to reduce internal and external delays. Implementing the principles of SAFER and Red and Green days across the Trust will see benefits of improved clinical outcomes, a reduction in length of stay, along with an improvement in patient flow and safety.

The percentage of patients discharged before noon in 2018/19 was 10.1%.

The aim and objective(s) (including the measures/metrics)
To improve the percentage of patients safely discharged from the Trust by midday on the day of discharge. This is a continued priority from 2018/19.

1) Reduce 0-1 day length of stays from 21% to 20% for 2019/20
2) Increase activity through ACC by 20% from 2382 in 2018/19 to 2858 (2019/20 increase activity by 50 patients per month, 10 patients per week)
3) Increase number of patients discharged before 12 noon, reported at 2018/19 – 10% (2019/20 - 20% and 2020/21 - 30%)

The planned activity to achieve this

1) Introduce post take ward round form
2) Review and refresh the admission clerking for medication booklet
3) Consistently monitor the admission predictor and day to day Predicted Discharge Dates (PDDs)

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Enhance Patient Feedback and Public Engagement

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse

Current position and why is it important?
Patient and Public Involvement and Engagement (PPIE) is a valuable tool to ensure our users are listened to and involved in decisions about the services we provide. Some good examples exist, particularly linked to specific clinical services, but a more consistent and co-ordinated Trust wide approach would be beneficial.

2017-18 In Patient Response Rate - Friends and Family

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Target 40%	56%	63%	60%	70%	60%	51%	58%	46%	43%	51%	49%	47%

2018-19 In Patient Response Rate - Friends and Family

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Target 40%	50%	50%	48%	54%	49%	54%	48%	47%	44%	43%	42%	48%

The aim and objective(s) (including the measures/metrics)
1) Achieve the Friends and Family Test Trust agreed response rate of 40% for all inpatient areas (48% in March 2019 but with 6 individual areas falling below the baseline)
2) Achieve the Friends and Family Test Trust agreed response rate of 10% for UECC (0.4% in March 2019)
3) To increase the number and range of opportunities for patients, carers and members of the public to be consulted with and have an opportunity to inform the decision making process within the Trust.
4) To liaise with local partners to ensure that Trust PPIE utilises existing best practice and can reach wider target audiences.

This is a continued priority from 2018/19.

The planned activity to achieve this
1) Employ an Engagement and Inclusion Officer.
2) To develop a Patient and Public Involvement and Engagement Strategy (PPIE).
3) To undertake a scoping exercise to identify the baseline PPIE position.
4) For Divisional leads to identify and promote PPIE opportunities within their services.
5) To develop a Trust wide process for PPIE events.
6) Implement 'I Want Great Care' to provide more qualitative feedback for medical staff.
7) Introduce online feedback for consultants

How will progress be monitored and reported?
Patient and Public Involvement and Engagement is a standing agenda item on the monthly Patient Experience Group agenda. The Patient Experience Group reports to Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Domain: Clinical Effectiveness

Improving The Effectiveness of the Transition Process from Child to Adult Services

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse

Current position and why is it important?
The experience of transitioning young people into adult services is variable, depending upon the service. Within paediatrics, there are certain agreed principles such as an accompanying adult during appointments, the opportunity for a carer to be resident during admissions and additional support to help navigate healthcare services. This ends once the young person reaches 16 years of age in most cases.

The Trust do not currently collect data showing the number of children transitioning from paediatric to adult services except in Diabetes where there has been an average of 72 transition clinic slots per year for the last two years. Diabetes data covers the 15-19 age group. During Quarter 1, a review will be undertaken to identify the number of children during 19/20 for each of the identified services that are in the 14-19 age range. This will enable these children to have their journey into adult services to be mapped. This data will be reviewed on a quarterly basis to demonstrate impact of interventions.

There are three main areas to consider:

a) Long Term Conditions - Predominantly this relates to Diabetes, Epilepsy and Asthma. As an example, the Diabetes team have made some progress with this but this is not yet meeting national recommendations. Approximately 48% of the diabetes caseload is aged 14-17 years (14-16 year olds account for 22.4% of the caseload and 17-19 year olds account for 26.2%). There is a monthly transition clinic for the over 17's which is a joint consultation with both paediatric and adult Consultants and specialist nurses from both areas. However, the adult specialist nurses have no designated time for this work and its development. The dietician for adult services also attends. There is not the capacity within this service to facilitate transitional clinics for all young people over 14, which is the age that transition should ideally commence. There also needs to be capacity within the paediatric diabetes team to facilitate this.

b) Complex Needs - Work has commenced on establishing links for transitioning young adults with complex needs however there is a significant challenge as there is no reciprocal adult service to transition into. There is also a lack of clarity regarding signposting into services.

c) Other Services - Many young adults have their first or an ad hoc encounter with healthcare, during the 14-19 age range. They may present for a variety of medical/surgical/mental health reasons with variable levels of physical and emotional maturity and vastly differing personal circumstances. There are limited opportunities for care to be delivered in a bespoke, age appropriate environment.

The aim and objective(s) (including the measures/metrics)
The aim is to ensure that as many children as possible can be seamlessly transitioned from child to adult services. The proposed activity to achieve this and anticipated success measurements will vary depending upon the pathway.

a) Where national recommendations are available, a baseline position should be established and The Rotherham NHS Foundation Trust (TRFT) should aim to meet the national recommendations. It is recognised that this may not be possible within one year but a measure of progress made against available recommendations should be recorded.

b) TRFT to develop a similar model to the 'Ready Steady Go' transition programme used in other organisations, which routinely commences for all children with long term conditions at 14 years.

c) The Trust should plan to offer a staged approach to transition at different ages, dependent on wishes and feelings of the young person, appropriate to the underlying healthcare requirement.

d) Metrics/Audit to be developed to monitor the progress for all services that transition into the adult service.

This is a new priority for 2019/20.

The planned activity to achieve this

a) To participate in the NHS Improvement Transition Programme during 2019/20 to access advice and support for the introduction of initiatives to improve transition.

b) To create and embed an action plan covering any initiatives resulting from participation in the national NHSI programme.

c) To include Transition as a key priority on the Children's Trustwide Steering Group Work Plan to ensure Trust wide engagement and support and provide a forum for cross divisional action to be monitored.

d) To look at capacity within both paediatrics and adults to facilitate progressing with this initiative. This may require consideration of a business case for recruitment of a Transition Nurse to work within this important and specific area of work – joint funding from both Paediatric and Adult services.

How will progress be monitored and reported?

a) Baseline data to be obtained, where available to provide a starting metric.

b) National guidance, including any provided through participation in the NHSI Transition programme, to be monitored and measured against.

c) Compliance rates and re-admission rates to be recorded to provide evidence of the impact of interventions.

d) Progress with this improvement priority will be reported through the Children's Trust-wide Steering Group, Divisional Governance Meetings, Clinical Governance Committee and Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve Mortality Reviews

Executive Lead: Medical Director
Operational Lead: Medical Examiner

Current position and why is it important?
It is imperative that all deaths are reviewed and in a timely manner in order to ensure that appropriate learning and opportunities for improvement are identified and actioned. Whilst the Trust has made significant improvements in its Learning from Deaths and its mortality review process, significant challenges remain in ensuring all deaths are reviewed, particularly within the Division of Integrated Medicine. Improvements are also required in how such reviews are captured, with the aim of capturing them all electronically via the Trust's Meditech system.

There were 81 mortality reviews in 2017/18

The aim and objective(s) (including the measures/metrics)
Improve the mortality review process undertaken within the Trust.
1) Increase the mortality reviews undertaken by the Medicine Division by 50% (10 in 2018/19)
2) Increase mortality reviews undertaken within two months of death by 50% (3 (30%) in 2018/19)

This is a new priority for 2019/20.

The planned activity to achieve this
1) Review the mortality policy
2) Improve the mortality review process including introducing the two stage reviews to the mortality review process.
3) Introduce medical examiners
4) Increase compliance using Meditech for reviews.

How will progress be monitored and reported?
Ongoing progress reports through the Mortality Group which reports to Clinical Governance Committee. A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Improve Policy and NICE Guidance Compliance

Executive Lead: Chief Nurse and Medical Director
Operational Lead: Quality Governance, Compliance and Risk Manager and Research, Innovation & Clinical Effectiveness Manager

Current position and why is it important?
The 2017 Care Quality Commission (CQC) inspection identified a concern around staff working to out of date policies. This was confirmed as an issue as part of the preparation for the 2018 CQC Inspection. Whilst improvements have been made with the use of a new intranet site where documents can be located easier, there are still 46% of policies which are out of date. There is therefore a risk that staff could be following out of date processes.

Policies	
2017/18	51.1%
2018/19	54%

NICE guidelines are evidence-based recommendations for health and care in England. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. NICE guidance helps TRFT staff to standardise and clarify care and improve efficiency, productivity, and safety.

NICE Guidance			
Time period	# requests to review	# returned ≤ 28 days	%
2017/18	**497**	**276**	**56%**
Q1	151	86	57%
Q2	118	77	65%
Q3	145	63	43%
Q4	82	49	60%
2018/19	**351**	**176**	**50%**
Q1	112	56	50%
Q2	84	52	62%
Q3	79	38	48%
Q4	79	30	38%

Confirmation that NICE guidance has been reviewed is important as the first step in a process to confirm quality of care and services. Without this confirmation the Trust does not have assurance that current practice is compliant or non-compliant with the current evidence base and unable to make a decision on whether changes in practice are required.

The current standard is that the Clinical Effectiveness Department receives a response to a request for review within 28 days.

The aim and objective(s) (including the measures/metrics)
Improve clinical practice and effectiveness through using up to date polices and complying with relevant NICE Guidance.
1) Increase the number of in date policies by 30% (baseline is 54% of policies in date at 31 March 2019)
2) Increase the number of NICE guidance compliance reviews undertaken in line with agreed timescales by 20% (baseline is 38% responses received in 28 days).

This is a new priority for 2019/20.

The planned activity to achieve this
1) Review the policy management process
2) Review the NICE guidance management process

How will progress be monitored and reported?
A quarterly report will be submitted to the Clinical Governance Committee and then the Quality Assurance Committee reviewing achievement against the measures and required actions to be undertaken.

Keeping our stakeholders Informed
The Trust will continue to share information on progress throughout the year with NHS Rotherham Clinical Commissioning Group and provide a mid-year update to Rotherham Health Select Commission. A quarterly report on progress against the indicators will be provided to the Council of Governors.

2.2: Statements of Assurance from the Board of Directors

Subcontracted services

During 2018/19 The Rotherham NHS Foundation Trust provided and/or subcontracted 65 relevant health services, both community and acute services. The Rotherham NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 65 of these relevant health services. The income generated by the relevant health services reviewed in 2018/19 represented 83% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2018/19.

Clinical Audit

During 2018/19, 53 national clinical audits and 11 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation provides. During that period The Rotherham NHS Foundation Trust participated in 50 (94%) of national clinical audits and 11 (100%) of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Rotherham NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	No	N/A	Data not collected as use of mesh procedure is on hold.
BAUS Urology Audits - Nephrectomy audit	Yes	100%	Not Applicable.
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	100%	Not Applicable.
Case Mix Programme (CMP)	Yes	100%	Not Applicable.
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)	Yes	98% (as at 31 Dec 2018 – patient completed questionnaire facilitated by external body).	Not Applicable.
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	100%	Not applicable
Falls and Fragility Fractures Audit programme (FFFAP) National Audit Inpatient Falls	Yes	Figure unavailable at time of report as audit started in January 2019.	Not Applicable.
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database	Yes	100%	NA
Feverish Children (care in emergency departments)	Yes	100%	Not Applicable.
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	No	N/A	Subscription required for participation.
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%	Not Applicable.
Major Trauma Audit	Yes	45-57% (January - July 2018) – This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.	Not Applicable.
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	100%	Not Applicable.
National Adult Community Acquired Pneumonia (CAP) Audit	Yes	N/A	Not Applicable.
National Adult Non-Invasive Ventilation (NIV) Audit	Yes	N/A	Not Applicable.

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Adult Asthma Secondary Care	Yes	N/A – data collection in progress.	Not Applicable.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Figures not available.	Not Applicable.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary rehabilitation	Yes	Figure unavailable at time of report as data collection started in March 2019.	Not Applicable.
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%	Not Applicable.
National Audit of Cardiac Rehabilitation	Yes	100%	Not Applicable.
National Audit of Care at the End of Life (NACEL)	Yes	60% – This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.	Not Applicable.
National Audit of Dementia (care in general hospitals)	Yes	100%	Not Applicable.
National Audit of Intermediate Care (NAIC)	Yes	Organisational questionnaire.	Not Applicable.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Figure unavailable at time of report as audit started in December 2018.	Not Applicable.
National Cardiac Arrest Audit (NCAA)	Yes	100%	Not Applicable.
National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (CRM)	Yes	100%*	Not Applicable.
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%*	Not Applicable.
National Cardiac Audit Programme (NCAP) National Heart Failure Audit	Yes	100%*	Not Applicable.
National Comparative Audit of Blood Transfusion programme Management of massive haemorrhage	Yes	No eligible cases.	Not Applicable.
National Diabetes Audit - Adults National Diabetes Foot Care Audit	Yes	Figure unavailable at time of report as data being collected.	Not Applicable.
National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDIA)	Yes	Organisational Questionnaire.	Not Applicable.
National Diabetes Audit - Adults NaDIA-Harms	Yes	100%	Not Applicable.
National Diabetes Audit - Adults National Diabetes Transition	Yes	100%*	Not Applicable.
National Diabetes Audit - Adults National Pregnancy in Diabetes Audit	Yes	100%	Not Applicable.

National Audit	Participation yes/no?	% Cases (of those required)	Reason for non-participation
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Organisational Questionnaire only – data not collected.	This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.
National Emergency Laparotomy Audit (NELA)	Yes	68% – This is due to resource issues, turnover in staffing and changes in clinical leadership. There is a renewed focus for 2019/20.	Not Applicable.
National GastroIntestinal Cancer Programme National Oesophago-gastric Cancer (NOGCA)	Yes	100%	Not Applicable.
National GastroIntestinal Cancer Programme National Bowel Cancer Audit (NBOCA)	Yes	100%	Not Applicable.
National Joint Registry (NJR)	Yes	99% (number of patients who consent for data to be used).	Not Applicable.
National Lung Cancer Audit (NLCA)	Yes	100%	Not Applicable.
National Maternity and Perinatal Audit (NMPA)	Yes	100%*	Not Applicable.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%*	Not Applicable.
National Ophthalmology Audit (NOD)	Yes	44% (100 case collected for each main surgeon over a set time period).	Not Applicable.
National Paediatric Diabetes Audit (NPDA)	Yes	100%	Not Applicable.
National Prostate Cancer Audit	Yes	100%	Not Applicable.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) *Antibiotic Consumption*	Yes	100%*	Not Applicable.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) *Antimicrobial Stewardship*	Yes	100%*	Not Applicable.
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%*	Not Applicable.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%	Not Applicable.
Seven Day Hospital Services Self-Assessment Survey	Yes	100%	Not Applicable.
Surgical Site Infection Surveillance Service	Yes	100%	Not Applicable.
Vital Signs in Adults (care in emergency departments)	Yes	100%	Not Applicable.
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%	Not Applicable.

(Source Respective audit provider website)

Data for projects marked with * require further validation. Where data has been provided these are best estimates at the time of compilation. Data for all continuous projects and confidential enquiries continues to be reviewed and validated during April - June 2019 and therefore final figures may change.

National Confidential Enquires	Participation yes/no?	Reason for non-participation	% Cases submitted
Young People's Mental Health	Yes	100%	Not Applicable.
Long-term ventilation in children, young people and young adults	Yes	Figure unavailable at time of report as project currently in progress.	Not Applicable.
Perinatal Mortality Surveillance (reports annually)	Yes	100%	Not Applicable.
Perinatal morbidity and mortality confidential enquiries (reports alternate years)	Yes	100%	Not Applicable.
Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Yes	100%	Not Applicable.
Maternal morbidity confidential enquiries (reports annually)	Yes	100%	Not Applicable.
Acute Heart Failure	Yes	100%	Not Applicable.
Cancer in Children, Teens and Young Adults	Yes	100%	Not Applicable.
Perioperative diabetes	Yes	70% - 3 anaesthetic clinical question-naires not completed.	Not Applicable.
Pulmonary embolism	Yes	100%	Not Applicable.
Acute Bowel Obstruction	Yes	Project currently in progress.	Not Applicable.

(Source: National Confidential Enquiry into Patient Outcome and Death (NCEPOD))

The reports of 27 national audits were reviewed by the provider in 2018/19 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title	Published	Report Reviewed	Action(s) to improve quality of care
BAUS Urology Audits - Nephrectomy audit	Yes	Yes	Currently no actions identified however they are being developed.
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	No actions required.
Case Mix Programme (CMP)	Yes	Yes	No actions required.
Elective Surgery (National PROMs Programme)	Yes	Yes national level.	No actions required from national report review, waiting for local results.
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	Yes	The Fracture Liaison Nurse is responsible for ensuring the following actions are completed during 2019/20. Improve the identification of patients for inclusion in the audit, particularly patients with spinal fractures. This will be achieved by accessing Accident and Emergency (A&E) attendance data to identify patients with eligible fractures. A Standard Operating Procedure (SOP) is also being developed with Radiology to improve on identification of patients over the age of 50 with fractures and any incidental findings of vertebral fractures on all imaging. Patients with vertebral fractures will be identified via the Trust re-portal every quarter. A new system to improve on follow up monitoring of patients at 16 weeks post fracture will be implemented. A letter will be sent to the patient to enquire about progress/medication if no telephone contact has been made following 3 attempts. A Growth Assessment Protocol (gap) analysis of the Fracture Liaison Service (FLS) has been undertaken with the National Osteoporosis Society (NOS).
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database	Yes	Yes	Ensure physiotherapists are prioritising the hip fractures to improve day 1 mobilisation of hip fractures.
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	Actions being developed.
Major Trauma Audit	Yes	Yes	No specific actions identified. Overall, continue to provide care in line with Operational Delivery network guidance.
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	No actions required.
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Actions being developed.
National Audit of Cardiac Rehabilitation	Yes	Yes	A business case proposal is pending for completion in 2019 by the Specialist Nurse and Operational & Performance Manager within Medicine, for the delivery of a cardiac rehabilitation exercise programme for heart failure patients as this is currently not commissioned by the Clinical Commissioning Group (CCG).
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Actions being developed.
National Audit of Dementia (care in general hospitals)	Yes	Yes	Actions being developed.
National Audit of Intermediate Care (NAIC)	Yes	Yes	No actions required.

Title	Published	Report Reviewed	Action(s) to improve quality of care
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Actions being developed.
National Cardiac Audit Programme (NCAP) National Heart Failure Audit	Yes	Yes	Actions under review.
National Diabetes Audit - Adults National Diabetes Transition	Yes	Yes	To focus on improving HbA1c[1] levels in patients on insulin pumps, to lower the number of patients with HbA1c between 58 - 86. In order to achieve this, increased insulin pump follow up clinics have been introduced. A Diasend transmitter is also being used, which is software that links with data from the insulin pumps to provide up to date information about the patient. This is reviewed and discussed with the patient at each contact.
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Increase the number of locked cases on a regular basis with regular feedback at Clinical Effectiveness meetings relative to Monthly NELA progress reports. Improve the percentage of cases for patients >70 having input from Health care of the Older Person by a formal service arrangement. Improve mortality rates via discussion at regular Mortality Group meetings. Improve the documentation of discussions with Critical Intensivists at the time of Emergency Laparotomy via discussion at Clinical Governance.
National GastroIntestinal Cancer Programme National Oesophago-gastric Cancer (NOGCA)	Yes	Yes	All High Grade Dysplasia (HGD) to be discussed at the local Multi-Disciplinary Team (MDT) meetings. The selection process of patients for palliative oncology requires review to investigate the reasons why patients who may have been sufficiently fit to be candidates for chemotherapy received best supportive care. To improve accurate reporting of performance status at the Multi Disciplinary Team Meeting (MDTM) as this is the single most important predictor of fitness for palliative oncology interventions.
National GastroIntestinal Cancer Programme National Bowel Cancer Audit (NBOCA)	Yes	Yes	No actions required.
National Joint Registry (NJR)	Yes	Yes	No actions required.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Actions being developed.
National Ophthalmology Audit (NOD)	Yes	Yes	No actions required.

Title	Published	Report Reviewed	Action(s) to improve quality of care
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	To Improve Transitional care and flow. To address issues with adult services capacity. To ensure updated clinical guidelines are on Trust website. Establish teaching for each batch of trainee doctors. Insulin e-learning package added to Mandatory training for nursing staff. All paediatric Medical & nursing staff to be offered e-Learning for health Diabetic Ketoacidosis (DKA) module. To improve structured patient education. To improve Diabetes clinical outcomes aiming for a clinic target HbA1c of <48mmol/mol (some patients will need different, individualised target). Establish Monthly 'Patient in difficulty' meetings. Standing agendas added to our quarterly operational meetings: to discuss age-banded median HbA1c and 'Was Not Brought' (WNB) rates. Introduce Virtual clinics and continually encourage patient's uptake. To reduce waiting times by changing clinic format. To provide alternative Psychology input to make up for 8 week gap. To introduce use of British Society for Paediatric Endocrinology & Diabetes (BSPED) DKA guidelines for all young people up to age of 18 years. Involve regular management input for operational planning.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	A number of actions are in progress for completion in 2019 by the Trust Transfusion Practitioner and Blood Bank Manager, which include the inclusion of basic ABO and RhD blood group principles into Module 5 paperwork of the nursing staff education. A business case is also to be formulated for the introduction of electronic bedside management systems in all clinical settings where transfusion takes place.
Seven Day Hospital Services Self-Assessment Survey	Yes	Yes	It was agreed to review the middle grade rota in medicine re additional middle grade cover weekends Review Consultant rota in regard to Acute Medical Unit cover Appoint to vacant Acute physician posts Review and increase Hospital out of hours cover and support Develop a dedicated weekend discharge team Review of estimated dates of discharge And development of internal professional standards
Surgical Site Infection Surveillance Service	Yes	Yes	No actions required

(Source: Trust Audit Database)

During the year, the Trust's internal auditor undertook an assurance review of clinical audit to assess the adequacy of governance arrangements, including in-year assurance reporting against an annual plan. The auditor found a lack of a Clinical Effectiveness Strategy, and noted that the clinical audit plan was predominantly pulled together with input from the Trust's Clinical Service Units. The outcomes of audits were shared locally, but not across the Trust, and a communication strategy is now being developed in order to have optimal impact on the quality improvement agenda.

Review of Local Clinical Audits

The reports of 93 local clinical audits were reviewed by the provider in 2018-19 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table at Appendix 1).

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2018/19 that were recruited to participate in research was 1255 compared to 988 in 2017/18. A significant number of recruits (434) are the result of participation in the Yorkshire Health Study, which is a questionnaire study available to staff, patients and members of the public which closed in September 2018 [figures taken from the Local Performance Management System, final numbers may change as updates are made].

To be consistent with previous submissions, this data includes all participants (patients and staff) recruited to NIHR Portfolio research studies actively recruiting at The Rotherham NHS Foundation Trust i.e. included all studies that received Trust confirmation of "Capacity

and Capability" as per Health Research Authority requirements. This includes studies that require research ethics approval and those that have no legal requirement to do so as per Governance Arrangements for Research Ethics Committees GAfREC (Department of Health, 2011).

The table below shows the total number of studies that have been actively recruiting during 2018/19

Study Type	Number of studies
NIHR Portfolio Commercially sponsored	2
NIHR Portfolio Non-commercial	27
Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC)	7
Non-portfolio The Rotherham NHSFT Sponsored	7
Other Non-portfolio (supporting academic qualifications)	3

(Source: TRFT Research Database)

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer to patients and to making our contribution to wider health improvements.

CQUINs (Commissioning for Quality and Innovation)

A proportion of The Rotherham NHS Foundation Trust income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between The Rotherham NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2018/19 £3.88 million of Trust income for all applicable Commissioners was conditional upon achieving the quality improvement and innovation goals compared with £3.77 million in 2017/18.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically from the Trust Website at: http://www.therotherhamft.nhs.uk/CQUINqualityindicatorframework/

CQUIN goals are being reviewed nationally but will continue to form part of the National NHS Standard contract for 2019-20 once finalised. All schemes agreed are national indicators. A high level summary of the indicators applicable in 2018/19 is provided on the next page:

National (N) Local (L)	Goal Name	Contract Year for delivery	Rationale for Inclusion
N	NHS Staff Health and Wellbeing	2018/19	To support and maintain a healthy and happy work-force, evidence of which is known to enhance quality and reduce sickness absence rates
N	Reducing the Impact of Serious Infections (Sepsis)	2018/19	To reduce the number of deaths from Sepsis through early identification and treatment
N	Improving Services for People with Mental Health needs who present to A&E	2018/19	To develop integrated pathways across organisations to support timely and appropriate access to services for patient with Mental Health needs
N	Advice and Guidance	2018/19	To provide specialist advice to General Practitioners (GPs) to support clinical decision making
N	Preventing Ill Heath by Risky Behaviours – alcohol and tobacco	2018/19	To improve the health of the local population through prevention

(Source: NHS England)

CQC Registration and Periodic Reviews/Specialist Reviews

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Registered with Conditions'. The Rotherham NHS Foundation Trust has the following conditions on registration.

In October 2018, the Care Quality Commission served a condition on the Trust registration relating to mitigating the risks within paediatric Urgent and Emergency Care Centre with a focus on medical and nursing staffing levels.

The Care Quality Commission has not taken enforcement action against the Rotherham NHS Foundation Trust during 2018/19.

The Trust was fully inspected by the Care Quality Commission in February 2015 with a follow-up re-inspection occurring between 27-30 September 2016 (and a further unannounced inspection on 12 October 2016) and then further unannounced inspections in September and October 2018.

At the 2018 inspection, the Trust was given an overall rating of Requires Improvement, with the rating broken down as follows;

	Rating
Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well Led	Requires Improvement

The tables opposite show the detailed ratings by key question and by core service for the re-inspection conducted in 2018.

CQC ratings for Trust Hospital services after 2018 re-inspection:

	Safe	Effective	Caring	Responsive	Well led
Urgent & Emergency Services	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate
Medical Care	Requires Improvement	Good	Good	Good	Requires Improvement
Surgery	Good	Good	Good	Good	Good
Critical Care	Good	Good	Good	Good	Requires Improvement
Maternity	Good	Good	Good	Requires Improvement	Requires Improvement
Children and young people	Good	Good	Good	Good	Good
End of life care	Good	Requires Improvement	Good	Good	Good
Outpatients and diagnostic imaging	Good	(Inspected not rated)	Good	Good	Good

CQC ratings for Trust Community services after 2018 re-inspection:

	Safe	Effective	Caring	Responsive	Well led
Adults	Good	Requires Improvement	Good	Good	Requires Improvement
Children & young people	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Inpatients	Good	Good	Outstanding	Good	Good
End of life Care	Good	Requires Improvement	Good	Good	Requires Improvement
Dental	Good	Good	Good	Good	Good

(Source: Care Quality Commission)

All reports from the Trust's inspection are available from the CQC website at: www.cqc.org.uk

How the Trust makes use of the CQC re-inspection report

A comprehensive action plan was created as a result of the inspection findings for the regulation breaches which was approved by the Board of Directors on 26th February 2019. The plan aims for all actions to be in place by 31 October 2019, with the audits to confirm this completed by 31 March 2020.

Throughout the course of the year the Trust has maintained contact with the CQC through regular conversations and correspondence with the Trust's lead CQC Inspector and quarterly engagement meetings.

The Chief Nurse is the nominated individual. Amendments were made to the Trust's CQC registration during 2018/19 which included changing the name of the individual undertaking the Chief Nurse role.

A copy of the Trust's registration certificate can be viewed at http://www.cqc.org.uk/provider/RFR/registration-info or by requesting a copy from the Company Secretary at the address below:
Ms Anna Milanec
Company Secretary
General Management Department, Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham, S60 2UD

Compliance with CQC standards is monitored internally through the Trust's clinical governance arrangements culminating in the Clinical Governance Committee and Quality Assurance Committee.

The Trust is also required to report any breaches of the **Ionising Radiation Regulation**s to the CQC. Below is a summary of the radiation incidents which have been reported to the CQC from 1 April 2018 to 31 March 2019.

	Reportable to				
Date	**MHRA**	**CQC**	**HSE**	**Dose (mSv)**	**Description**
18-Apr-18	No	Yes	No	8.7	Patient had an unnecessary Thorax CT examination due to an incorrect request. The Trust understands that the referrer accidentally requested a scan on the wrong patient. The intended patient had the same name and a very similar date of birth to the person that received the scan.
01-May-18	No	Yes	No	2.3	An incorrect patient was scanned for an unnecessary CT head due to the referrer requesting the wrong patent.
09-May-18	No	Yes	No	19.2	Patient received Chest Abdo Pelvis CT scans, intended for another patient, due to referrer error. Patient has been notified and told that the doctor had referred the wrong patient.
18-May-18	No	Yes	No	0.3	A patient recently underwent the initial portion of a CT examination unnecessarily due to an incorrect referral. After the CT Topogram was performed, it was noted the clinical details did not match the request. The remainder of the exam was then cancelled.
31-July-18	No	Yes	Yes	5.2	An incorrect patient was scanned for an unnecessary CT chest as the referrer had selected the wrong patient when requesting imaging. The referrer realised their mistake and tried to cancel the examination but did not follow proper procedure and the cancellation request did not come through to the Radiological Information System (RIS) SCBU system from the Electronic Patient Record (EPR) system.
07-Aug-18	No	Yes	No	5.2	A patient received a chest CT scan, intended for another patient, due to referrer error. The referrer recognised the error and cancelled the scan on the Electronic Patient Record (EPR) system (Meditech). However, the referrer failed to follow the instructions of the EPR system to also telephone Clinical Radiology to cancel the request. The Meditech EPR system does not currently update cancelled orders in the AGFA RIS. Hence there is an additional requirement for the referrer to telephone Clinical Radiology to cancel the request.
14-Nov-18	Yes	Yes	No	55	Equipment error in X-ray room 5 (AGFA DR 600) caused a patient to receive 25 times the expected dose when undergoing a chest radiograph. The incident was initially thought to be operator error; however on inspection by the RPS and Modality Lead the fault was not re-creatable and the use of the equipment suspended.
30-dec 2018	No	Yes	No	0.05	The incorrect patient was x-rayed for a chest x-ray, this occurred due to a misinterpretation of patient information passed from one radiographer to another. Since this incident we have made sure that one radiographer is responsible for the identification of the patient, therefore reducing the chances of error. We have passed this information on to all staff via the communication book and morning staff meetings.
8-Jan- 2019	No	Yes	No	0.3	This incident occurred when a patient had a pelvis x-ray instead of a chest x-ray due to a miscommunication regarding patient information between radiographers. Since this incident we have made sure that one radiographer is responsible for the identification of the patient and justification of the referral, therefore reducing the chances of error. We have passed this information on to all staff via the communication book and morning staff meetings.
15-Jan 19	No	Yes	No	0.025	Paediatric chest and neck x-ray was incorrectly requested from the clinicians on the wards. Reflective statement acquired from the clinician. Accurate ID checks made by the radiographer.
7-Feb-19	No	Yes	No	2	CT head scan requested on incorrect patient referrer error.
12-Feb-19	No	Yes	No	0.03	Incorrect identification of a patient for a chest x-ray by the ED department.

(Source: Datix and Radiation Protection Advisors Report)

Each of the incidents have been investigated and all have been escalated through to the Clinical Support Services Divisional Governance meeting and onto the Trust's Clinical Governance Committee to provide assurance as to the quality of the investigation and the robustness of the remedial actions taken. The incidents caused no harm to the patients concerned.

Special Reviews and Investigations

The Rotherham NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data Quality

The Rotherham NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data April 2018 – January 2019.

The percentage of records in the published data; which included the patient's valid NHS number was:

99.9% (99.9% for 2017/18) for admitted patient care
100.0% (100.00% for 2017/18) for outpatient care
99.5% (99.2% for 2017/18) for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

100% (100% for 2017/18) for admitted patient care
100% (100% for 2017/18) for outpatient care
100% (100% for 2017/18) for accident and emergency care

Please note: 2018/19 data in this section is based on a refreshed data position from NHS Digital submissions. The 2017/18 data is based on the published data April 2017 – January 2018 from the same source.

Information Governance Toolkit attainment levels

The replacement of the Information Governance Toolkit, with the Data Security and Protection Toolkit (DSPT) during 2018/19, means that The Rotherham NHS Foundation Trust, like other organisations, is no longer able to produce an Information Governance Assessment report.

The DSPT demonstrates that the Trust is working towards the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care. The format of the new toolkit has removed the former 'attainment levels', and instead, works on an a 'standards met' (requiring 100% compliance), or 'standards not met' (anything less than 100%), basis.

Organisations are expected to achieve the 'standards met' assessment on the DSPT by 31 March each year. However, with this being the first year of the DSPT, organisations have been able to publish a DSPT assessment if they are approaching a level of 'standards met' in all but a few areas. In this case, the submission of an action plan to achieve full compliance would need to be submitted by the organisation and agreed by NHS Digital.

The Rotherham NHS Foundation Trust's DSPT assessment as at 28 March 2019, was "standards not fully met (plan agreed)".

Payment by Results

The Rotherham NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. (Note: NHS Improvement (NHSI) Comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHS Improvement. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'costing audit'.)

The Rotherham NHS Foundation Trust will be taking the following actions to improve data quality and clinical coding.

The Trust engaged in implementing the NHS Spine to the clinical information system Meditech in January 2018 and are the first Trust using Electronic Patient Record (EPR) (Meditech) to transition to Patient Demographics Service in the country. It was anticipated that additional improvements would be seen, in particular in Emergency Care data which had recently migrated from a legacy system Symphony onto Meditech. This is now evidenced in the NHS Digital Data Quality Dashboards where it is clearly shown that the Trust now has an NHS Number completeness rating well above the national average.

The Rotherham NHS Foundation Trust was subject to the mandatory clinical coding Information Governance (IG) audit in November 2018 during the reporting period as required by NHS Digital. The Trust again achieved an IG rating of level three which is the highest possible rating that can be achieved.

In addition, TRFT have also had external audits of the following specialities; Obstetrics and Gynaecology. Feedback was very good for both diagnosis / procedure coding and the depth of coding.

Data Quality Index (HRG4+ based)

CHKS continues to be the source of information for the Data Quality Index and at the time of reporting data for the period April 2018 to December 2018 is available. There has again been an increase from the previous year; the Trust continues to outperform peer averages with an index of 97.69% compared to a peer average of 96.21.

The Rotherham NHS Foundation Trust will be taking the following actions to improve data quality;

As a team the Data Quality Indicators are reviewed monthly both from a CHKS perspective and from the NHS Digital Data Quality Dashboard perspective. Any fluctuations in performance are identified and actions plans are put in place to resolve. If aide memoires are required the Data Quality Team will work with the Training Team to put the best possible processes in place, to resolve these issues. The Data Quality Team also works closely with the Reporting Teams to ensure that they are aware of any errors that may be present from a submission perspective to ensure these are rectified at source, thus ensuring the Trust maintains its high standards with regards to the integrity of our data.

Blank, invalid or unacceptable primary diagnosis rates (HRG 4 based)

The Trust position for unaccepted diagnosis codes in the period up to December 2018 has improved, achieving 0.02% against a previous measurement of 1.17% for 2017/18. The action plans put in place

following the migration of our Emergency Department onto a primary Acute System Meditech, have improved this position. The Trust continues to take steps to reduce the impact of this change on data. The depth of coding (average number of diagnoses per coded episode) continues to increase from 6.8 in December 2017 to 7.2 in December 2018, this is an improvement of 5.6% in year.

Clinical Coding

The Trust was subject to the external clinical coding audit during the reporting period and the compliance rates (%) reported for a sample of 200 sets of case notes for diagnosis and treatment coding were:

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	95.5	97.1	100	97.1

(Source: The Rotherham NHS FT Information Governance Audit Report 2018/2019)

These scores helped achieve assurance Level 3 of the Information Governance Toolkit for coding accuracy, this is the second time that the Trust has managed to achieve the highest grade Level 3 for the Information Governance Audit.

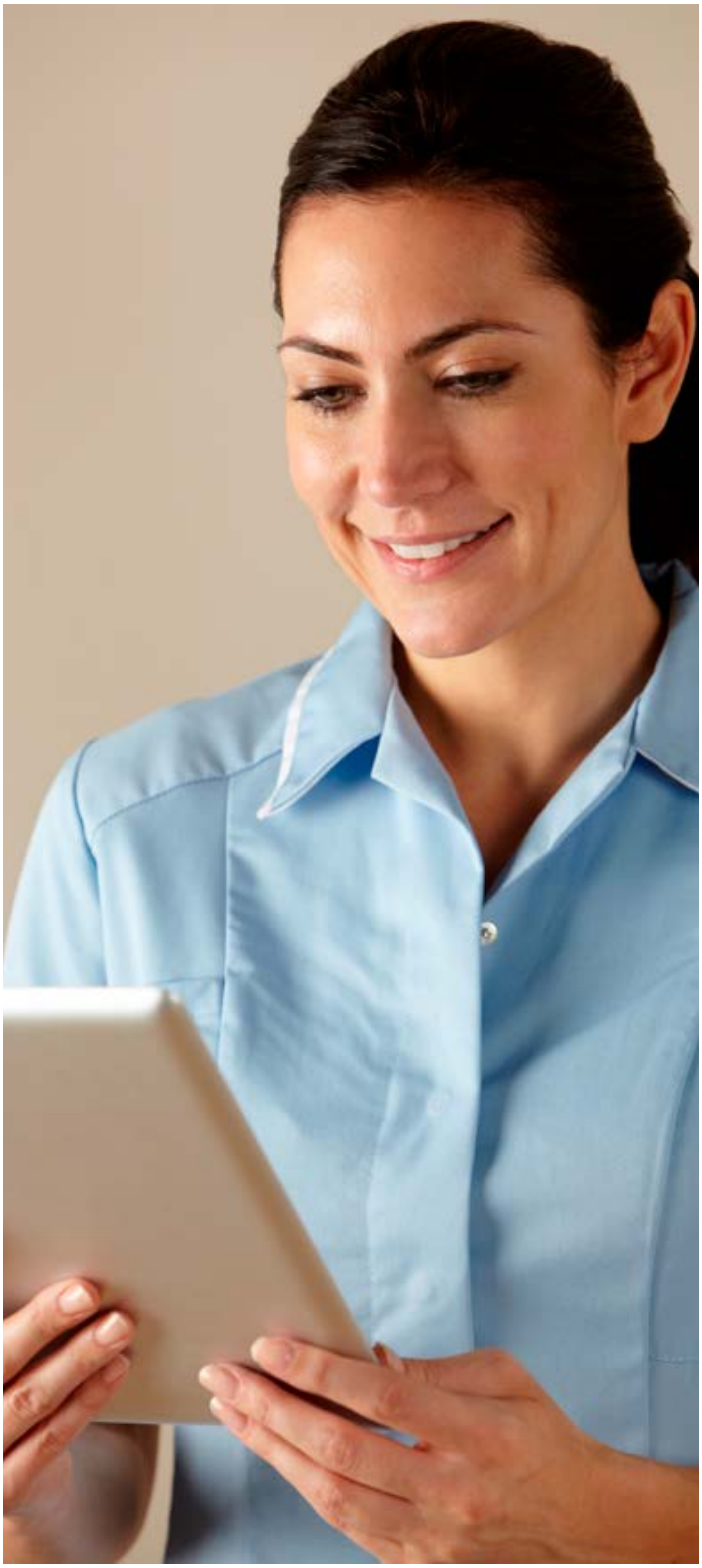
In 2017/18 the Trust took the following actions to improve clinical coding data quality and these continued throughout 2018/19:

- Using data analysis to flag up potential coding and data quality errors and generate regular reports to monitor coding and data quality, using the ever expanding locally designed clinical coding indicators
- Engaged clinicians across specialties, creating coder/clinician two way communications through coding/documentation review sessions
- Provided in-house coding training sessions for consultants.
- Annual coding training sessions included on the F1 junior doctor's induction.
- A service level agreement has been put in place for professional coding support from Barnsley Hospital Trust 0.2 whole time equivalent. Plans have been put in place to implement regular internal individual and departmental audits.

Improvements and actions to further improve clinical coding during 2018/19 included:

- Reviewing coding processes across the organisation to benefit from coding at source and in near-real time wherever practicable.
- Implement and review coding performance indicators.
- The Trust is now rated in the top quartile nationally for depth of coding, although this is not a clear indicator of clinical coding quality it does better demonstrate the complexity of the patients care for the respective episodes, and by also attaining the IG level 3 the auditors are of the opinion that we are also rated in the top quartile nationally from that perspective too. Combined these indicators demonstrate an improvement in the quality of the clinical coding.

An Operational Manager was appointed in April 2017 to lead the team and two Supervisors appointed within the team to handle day to day support of the team. Additional steps were taken to integrate the Data Quality Teams into the Clinical Coding department which has improved the engagement between the two teams and the Trust staff, enabling them to react more quickly to issues being identified at source of coding.



	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2017-18	Qtr 2 2017-18	Qtr 3 2017-18	Qtr 4 2017-18	YTD	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 -16	96	Increase	96.12%	95.38%	96.82%	97.53%	96.43%	
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 -16	0.46%	Decrease	1.23%	1.39%	0.86%	0.27%	0.96%	
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)	2015 -16	8.84%	Decrease	12.07%	12.15%	9.96%	9.64%	11.43%	
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)	2015 -16	11.99%	Decrease	16.99%	17.59%	15.12%	12.53%	16.64%	
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015 -16	99.80%	Increase	99.90%	99.90%	99.80%	99.90%	99.90%	
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015 -16	100.00%	Maintain	100.00%	100.00%	100.00%	100.00%	100.00%	
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	100.00%	99.90%	99.90%	100.00%	100.00%	
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 -16	99.90%	Maintain	100.00%	100.00%	100.00%	100.00%	100.00%	
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 -16	86.60%	Increase	99.20%	98.40%	98.80%	99.20%	99.20%	
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.10%	Increase	100.00%	100.00%	100.00%	100.00%	100.00%	

(Source: NHS Digital and CHKS Live)

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2018-19	Qtr 2 2018-19	Qtr 3 2018-19	Qtr 4 2018-19	YTD	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 -16	96	Increase	97.86%	97.88%	97.34%	Data not yet available	97.69%	↑
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 -16	0.46%	Decrease	0.28%	0.20%	0.48%	Data not yet available	0.32%	↓
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)**	2015 -16	8.84%	Decrease	9.53%	9.98%	10.68%	Data not yet available	10.07%	↑
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)**	2015 -16	11.99%	Decrease	11.51%	12.41%	15.50%	Data not yet available	13.21%	↑
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015 -16	99.80%	Increase	99.90%	99.90%	99.90%	Data not yet available	99.90%	↑
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015 -16	100.00%	Maintain	100.00%	100.00%	100.00%	Data not yet available	100.00%	→
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	100.00%	100.00%	100.00%	Data not yet available	100.00%	↑
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 -16	99.90%	Maintain	100.00%	100.00%	100.00%	Data not yet available	100.00%	↑
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 -16	86.60%	Increase	99.40%	99.50%	99.50%	Data not yet available	99.50%	↑
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.10%	Increase	100.00%	100.00%	100.00%	Data not yet available	100.00%	↑

(Source: NHS Digital and CHKS Live)

** Due to clinical coding team coding from Electronic Medical Record (EMR) and not notes due to lack of access to notes there is always a tendency to have signs and symptoms as this is usually only the data that the patient had recorded on admission

The baseline was established in 2015-16 and the Trust uses that baseline to compare against. The data for Q4 was not available at the time of production of the report.

Learning from Deaths

During 2018/19, 1,016 of TRFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 234 in the first quarter
- 236 in the second quarter
- 235 in the third quarter
- 311 in the fourth quarter

By 15 April 2019, 45 case record reviews and 0 investigations have been carried out in relation to the 1,016 deaths included in the above. In 0 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 16 in the first quarter
- 9 in the second quarter
- 12 in the third quarter
- 8 in the fourth quarter

6 representing 0.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 3 representing 1.3% for the first quarter
- 0 representing 0% for the second quarter
- 3 representing 1.3% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the Preventable Incidents Survival and Mortality (PRISM) methodology.

What the provider has learnt from case record reviews

The Trust has been conducting case record reviews on selected patients within the Trust at random and following specific diagnosis codes that have been identified through the data. The specific diagnosis codes reviewed were septicaemia, intestinal hernia without obstruction, and 30-day mortality following both emergency and elective surgery.

There were specific themes that arose from these case note reviews, such as poor communication and failure to recognise a deteriorating patient; however, the Trust is making good progress with improving the recognition of and timely response to the deteriorating patient, which is reflected in a sustained improvement in our Hospital Standardised Mortality Ratio (HSMR).

Description and assessment (including actions)

The mortality data provider for the Trust, CHKS, highlighted issues with septicaemia, but the Trust is making good progress with improving the recognition of the deteriorating patient and sepsis; this is triangulated with the CQUIN target.

The restructuring of the deteriorating patient pathway with earlier intervention by senior medical staff and highlighting the Modified Early Warning System (MEWS) scores undertaken in 2018/19 has continued to reduce the number of unexpected admissions to critical care and the number of cardiac arrests within the ward based areas, both of which are monitored at the Trust's weekly Harm Free meeting chaired by the Medical Director and the Chief Nurse.

The Trust successfully rolled out the new National Early Warning Score (NEWS2) towards the end of quarter 4, which is the replacement to MEWS. As a result, the Trust is currently developing plans to replace the current Hospital at Night Service with a 24/7 Acute Response Team, in order to further improve patient safety by supporting the medical workforce and by improving the timely response to deteriorating patients.

There has also been a significant amount of work around the acute kidney injury care pathway, including the sustained use of the acute kidney injury bundle, which has helped lead to a decrease in the number of serious incidents and inquests relating to the deteriorating patient.

The palliative care team have worked extremely hard with advance care planning, which has shown a marked improvement in the mortality data related to the length of stay of palliative patients. This has also reduced the number of patients who have been inappropriately admitted to hospital, with this year's data shows that there has been a decreasing trend in the number of patients dying within 0-1 day length of stay.

There has been an in-depth review of 30-day mortality following emergency surgery and 30-day mortality following elective surgery. Most of these patients have died expectedly from medical causes not relating to the surgical procedure, and some have been placed under surgeons as the responsible consultant, when in fact they were a medical patient. Ongoing work is underway to ensure that there is always an appropriate level of care from all necessary specialist teams throughout the stay of all patients, in line with the standards for 7-day services.

The Trust alerted with intestinal obstruction without hernia; however, following an in-depth review of all of these cases, whilst various improvements were identified, none were of significant concern. The main issue was one of coding in view of the fact that most did not have intestinal obstruction. There has been an incredible amount of work around educating clinicians and coding on documentation and data capture.

A significant amount of work and improvements have been made following reviews of fractured neck of femur. Indeed, whilst it was previously highlighted that there were issues with this cohort of patients, following quality improvement projects that have been very successful, the Trust has moved from one of the worst performing to one of the best performing nationally, with sustained performance.

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

The Trust will also be introducing its first Medical Examiner role in quarter one of 2019/20, in line with national guidance and best practice. This will be a pivotal role in improving the Trust's Learning from Deaths by ensuring that all deaths are independently reviewed, in addition to the standard mortality review process. They will liaise directly with HM Coroner and the Medical Director, and will seek the input of each patient's next-of-kin.

30 case record reviews and 0 investigations completed after 1 April 2018 which related to deaths which took place before the start of the reporting period.

1 representing 0.1% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Preventable Incidents Survival and Mortality (PRISM) methodology.

1 representing 0.1% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3: Reporting against core indicators

The Department of Health asks all Trusts to include in their Quality Report information on a core set of indicators, including Patient Reported Outcome Measures (PROMS), using a standard format.

This data is made available by NHS Digital and in providing this information the most up to date benchmarked data available to the Trust, has been used and is shown in the table below, enabling comparison with peer acute and community trusts.

The Summary level Hospital Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge. The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline. The banding for TRFT is "as expected".

Indicator name	Latest & previous reporting periods	TRFT value Oct 17 - Sept 18	TRFT previous value July 17 - June 18	Acute Trust average Oct 17 - Sept 18	Acute Trust previous average July 17 -June 18	Acute Trust highest value Oct 17 - Sept 18	Acute Trust previous highest value July 17 -June 18	Acute Trust lowest value Oct 17 - Sept 18	Acute Trust previous lowest value July 17 - June 18
Summary Hospital Mortality Indicator – Value	July 17 - June18 Oct 17 - Sept 18	105.72	103.13	100.34	100.35	126.81	125.72	69.17	69.82
Summary Hospital Mortality Indicator – Banding	July 17 - June18 Oct 17 - Sept 18	2	2	2	2	1	1	3	3
SHMI: Percentage of patient deaths with palliative care coding at diagnosis level	July 17 - June18 Oct 17 - Sept 18	32.4	32.4	33.6	33.1	38.9	58.7	26.3	13.4

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient's perspective. Currently covering hip replacement and knee replacement surgery, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

Patient Related Outcome Measures (PROMS)

DOMAIN	Indicator title	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened
Domain 3 - Helping people to recover from episodes of ill health or following injury	Primary hip replacement surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	79	0.17	0.75	0.577	72 (91.1%)	1 (1.3%)	6 (7.6%)
	1st April 2018 - September 2018	15	0.29	0.75	0.46	14 (93.3%)	0 (0%)	1 (6.6%)
	Groin hernia surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	*	*	*	*	*	*	*
	1st April 2018 - September 2018	*	*	*	*	*	*	*
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	92	0.37	0.77	0.4	82 (89.1%)	5 (5.4%)	5 (5.4%)
	1st April 2018 - September 2018	11	0.57	0.8	0.22	8 (72.72%)	1 (9.09%)	1 (9.09%)
	Varicose vein surgery (EQ-5D Index) - health gain							
	1st April 2017 - 28th March 2018	*	*	*	*	*	*	*
	1st April 2018 - September 2018	*	*	*	*	*	*	*

* No Data - On the 1st October 2017, PROMs data for varicose veins and groin hernia surgery ceased collection, following on from the NHS England Consultation on the future of PROMs

Please note: Results in this document are provisional for April 18 - September 18 and subject to change until the publication of finalised data, which is expected to be on 09 August 2019 (after production of the report). (Source: NHS Digital)

Re admissions within 28 days of discharge from Hospital: Please note that this indicator was last updated in December 2013 and future releases have been suspended pending a methodology review. Further information is located at Appendix 2.

DOMAIN	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
Domain4: Ensuring that people have a positive experience of care.	*CQUIN: Responsiveness to patients personal needs	2016/17	65.1	68.1	85.2	60
		2017/18	68.6	68.6	85	60.5
	Staff who would recommend the Trust to their family or friends (Acute Trusts for comparison)	July 17 - Sept 17	45%	62%	96%	25%
		July 18 - Sept 18	68%	64%	94%	31%

*Please note data for 18/19 is not published until 22nd August 2019 which is after the deadline date of the report and so is not included. (Source: NHS Digital)

DOMAIN	Indicator name	Latest & previous reporting periods	TRFT value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
Domain5: Treating and Carng for people in a safe place.	*Percentage of patients admitted to hospital and risk assessed for Venous Thromboembolism (VTE)	Jul18 - Sept 18	95.89%	95.44%	100%	68.67%
		Oct 18 - Dec 18	95.65%	95.37%	100%	54.86%
	*Rate per 100,000 bed days of cases of C Diff amongst patients aged 2 or over	Apr 16 - Mar 17	1.7	3.0	11.9	0
		Apr 17 - Mar 18	1.5	3.1	13.8	0
	*Patient safety incidents: rate per 100 admissions (medium acute for comparison)	Apr 17 - Sept 17	48.14	42.84	111.7	0
		Oct 17 - March 18	37.3	21.8	101.4	0
	Patient safety incidents: % resulting in severe harm or death (medium acute for comparison)	April 17 - Sept 17	30%	15.12%	64%	0%
		Oct 17 - March 18	14%	17.10%	55%	0%

* C Diff figures 18/19 published July 2019 (which is after the deadline date of the report and so is not included)
* Patient safety incidents: next publication 23rd May 2019 (which is after the deadline date of the report and so is not included)
(Source: NHS Digital)

The Rotherham NHS Foundation Trust considers the above data is as described for the following reasons, appearing in the (second column) of the table below.

The Trust intends to take the following actions (third column) to improve the outcomes above and so the quality of its services, a rationale for these figures is provided along with a brief description of proposed improvement actions as described in the table opposite.

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to improve this score and so the quality of its services by:
12a. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period	Data validated and published by NHS Digital. See page 62 The Trust has experienced a fall in mortality indicators after the number of deaths decreased between July 2017 and June 2018. There has been a subsequent fall in deaths and the review process continues. The SHMI reported rose until the most recent result in June 2018 when it has started to come down as the reporting period no longer includes the rise in deaths in 2016.	The Trust holds regular meetings of the Mortality Review Group which reports to the Clinical Governance Committee. Data (SHMI and HSMR) and incidents are reviewed to help identify trends and areas of concern. A summary of the Trust's performance and mitigating actions taken is shared in Board reports. Deaths are reviewed and reported quarterly in the Learning from Deaths Report to the Board.
12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	The Trust's Consultant-led Specialist Palliative Care Team identifies and assesses all patients receiving palliative care. Only patients receiving care from the team are included in the data. See page 62	To improve the percentage score the Trust's Consultant-led Specialist Palliative care Team continue to identify and assess all patients receiving palliative care.
18. Patient Reported Outcome Measures scores for	The data is considered to be accurate based on the number of returns received and the data validated and published by NHS Digital.	PROMS are measures recorded pre- and post-operatively by patients. They measure changes in quality of life and health outcomes. The Trust will continue to collect PROMs data to help inform future service provision.
(i) groin hernia surgery; (ii) varicose vein surgery; (iii) primary hip replacement surgery (iv) primary knee replacement surgery during the reporting period.	The latest reporting periods vary between the type of surgery performed. Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement. See page 63	(i) No longer collected. (ii) No longer collected. (iii) 93% 14/15 patients stated they noticed an improvement post surgery. (iv) 72.72% 8/11 patients stated they noticed an improvement post surgery.
19. Percentage of patients aged— (i) 0 to 15; and (ii) 16 or over, Readmitted to any hospital within 28 days of discharge from the Trust	This indicator is not presently being updated by NHS Digital; as yet there is no date available for the next data release. The latest update available from NHS Digital is for the period 2011/12. Therefore, the internal TRFT data Warehouse is used for all reporting of re admissions for the performance reports for the Board, the Divisions, the clinical support units (CSU) and for the Service Line Monitoring (SLMs) reports See page 63	The Indicator continues to be monitored through the Board Integrated Performance Report based on the Trust's own data. The Transfer of Care Team works to reduce readmission rates through better planning of discharge. The Care Home Team identifies factors leading to admission and readmission of Care Home Patients and works with the sector to improve effectiveness.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's position is drawn from 5 key questions asked in the national in-patient survey (administered by the CQC). The most recent data is from the survey conducted between August 2017 and January 2018. Full results are available later in this report.	CQC will publish 2018 patient survey results in August 2019.

Core Indicator	TRFT considers that this data is as described for the following reasons	TRFT intends to take or has taken the following actions to improve this score and so the quality of its services by:
21. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	Department of Health conduct an annual independent survey of staff opinion. See page 97	Complete
21.1 Friends and Family Test – " How likely are you to recommend our hospital to friends and family if they need similar care or treatment" Services covered: - Inpatients - Day Cases - Accident and Emergency - Outpatients - Maternity - Community	The data is considered to be accurate based on the number of forms inputted into the system received for each area. The data is submitted to NHS Digital monthly for publication. The published data relates to the positive and negative scores for each area derived from the number of patients who would or would not recommend our services. Since March 2017 the Trust has run the Friends and Family test in house, previously it was out sourced to an external contractor. Due to the large number of outpatient clinics there is a rota system in operation which ensures all clinics are captured at certain months throughout the year. See page 82	Complete
23. Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	Data is validated and published by NHS DIGITAL See page 114	The Trust will continue to monitor VTE rates, and report through local clinical governance structures to the Clinical Governance Committee.
24. The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	Data is validated and published by NHS DIGITAL See page 113	The Trust will continue to monitor rates through root cause analysis and audits and report through local clinical governance structures to the Clinical Governance Committee; for further actions to reduce rate of c-diff see Part 3.
25. The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Data validated and published by NHS Digital (National Reporting and Learning System (NRLS)); latest data is for the period Oct 2017 - March 2018. This was the latest reporting period where TRFT has submitted its data. The next publication is due 23rd May 2019 which will cover the period April18 - Sept 18 (after the report deadline and so not included). Number of incidents occurring in this period – 2, 877.	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures.

(Source: Trust Information System)

Her Majesty's Coroner's Inquests 2018/19

From 1 April 2018 responsibility for the co-ordination and management of Coronial Inquests transferred from the Patient Safety team to the Legal Affairs team. This alignment facilitates effective triangulation and analysis of data in relation to any incidents or experiences that result in an investigation, whether through the complaints, claims, inquest or incident process. By continuing to work collaboratively with the divisions, the identification and embedding of learning as a result of an investigation via these routes will assist in improving the safety, care and experiences of our patients and their families.

The number of Inquests held involving the Trust has risen sharply over the last 12 months, with 63 inquests held during 2018/19 in comparison to 38 in total for 2017/18.

Learning from Inquests continues to be a priority for our organisation. During 2018/19 the Trust did not receive any "Reports to Prevent Future Deaths"; the power that comes from regulation 28 of the Coroners (Inquests) Regulations 2013. Learning has however been identified in a number of Inquest cases, and this has been widely shared within the organisation through the Patient Safety Group, Clinical Governance Committee and Divisional Governance Meetings in order to avoid repeat of harm events and improve the quality of patient care.

Part Three: Other Information

3.1 Overview of quality of care based on performance in 2018/19

A summary of the Trust's quality priorities for 2018/19 is provided below with an indication as to whether the priority was achieved or not by the year end.

For all RAG ratings throughout this document the colours mean:
Green: Met; Amber: Partially Met; Red: Not met.

Reference	Metric	RAG Rating
Patient Safety		
Missed or Delayed Diagnosis	Improve the percentage of positive electronic acknowledgement of radiology examinations requested by TRFT clinicians from 30% to 100% by 31 March 2019.	
Deteriorating Patient (including Sepsis)	To improve the percentage of patients who met the criteria for screening for sepsis and were screened for sepsis using the appropriate tool within one hour of having identified that the patient needed screening from 71.5% to 90% by 31 March 2019.	
	To improve the percentage of patients receiving Intravenous Antibiotics within one hour of having identified that the patient has sepsis from 60.5% to 90% by 31 March 2019.	
Medication Safety	Improve the percentage of medication administrations signed for or, a reason for non-administration recorded on the medication chart, from 96% to 100% by 31 March 2019.	
	Improve the percentage of patients leaving the organisation with a discharge letter, their medication and having received information about their medication from the discharging ward/nurse from 80% to 100% by 31 March 2019.	
Patient Experience		
End of Life Care	Improve the percentage of registered nursing staff and relevant Multi-Disciplinary Team Members trained in the use of end of life care plans from 0% to 80% on two wards (Ward A1 and Ward A4) by 30 June 2018 and repeat this each quarter for 2 new wards.	
	Improve the use of end of life care plans for patients receiving end of life care on the two wards from (A1 0% and A4 6%) to 100% by 30 June 2018 and repeat this each quarter for the wards identified.	
Patient Discharge from Hospital	Improve the percentage of patients discharged across the site by 12 midday from 10% to 20% by 31 March 2019. Increasing by 2.5% each quarter, sharing information across divisions and teams on how this metric is progressing each quarter.	

Reference	Metric	RAG Rating
Learning from the Views of Inpatients	To improve the percentage of patients reporting that they were not bothered by noise at night from other patients from 49.5% to 62.5% by 31 March 2019.	
	To improve the percentage of patients reporting that they were given the right amount of information about their condition or treatment from 72% to 81% by 31 March 2019.	
	To improve the percentage of patients reporting that they were given enough privacy when discussing their condition or treatment from 78.6% to 85.6% by 31 March 2019.	
	To improve the percentage of patients reporting that before leaving hospital they were given written information on what they should or should not do after leaving from 48.5% to 63.5% by 31 March 2019.	
	To improve the percentage of patients reporting that hospital staff discussed whether any additional equipment or adaptations were required at the patient's home from 66.8% to 81.8% by 31 March 2019.	
	To improve the percentage of patients reporting that they were asked to give their views on the quality of care during their stay in hospital from 20.5% to 35.5% by 31 March 2019.	
	To increase the percentage of patients reporting that they received information on how to complain to the hospital about the care they received from 19.5% to 34.5% by 31 March 2019.	
Clinical Effectiveness		
Preparing for the CQC Inspection	Reflecting on individual services highlighted in the 2016 inspection and gaining assurance on where improvements have been made and where further improvements can be implemented.	
	Review the actions allocated by the CQC and identify the current position and any improvements needed, thereby ensuring the standards of quality care are met.	
Improved Compliance with the Mental Capacity Act	The percentage compliance with the Mental Capacity Act based on three assessment criteria being: Compliance with the Adult Safeguarding training (that includes Mental Capacity Act) from 84.27% (October 2017) to 95% by 31 March 2019.	
Effective Outcomes for Women and Baby	Improve the percentage of Small for Gestational Age (SGA) babies detected from 43.9% to 58% by 31 March 2019.	

3.1.2 Performance against the 2018/19 Priorities

There were nine quality priorities for 2018/19, as follows;

- Patient Safety
  - Missed or delayed diagnosis
  - Deteriorating patient (including sepsis)
  - Medication safety
- Patient Experience
  - End of life care
  - Patient discharge from hospital
  - Learning from the views of inpatients
- Clinical Effectiveness
  - Preparing for the CQC inspection
  - Improved compliance with the Mental Capacity Act
  - Effective outcomes for women and baby

Details of the achievement against these in the year are included overleaf.

Domain: Patient Safety

Missed or delayed diagnosis

Executive Lead: Medical Director
Operational Lead: Associate Medical Director (AMD) Health Informatics

Rationale
The systems of acknowledging the results of radiology investigations was a hybrid of electronic and paper based systems. By introducing a single electronic system, the Trust can reduce the risk of a result being either missed or there being a delay in it being reviewed.

This was one of the 17 priorities in the Trust Quality Improvement Plan in 2017/18.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to improve the current rate of electronic acknowledgement of radiology results by reducing to one system of reporting radiology results and ceasing the production of paper results.

The objective for 2018/19 was to improve the percentage of positive electronic acknowledgement of radiology examinations requested by TRFT clinicians from 30% to 100% by 31 March 2019.

What did we achieve?
Paper Reports were turned off in August 2018, for the main Hospital site for Inpatients and Outpatients, with all radiology reports now being delivered through Meditech. Additional paper copies are still being sent out for Urgent and Critical Reports. The Policies around Results Acknowledgement have been updated, and are out for consultation.

By March 2019 the electronic acknowledgement of radiology notices was at 30%.

How was progress monitored and reported?
Progress is being monitored by Associate Medical Director for Health Informatics through a PowerBI Dashboard. Progress of the Project was reported at Clinical Health Informatics Development Group (CHID), Clinical Governance Committee (CGC), and Quality Assurance Committee (QAC).

What further actions need to be undertaken?
To expand the system into out of scope areas (e.g. UECC, and community areas). To disseminate the updated policy, and get each Division to update their own Policies for Result Acknowledgement, and to delegate responsibility for monitoring the process to each area.

Work is also required to re-engage with clinicians. Results Acknowledgement is frequently discussed at the Patient Safety Group and work is ongoing between the Medical Director and Chief Clinical Information Officer.

Deteriorating patient (including sepsis)

Executive Lead: Medical Director
Operational Lead: AMD Patient Safety & Acute Medical Unit (AMU) Consultant

Rationale
In 2016 there was a noted rise in crude mortality across The Rotherham NHS Foundation Trust associated with an increase in Serious Incident (SI) reports about late identification of clinical deterioration. Steps were taken to change the processes used to identify, quantify and respond to clinical deterioration and subsequently there has been an improvement in mortality metrics for subsequent time periods and a reduction in SIs being reported in relation to failure to recognise clinical deterioration.

However, TRFT's quarter 1 performance on the Sepsis CQUIN was poor on the parameter looking at the timely delivery of antibiotics. Whilst sepsis is recognised promptly, there was also a lack of evidence to demonstrate that an appropriate antibiotic was then administered within 60 minutes (the CQUIN standard).

This priority continued from 2017/18.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to improve the time between the identification of the need to screen a patient to identify if they have sepsis and the administration of the first dose of intravenous antibiotics for those patients that require treatment for sepsis.

The objectives for 2018/19 were:

To improve the percentage of patients who met the criteria for screening for sepsis and were screened for sepsis using the appropriate tool within one hour of having identified that the patient needed screening from 71.5% to 90% by 31 March 2019. (Note: Baseline using Quarter 3 data 2017/18, taken as an average of Emergency Department and Inpatient figures, 69% and 74% respectively.)

To improve the percentage of patients receiving Intravenous Antibiotics within one hour of having identified that the patient has sepsis from 60.5% to 90% by 31 March 2019. (Note: Baseline using Quarter 3 data 2017/18, taken as an average of Emergency Department and Inpatient figures, 39% and 82% respectively.)

What did we achieve?
NEWS2 (National Early Warning Score)
The use of NEWS2 was mandated for use in all acute NHS trusts by March 31st 2019. The Critical Care Outreach Team wrote a guide to introduce the management of the deteriorating ward patient (age 16 and above) using the NEWS2 document for roll out during March 2019. This guide includes stop the shift information, demonstrates how to use the document, details what the changes are compared to the previous early warning MEWS (modified early warning score), and includes "Think Sepsis". NEWS2 doesn't include a calculation for urine output; this is also included within the guide, and the Fluid balance charts have been reviewed and updated. Paediatrics and Obstetrics have separate tools specific to those patient groups. The Trust successfully rolled out NEWS2 across the Trust before the end of March 2019 and will continue to roll-out electronic observations (e.Obs) throughout the Trust during Financial Year 19/20.

Sepsis screening tool

A sepsis early warning detection system has been built into Meditech which links to the electronic observations (e.Obs). The initial trial was rolled out within UECC during January 2019, followed by a pilot within the Surgical Assessment Unit (SAU), with training support from the Electronic Patient Record (EPR) and Practice Development Team. All other areas continue with the paper form of the tool pending the full roll-out of e.Obs.

CQUIN

The National CQUIN for sepsis is focussed on the timely identification and treatment of sepsis in emergency departments (ED) and in the acute in-patient setting, including appropriate antibiotic review and an overall reduction in antibiotic consumption per 1000 admissions.

For the percentage of patients who met the criteria for screening for sepsis and who were subsequently screened for sepsis using the appropriate tool within one hour (of having identified that the patient needed screening). The table below shows the improvements made over the space of this financial year:

	ED	Acute Inpatients
Qtr 1 17/18	83%	39%
Qtr 1 18/19	74.80%	*
Qtr 2 17/18	71.40%	76.20%
Qtr 2 18/19	88.60%	98.10%
Qtr 3 17/18	69.20%	73.80%
Qtr 3 18/19	99.40%	100%
Qtr 4 17/18	78.10%	74.50%
Qtr 4 18/19	100%	100%

For the percentage of patients receiving intravenous antibiotics within one hour (of having identified that the patient has sepsis). The table below shows the improvements made over the space of this financial year:

	ED	Acute Inpatients
Qtr 1 17/18	36%	39%
Qtr 1 18/19	54.20%	*
Qtr 2 17/18	40.20%	83.90%
Qtr 2 18/19	54.30%	78%
Qtr 3 17/18	42.20%	95.50%
Qtr 3 18/19	75.20%	75%
Qtr 4 17/18	73.70%	81.30%
Qtr 4 18/19	59.70%	70.10%

* There was no submission for Quarter 1 for the Inpatients.

How was progress monitored and reported?

Reports were provided to the Deteriorating Patient/Sepsis Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

Regular meetings are being held to identify how this can be improved and support is being obtained from other divisions. In addition, the divisions (in particular medicine) have been asked to identify what, if any, additional resource may be required to improve our achievement of the CQUIN moving forward. The launch of the Trust's new Safe & Sound Quality Framework will help drive improvements in the recognition and treatment of the deteriorating patient, including those with sepsis. A full Training Needs Analysis of current training and education provision to clinical staff in recognising the deteriorating patient and sepsis will be undertaken during Financial Year 19/20.

Medication Safety

Executive Lead – Medical Director
Operational Lead - Chief Pharmacist

Rationale
Medicines optimisation is a strategic issue fundamental to the way that hospitals work and to the quality of patient care provided. The consequences of failing to deliver an effective system are significant and include: exposure of patients to unnecessary risk and harm; failure of patients to get the benefits from the medicines they are prescribed; whole system inefficiency; unnecessary expenditure and other avoidable costs; poor patient experience; and loss of reputation.

Several opportunities for improvement in governance and performance exist within the Trust with respect to medicines use. There have been some positive developments but further significant change and action is required to deliver the level of care that our patients need.

A fundamental requirement is to have a safe and effective system for managing medicines to ensure that all patients receive the medicines that they need, when they need them and irrespective of their location within the Trust. Medicines are complex so it should be as easy as possible for staff to do the right thing, each and every time. The Trust wants patients to get the best out of their treatment, ensuring that they receive the information, help and support that they need and are given real input into the decisions made about the medicines they receive and the services used to provide them.

This priority continued from 2017/18.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to increase the proportion of medication administration signed for or, a reason for non-administration to be recorded on the drugs kardex and to increase the proportion of patients who are discharged, and receive their medication and information in a timely and appropriate manner.

The objectives for 2018/19 were to:

- Improve the percentage of medication administrations signed for or, a reason for non-administration recorded on the medication chart, from 96% to 100 % by 31 March 2019.
- Improve the percentage of patients leaving the organisation with a discharge letter, their medication and having received information about their medication from the discharging ward/nurse from 80% to 100% by 31 March 2019.

(Note – Medication Safety is also covered in metrics in other priorities, including Discharge and Learning from the Views of Inpatients)

What did we achieve?
The latest audit of omitted medications took place in March 2019.

For 2018/19 the aim was to improve the percentage of medication administrations signed for, or, a reason for non-administration recorded on the medication chart, from 96% to 100% by 31 March 2019. Following the latest omissions audit in March 2019, this remains at 96%.

An audit of medication omissions occurs quarterly (June, September, December and March). The audit report/results are shared and discussed with Ward Managers, Matrons, Heads of Nursing and Pharmacy colleagues, and presented at Medication Safety Group, Patient Safety Group, Clinical Governance Committee and Quality Assurance Committee.

There has been a strong drive to share the omissions information with nurses at ward level in order to improve practices. This is done at the time of the audit. Pharmacy staff at ward level also raise omissions and blanks with ward staff when reviewing prescription charts; if blanks are present they follow up with nursing colleagues with a view to getting the administration signed or an appropriate omission reason code applied.

Over the course of 2017/18 and 2018/19 it has proved very challenging to reduce the number of blanks on the administration record where a signature or a reason-for-omission code should have been used.

The March 2018 omissions audit reviewed the medication charts of 5 patients from each inpatient area.

A total of 89 patient medication charts were reviewed and included in the audit on this occasion.

A total of 6,602 doses were possible to administer with 972 doses omitted. This gives a crude omission rate of 14.7% (similar to previous audit results).

The adjusted (validated) omissions, i.e. the rate when valid omissions are removed, was 686 omissions, giving an adjusted (validated) omission rate of 7.1%.

For reference, valid omissions are:
- Code 3: Patient refused dose
- Code 5: Withheld at nurse's discretion and reasons documented
- Code 6: Withheld at doctor's request and reasons documented

Of the 686 (7.1%) invalid omissions:
- 458 (66.8%) were blanks (no signature nor omission code used)
- 0 (0%) were Code 1 (patient away from ward)
- 51 (7.4%) were Code 2 (patient could not take dose)
- 177 (25.8%) were Code 4 (dose not available)

The March 2019 omissions audit reviewed the medication charts of 5 patients from each inpatient area.

A total of 85 patient medication charts were reviewed and included in the audit on this occasion.

A total of 6,733 doses were possible to administer with 1082 doses omitted. This gives a crude omission rate of 16.1% (similar to previous audit results).

The adjusted (validated) omissions, i.e. the rate when valid omissions are removed, was 616 omissions, giving an adjusted (validated) omission rate of 9.1%, an increase from audit in December 2018. For reference, valid omissions are:

- Code 3: Patient refused dose
- Code 5: Withheld at nurse's discretion and reasons documented
- Code 6: Withheld at doctor's request and reasons documented

Of the 616 (9.1%) invalid omissions:

- 269 (43.6%) were blanks (no signature nor omission code used)
- 8 (1.3%) were Code 1 (patient away from ward)
- 134 (21.8%) were Code 2 (patient could not take dose)
- 205 (33.3%) were Code 4 (dose not available)

The proportion of omissions due to "blanks" is same as the audit in December 2018.

A total of 119 (11.0%) key critical medicines were omitted: anticoagulants (45), antimicrobials (38) and insulins (16), Parkinson medicines (9) and chemotherapy (2). These five will be monitored over the next 12 months.

How was progress monitored and reported?

Reports were provided to the Patient Safety Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

Work needs to continue in terms of sharing audit data with ward managers and nurses at ward level in order to change and improve practice. Matrons forums and Ward Managers forums will be utilised to share omissions data with a view to improving practice at ward level.

Next steps: the following work will be carried out with wards:

- Ward staff to escalate if patient unable to take doses via the route prescribed
- Display ward stock lists prominently for reference in medicines storage areas
- Educate ward staff regarding pharmacy annotations when a supply is made
- Emphasise the importance of transferring medicines with patients on transfer to another ward
- Reinforce the message that patient's own supplies when available need to be used
- Inform ward staff of common approved names and brand names e.g. macrogol = Movicol
- Review and update stock lists to expand the range of medicines available at ward level

Domain: Patient Experience

End of life care

Executive Lead – Chief Nurse
Operational Lead – Assistant Chief Nurse (Vulnerabilities)

Rationale

The Care Quality Commission (CQC) Trust re-inspection in 2016 identified a number of excellent examples of systems and processes of care provision. However, the re-inspection also identified the following areas that require improvement and a Regulatory Action was issued to the Trust by the CQC:

Acute – End of Life Care

Ensure all "do not attempt cardio-pulmonary resuscitation" (DNACPR) decisions are always documented in line with national guidance and legislation.
Ensure there is evidence that patients' capacity has been assessed in line with the requirements of the Mental Capacity Act (2005).

Community - End of Life Care

Ensure that all DNACPR forms are completed appropriately and accurately ensuring that mental capacity assessments are completed for patients where it has been assessed they lack capacity.

In addition to the above, the following areas were also identified for improvement:

All areas in the community adopt and embed the individualised end of life care plan and ensure that advanced care planning is discussed to prevent any inappropriate admissions to hospital.
Arrangements reviewed to monitor the patient's preferred place of care and death.

The Trust has had an opportunity as one of 15 Trusts to take part in an NHS Improvement, End of Life Care Collaborative. The first 2 areas identified are wards A2 and Fitzwilliam (a surgical and medical ward and both have a purple butterfly room, which is a dedicated facility for patients and their families at the end of their life).

This priority continued from 2017/18.

In 2018/19 the Trust aimed to continue to ensure that patients requiring palliative or end of life care receive care consistent with the best practice standards of One Chance to Get It Right. (Leadership Alliance for the Care of Dying People 2014)

The aim and objective(s) (including the measures/metrics)

The aim for 2018/19 was to embed improvements in the care of patients on the End of Life Care Pathway through progressing the improvements achieved on wards A2 and Fitzwilliam following their participation in the NHS Improvement End of Life Care Collaborative.

The objectives for 2018/19 were to:

- Improve the percentage of registered nursing staff and relevant Multi-Disciplinary Team Members trained in the use of end of life care plans from 0% to 80% on two wards (Ward A1 and Ward A4) by 30 June 2018 and repeat this each quarter for 2 new wards as outlined in the roll out.

- Improve the use of end of life care plans for patients receiving end of life care on the two wards from (A1 0% and A4 6%) to 100% by 30 June 2018 and repeat this each quarter for the wards identified in the roll out plan.

What did we achieve?

Outcome as per finding at the end of each quarter and area focus of support

Ward	Staff Trained	End of Life Care Plan
A2	100%	100%
Fitzwilliam	100%	72%
A1	81%	88%
A4	70%- ward manager to cascade training to night staff	40%
Medical Assessment Unit	86%	55%
Stroke	81%	50%
A5	86%	26%
A7	92%	44%
B4	83%	To be collected April-June 2019
B5	83%	To be collected April-June 2019

How was progress monitored and reported?

Reports were provided to the Patient Experience Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

- To continue to maintain a high focus on End of Life Care and use of the individualised care plan led by the Specialist Palliative Care Team.
- To continue to undertake quarterly audits and reviews to provide assurance of use of the end of life care plan or to identify areas where additional support or action is required.
- To sustain and improve leadership of areas as required by providing additional support and training in relation to end of life care – support provided from Specialist Palliative Care Team.
- Monitoring and oversight of priority actions and improvement trajectory via the Clinical Governance Committee and Quality Assurance Committee.
- Executive support

Patient discharge from hospital

Executive Lead: Chief Operating Officer
Operational Lead: Director of Operations

Rationale
The NHS Improvement SAFER patient flow care bundle (NHS Improvement) is a practical tool to reduce delays for patients in adult inpatient wards. Each letter of SAFER stands for an action and the E is for Early discharge. NHS Improvement recommend that 33% of patients will be discharged from base inpatient wards before midday. This then allows emergency admissions from the Emergency Department to be accommodated without delay.

This priority continued from 2017/18.

The aim and objective(s) (including the measures/metrics)
In 2018/19 the Trust aimed to continue to improve the management of hospital discharge ensuring people leave hospital in a safe, timely way.

The aim for 2018/19 was to increase the proportion of discharges that take place in the morning as part of implementing the SAFER patient flow care bundle.

The objective for 2018/19 was to improve the percentage of patients discharged across the site by 12 midday from 10% to 20% by 31 March 2019. Increasing by 2.5% each quarter, sharing information across divisions and teams on how this metric is progressing each quarter. This was achieved on the two wards where measurement was undertaken.

(Note – discharge is also covered in metrics in other priorities, including Medication Safety and Learning from the Views of Inpatients)

What did we achieve?
Pre-Noon Discharge
The Trust identified that not all discharges were entered on to Meditech at the time patients were discharged and those patients transferred to the Discharge Lounge prior to discharge were not discharged off the system until later in the day, by the discharge lounge team. To reflect the true position of Pre-noon discharges a pilot of manual data collection was undertaken on Wards A1 and A5 (Medical Wards).

The month of March 2019 showed that 25% of patients on A1 were discharged before midday and 31% of patients were discharged before midday on A5, above the 20% Trust target. In the short term, the plan is to roll out manual data collection to the rest of the wards so the Trust has a clear understanding of when patients are being discharged throughout the day.

The month of March 2018 showed that 20% of patients on A1 were discharged before midday and 14.29% of patients were discharged before midday on A5, above the 20% Trust target.

Criteria Led Discharge
Some elements of criteria led discharge were being adopted at ward level but not fully embedded across the Trust. A5 is one of the exemplar wards for SAFER and were following the principles of Criteria Led Discharge although it is not fully embedded into practice 7 days.

Criteria Led Discharge is one of the principles of SAFER patient flow bundle. The plan is to incorporate criteria led discharges in to the ward rounds, initially on the exemplar wards A5 and A1 and then roll out across the rest of the Trust.

Long Length of Stay (LLOS) Reviews
Initial work with Emergency Care Intensive Support Team (ECIST) commenced in October 2018, with a review of current processes and at that point the Trust was introduced to NHS Improvement methodology for Long Stay Reviews.

#LongStayWednesday was implemented across the Trust in November 2018, there is an MDT approach with representation from nursing, medical, therapy and Integrated Discharge Team (IDT). The long stay review team visit ward areas weekly to understand why patients are still in hospital, they identify themes, areas of good practice and areas requiring focus where there is an opportunity for improvement. Themes are emerging and the information will be available for dissemination in 2019/20.

Initially patients with a Length of Stay (LOS) over 21 days were identified for review, this reduced to 14 days. #LongStayWednesday has been greatly received by the ward areas and the Trust has seen a reduction in long stay/stranded patients since implementation in November 2018.

ECIST reviewed the #LongStayWednesday process in February 2019 and commended the team on the investment in time and commitment to the reviews. Very positive feedback with further opportunities identified for improvement. Work continues internally to evolve the membership of the MDT review Team, improve the process and work towards reviewing patients with a length of stay over 7 days.

SAFER/Red2Green
The Trust initiated conversations with NHS Improvement to participate in the 3rd Cohort of the SAFER/Red2Green/LLoS Collaborative and the SAFER team attended back in November 2018 and in March 2018 to share and learn from experiences. The Trust is paired with Mid Cheshire Hospitals NHS Foundation Trust and a peer visit took place in April 2019.

There is a SAFER working group with a membership that is evolving, again using an MDT approach. The group meets weekly to discuss plans and progress is made using the Plan, Do, Study, Act (PDSA) methodology.

An Operational Improvement Lead has been secured and will remain in the Trust for 6 months to support wards in SAFER/Red2Green/LLoS.

Progress has been made on the wards with Estimated Date of Discharge (EDD) the 'Golden Patient' with board and ward rounds ongoing. The SAFER team are currently working with the ward team on A5 around the quality of board rounds, criteria led discharges and a push for early discharges and this will start on A1 early April.

How was progress monitored and reported?
Reports were provided to the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?
Continue work with SAFER Collaborative and peer to peer learning. The next Collaborative meeting the Trust will be attending is 14 May 2019 and Mid Cheshire NHS Foundation Trust visit in April 2019.

Continue the process of gathering SAFER data to monitor progress, a SAFER/Red2Green dashboard is in draft ready to be reviewed. A SAFER Baseline Ward Assessment is to be undertaken initially on A1 and A5 and rolled out over 3 months across the rest of the Trust, this includes asking patients the 4 key questions: What is the matter with me? What is going to happen today? What is needed to get me home? When am I going home? To be completed throughout April 2019.

Work with the Chief Nurse and Medical Director to re-launch the SAFER/Red2Green as part of the 'Safe as Sound' Trust Quality Agenda and send communication out to all staff to raise awareness.

Educating staff at ward level for SAFER principles and Red2Green with support from NHS Improvement, this will start April 2019.

Implementation of SAFER/Red2Green will be a phased approach with a plan to work with A1 and A5 and identify another ward in medicine and surgery for the month of April.

Learning from the views of inpatients

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse

Rationale
The annual national inpatient survey (2016) showed 5 areas where The Rotherham NHS Foundation Trust (TRFT) was performing worse than the majority of Trusts in the country. Subsequently 'Learning from the views of inpatients' was identified as a Quality Priority for 2018/19 and an action plan was devised to address the key concerns identified. Monthly surveys take place on in-patient wards to establish if responses to poorer performing questions are improving.

The 2017 adult inpatient survey was completed before the action plan was fully embedded and therefore the objectives were set linked to the outcomes of the 2018 survey. The 2017 results do however give a useful indication in changes in perceptions of our patients. Data collection for the 2018 survey is now complete so any further actions taken will not impact upon results this year.

Quarterly surveys provide a useful barometer showing how we are performing but as the year has progressed, it has become evident that the methodology is too different from the national postal survey to provide an accurate assessment of likely outcomes within the national survey.

This was a new priority for 2018/19

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to improve our patient's experience, which will then be reflected in our scores reported in the annual national inpatient survey. The comparison of current performance and planned improvement is shown below based on benchmarking the Care Quality Commission scores against other Trusts (Table 1) and comparing the Trust data with data from the previous year (Table 2).

Table 1 – Performance against other Trusts

	Number of responses in 2016 survey in each category	Planned improvement for 2018 survey
Below national average	5	Decrease by 2
About the same	60	
Above national average	0	Increase by 8

(Source: Care Quality Commission)

Table 2 – Internal performance against previous years

	2016 (compared to 2015)	2018 (compared to 2016)
Lower score	45	Decrease by 20
About the same	18	
Improved score	2	Increase by 20

(Source: Care Quality Commission)

Specific objectives were:
1. To improve the percentage of patients reporting that they were not bothered by noise at night from other patients from 49.5% to 62.5% by 31 March 2019.
2. To improve the percentage of patients reporting that they were given the right amount of information about their condition or treatment from 72% to 81% by 31 March 2019.
3. To improve the percentage of patients reporting that they were given enough privacy when discussing their condition or treatment from 78.6% to 85.6% by 31 March 2019.
4. To improve the percentage of patients reporting that before leaving hospital they were given written information on what they should or should not do after leaving from 48.5% to 63.5% by 31 March 2019.
5. To improve the percentage of patients reporting that hospital staff discussed whether any additional equipment or adaptations were required at the patient's home from 66.8% to 81.8% by 31 March 2019.
6. To improve the percentage of patients reporting that they were asked to give their views on the quality of care during their stay in hospital from 20.5% to 35.5% by 31 March 2019.
7. To increase the percentage of patients reporting that they received information on how to complain to the hospital about the care they received from 19.5% to 34.5% by 31 March 2019.

The percentage increases shown for objectives 1-5 are to increase the Trust to the level of the national average performance for 2016. The performance for objectives 6-7 is already above national average and therefore a target of 15% increase is proposed.

In order to establish that the level of progress required to achieve these improvements in the National Inpatient Survey is achieved. A Trust baseline score for these 7 questions was established during Quarter 4 2017/18 using a local survey methodology and this baseline then had the appropriate percentage increases applied to provide the target score for 2018/19.

What did we achieve?

The results show an improved picture with improvement aims being met in 5 of the 7 categories within locally conducted surveys. All inpatient divisions were included.

Objective	2016	2017	Quarter 4 2018/19	2018 (aim) – Data not yet available
To increase the percentage of patients reporting that they were not bothered by noise at night from other patients by 13%	49.5%	56.1%	53%	62.5%
To increase the percentage of patients reporting that they were given the right amount of information about their condition or treatment by 9%	72%	76%	94%	81%
To increase the percentage of patients reporting that they were given enough privacy when discussing their condition or treatment by 7%	78.6%	76%	97%	85.6%
To increase the percentage of patients reporting that before leaving hospital they were given written information on what they should or should not do after leaving by 15%	48.5%	59%	63%	63.5%
To increase the percentage of patients reporting that hospital staff discussed whether any additional equipment or adaptations were required at the patient's home by 15%	66.8%	77.9%	88%	81.8%
To increase the percentage of patients reporting that they were asked to give their views on the quality of care during their stay in hospital by 15%	20.5%	20.1%	22%	35.5%
To increase the percentage of patients reporting that they received information on how to complain to the hospital about the care they received by 15%	19.5%	28.9%	69%	34.5%

Quarter 4 results showed that targets had been achieved in 5 of the 7 domains. The greatest change within the quarter was in relation to the number of patients knowing how to make a complaint. Comments from patients included knowing there was a Patient Experience Team, awareness of the dedicated telephone number, knowledge of signs about making a complaint and an understanding of the role of the nurse in charge to assist.

During the year, there has been very little improvement in the number of patients being disturbed at night by other patients with snoring being the most commonly named disturbance. It is proposed to trial an offer of earplugs on a medical ward and evaluate the uptake and effectiveness. Although the Quality Improvement Priority does not include noise from staff (as this did not show as an outlier on the national survey), it is recorded each quarter on the internal surveys. This has shown a significant improvement in quarter 4 with only 15% of respondents identifying noise at night from staff being problematic compared to 53% last quarter. Bins were identified as being noisy at night in some areas and this has been fed back for action by Ward Managers. It is hoped that this improvement reflects a growing awareness of the night noise issue amongst staff and will continue to be monitored to ensure sustained change.

The second area to not show any improvement during the year is the percentage of patients being asked about the quality of their experience. Although this quarter's results are the best results achieved during the year, this still falls short of the desired improvement. Whilst this is disappointing, it is expected that the percentage would increase within the postal survey due to the Friends and Family Test only being offered at the point of discharge. This metric will continue to be monitored to identify if additional interventions prior to discharge would be beneficial. Matrons will be asked to talk to patients about

their perceptions of quality as part of their ward assurance processes. It is hoped that planned developments for next year, linked to the Safe and Sound strategy will also help to improve this domain.

The results of local surveys do not always reflect expected findings from the national data survey due to the differences in data collection methodology. Key differences include the timing of the survey and the point the patient is upon their journey. As an example, the timing of the surveys means that many patients do not think it is yet appropriate to be receiving written discharge information or do not require adaptations (50% and 71% respectively). The positive responses above therefore only relate to the patients who felt these questions were applicable. The results however, were encouraging and were supported by a range of positive comments from patients, particularly in relation to therapy adaptations.

Quarter 4 has shown an improved picture when compared to the 2016 and 2017 surveys and previous quarters. The improvement aims have been met in 5 of the 7 categories. Data collection for the 2018 survey is now complete so any further actions taken will not impact upon results this year. It is acknowledged that the findings may vary from the national inpatient survey due to the different method of data collection and timing of the collation of information. The 2018 National Inpatient Survey findings will be published in early summer 2019.

How was progress monitored and reported?
Reports were provided to the Patient Experience Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?
The Patient Experience Group will consider the results of the 2018 Inpatient Survey once published. An action plan will be developed to support continuous improvement and will be monitored quarterly through the group with escalations to Clinical Governance Committee as required.

Domain: Clinical Effectiveness

Preparing for the CQC inspection

Executive Lead – Chief Nurse
Operational Lead – Quality Governance, Compliance and Risk Manager

Rationale
The Care Quality Commission is the independent regulator of all health and social care services in England. They monitor, inspect and regulate hospitals and other care providers.

The Trust was inspected in September 2016 and whilst there was a lot of good practice identified, there were also areas for improvement, which led to 3 requirement notices (compared to 12 in 2015) and a total of 65 actions – a combination of Must Do (29) and Should Do (36) actions (compared to 15 Must Do and 12 Should Do actions in 2015). Most actions fall within the effective and well-led domains. At this inspection, the overall key question of well-led was reviewed and based upon the findings in the inspection this was rated as Requires Improvement which remains at the same level as at the previous inspection in 2015.

The CQC have revised their inspection process and confirmed that all Trusts will be inspected again by June 2019.

This is an opportunity to revisit where the Trust is at and through ensuring that the CQC standards are met, further improve the quality of services.

This was a new priority for 2018/19.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 was to use the opportunity of the CQC inspection cycle to promote better quality of care. This includes:

1. Reflecting on individual services highlighted in the 2016 inspection and gaining assurance on where improvements have been made and where further improvements can be implemented.
2. Review the actions allocated by the CQC and identify the current position and any improvements needed, thereby ensuring the standards of quality care are met.

What did we achieve?
In order to prepare staff for the inspections the following has been undertaken:

- The processes for the CQC inspections have been developed (including for the Factual Accuracy process) and have been circulated to all relevant individuals to ensure that they are aware of their role in an inspection.
- 13 staff awareness sessions have been held (a mixture of in the hospital and community). A leaflet has been developed to support staff with the inspection.
- NHS Improvement supported the Trust on 29 August 2018 with some peer reviews and mock interviews. The feedback has been positive, and each team were welcomed to the area, colleagues were open and honest about the care they provide and patients were complimentary about those caring for them and the service they received. A series of key areas for improvements were identified and include and actions put in place. The Trust then replicated these peer reviews with Executive Directors leading the reviews.
- A bi-weekly CQC Steering Group meeting was held to prepare staff and share the work that is being undertaken.

The Trust received a focused inspection on 17 July 2018 looking at Non Invasive Ventilation and treatment of paediatric patients in the Urgent and Emergency Care Centre (UECC). Acton plans were submitted to the CQC and these were being reviewed and resubmitted on a fortnightly basis. The CQC have now agreed that these no longer need to be submitted to the CQC.

The Trust received the following inspections;
- core service unannounced inspection on 25-27 October 2018 of four core services;
  - Acute - Maternity
  - Acute – Children and Young People
  - Acute – Medicine
  - Acute – Urgent and Emergency Services.
- Use of resources inspection on 28 September 2018
- Community unannounced inspection on 16-18 October 2018 - Community Children and Young People core service only
- Well led inspection on 22-24 October 2018

The final reports were published on 31 January 2019. A communication plan had been developed and various presentations were delivered towards the end of that week and the beginning of the next to ensure that staff were aware of the findings in the report.

Four requirement notices have been given to the Trust. These are the legal requirements that the Trust were not meeting, they are as follows;

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

An action plan was required to be produced for each of the above, using the CQC template. These were submitted to the CQC in February 2019.

The CQC have also issued the Trust with 74 actions (a combination of Must Do (47) and Should Do (27) actions). They are split as follows:

	Service	Must Do	Should do
	Trust Level	7	3
Hospital	Urgent and Emergency Care	12	10
Hospital	Medical Care	11	9
Hospital	Surgery	Not Inspected	
Hospital	Critical Care	Not Inspected	
Hospital	Maternity	9	2
Hospital	Children and Young People	4	3
Hospital	End of Life Care	Not Inspected	
Hospital	Outpatients and diagnostic imaging	Not Inspected	
Community	Community adults	Not Inspected	
Community	Community end of life care	Not Inspected	
Community	Community inpatients	Not Inspected	
Community	Community Children and Young People	7	8
Community	Community Dental	Not Inspected	
	TOTAL OVERALL	47	27

How was progress monitored and reported?

Reports were provided to the CQC Steering Group, along with the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

Continue to address the findings from the CQC inspection and prepare staff for the next inspection.

Improved compliance with the Mental Capacity Act

Executive Lead:Chief Nurse
Operational Lead: Assistant Chief Nurse (Vulnerabilities)

Rationale

The CQC Trust inspection in 2015 and more recently at the CQC Trust re-inspection in September 2016 identified compliance with the Mental Capacity Act (MCA) as an area that required improvement and was identified as a 'Must Do' and regulatory action. Although a significant amount of work to improve has been undertaken, this remains an important area of focus. The Trust aims to safeguard vulnerable adults and achieve full compliance with the Mental Capacity Act and statutory regulations relating to vulnerable people, including those assessed as lacking capacity to make decisions for themselves.

This priority continued from 2017/18.

The aim and objective(s) (including the measures/metrics)

The aim for 2018/19 was to ensure compliance with the Mental Capacity Act, through learning from the CQC and other Trusts who are demonstrating outstanding compliance in relation to the Mental Capacity Act (MCA).

The objectives for 2018/19 were to improve:

- The percentage compliance with the Mental Capacity Act based on three assessment criteria being:

(A) Is there evidence of a capacity assessment in the patient's record
(B) Is there evidence of a best interest decision in the patient's records
(C) Has a Deprivation of Liberty (DoL) request been completed (where appropriate) (Acute Adult Services only)

Benchmark data obtained during March 2018
(A) 17% to 80% by 31 March 2019
(B) 14% to 80% by 31 March 2019
(C) 34% to 80% by 31 March 2019

- Compliance with the Adult Safeguarding training (that includes Mental Capacity Act) from 84.27% (October 2017) to 95% by 31 March 2019.

What did we achieve?

Audit	Benchmark Data Q3/Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) - Acute - Community	Audit undertaken 12 - 15 March 2018				
(A) Is there evidence of a capacity assessment in the patient's record	23.5%	Target 30% Actual 53%	Target 45% Actual 61%	Target 60% Actual 70%	Target 80% Actual 68%
(B) Is there evidence of a best interest decision in the patient's records	21%	Target 30% Actual 56%	Target 45% Actual 57%	Target 60% Actual 70%	Target 80% Actual 64%
(C) Has a DoLS request been completed (where appropriate) Acute Adult Services only	35%	Target 50% Actual 57%	Target 60% Actual 53%	Target 70% Actual 63%	Target 80% Actual 50%
Safeguarding Training	End of Feb 2018 85.01%	Target 87% Actual 84.35%	Target 89% Actual 87.2%	Target 93% Actual 86.48	Target 95% Actual 76.2%

As per the agreed actions for the end of Quarter 4, an audit was completed and led by the Safeguarding Adults Team. The audit is to assess compliance of assessment of capacity against the agreed trajectory as described above and below.

Overall the findings of the audit for Q4 were not as expected as per trajectory however have demonstrated a significant overall increase from the initial commencement of the priority actions.

Quarter 4 2018/2019 Adult Safeguarding Training Compliance was:

- January 84%
- February 79.3%
- March 76.2 %

The trajectory for training was to achieve 95% so not achieved. All Actions have been taken as per the agreed plan above and support is provided for the Divisions to achieve compliance in relation to options for training. Further support is required from the Heads of Service in the Divisions and for individuals to take ownership to achieve compliance as per MAST requirements. The Learning and Development Team have also put in place a number of processes to try to improve MAST compliance such as reminders 3 months in advance of expiry and Managers Dashboard are sent out on a monthly basis to ensure visibility of colleagues' compliance with MAST are some examples.

Overall in relation to DoLS requests this has increased overall by 25%.

How was progress monitored and reported?

Reports were provided to the Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

- To continue maintain a high focus and priority of MCA compliance as a Trust – sustained commitment at all levels
- To continue to undertake bespoke audits as required including targeted support as appropriate and reviews to provide assurance of compliance and understanding of the MCA
- For all colleagues to be fully aware of expectations in relation to training, standards and adherence to the Mental Capacity Act – achieved via compliance of level 2 safeguarding training, review of competency and confidence, compliance of MAST requirements and Personal Development Review (PDR) and accountability
- To identify 'MCA champions' and provide an enhanced level of training to enable them to cascade and embed training in their work area
- Review of workload of the Safeguarding Team and prioritisation of specific actions
- Review of how MAST training is provided
- Monitoring and oversight of Priority actions and improvement trajectory via the Clinical Governance Committee and Quality Assurance Committee
- Executive support

Effective outcomes for women and baby

Executive Lead – Chief Nurse
Operational Lead – Head of Midwifery

Rationale

The improved detection of small for gestational age (SGA) babies is a clinical priority for the Rotherham Maternity Service. Across the community there are notable public health challenges affecting optimum foetal growth and therefore the detection of pregnancies affected in this way is vital to improving foetal wellbeing and neonatal outcomes, in particular the reduction of stillbirths and long term morbidity.

The position at the start of this piece of work was a detection rate of 35% for SGA babies (Quarter 1 2016/17). Rotherham has a high level of babies born that are SGA (approximately 13.5% v 10% in the national population) and is currently at 43.4% (Quarter 3 2017/18).

This was a new priority for 2018/19.

The aim and objective(s) (including the measures/metrics)

The aim for 2018/19 was to continue to increase the detection rate and to continue to improve detection by more than 1% per quarter, beginning with a 44.5% detection rate for Q 1 of next year. This would represent a significant improvement in the first year of the programme, with a clear trajectory for year 2.

The objective for 2018/19 was to improve the percentage of small for gestational age babies detected from 43.4% to 50% by 31 March 2019.**What did we achieve?**

Audit	Benchmark Data Q3 2017/2018	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Trajectory - Small for Gestational Age – Detection Rate	End of December 2017 43.4% End of March 2018 40.4%	45.5%	47%	48.5%	50%
Actual – as per data information below		40.4%	37.8%	35.6%	38.6%

The data in the chart shows that Rotherham SGA detection for the Quarter 3 (Oct-Dec) 2018/2019 was 35.6%. The Rotherham data shows that SGA detection appears to be falling. The peak detection was back in Q2 of 2017/18 at 49.5%. The reasons for this are unclear however the information provided below will attempt to provide some context and the plans to improve moving forward.

Rotherham has a higher incidence of SGA than average (16.1 vs 12.1% for the last quarter). This is likely to be due to a high incidence of raised BMI and smoking in our area. Both are strong risk factors for SGA and we currently do not scan smokers at all and do not scan women with raised BMI (or any women routinely) to term. This data is reported by the Perinatal Institute but is a result of data entered by midwives on labour ward after birth of the baby. A recent audit has questioned the accuracy of this data entry (data fully correct for only around 55% of births). This is currently being addressed via education and introduction of a sticker to improve data accuracy. Once this is implemented we can be sure that the report is accurate as a baseline.

The figure of 36% detection is actually what might be expected with our current practice of scanning until 36 weeks as the literature show that SGA detection rate with scan at this gestation is 36.1%.
The reason that 100% detection cannot be achieved is

- Not all women are scanned. Detection of SGA in low risk women relies on Symphysis Fundal Height (SFH) measurement (this is a measure of the size of the uterus used to assess fetal growth and development during pregnancy. It is measured from the top of the mother's uterus to the top of the mother's pubic symphysis which is less accurate than scan)
- Even with best scanning there is inaccuracy of 10-20% in the estimated fetal weight

A Business Case was submitted to the Business Investment Committee in August 2018. The Committee supported the need for increased scanning provision but no additional finance was provided. From November 2018 a number of discussions have taken place including liaison with the Director of Finance and a plan is now in place to progress.

The additional sonographer input will enable the women to have a scan undertaken at 28, 31, 34, 37 and 40 weeks instead of currently the provision is a scan at 28,32 and 36 weeks (2 additional scans in theory but in practice shown to be an average of 1.5 additional scans – 4.5 scans per high risk woman due to the number of women giving birth spontaneously or being induced before the last scan). This will be for all high risk pregnancies and will identify SGA for appropriate management plans to be put in place to prevent a poor outcome. The additional scanning will also be for women who smoke; therefore this will also support our on-going improvements for this work stream. The SGA detection and actions also forms part of the improvement work following the NHS Improvement collaborate work stream.

How was progress monitored and reported?

Reports were provided to the Clinical Governance Committee and Quality Assurance Committee.

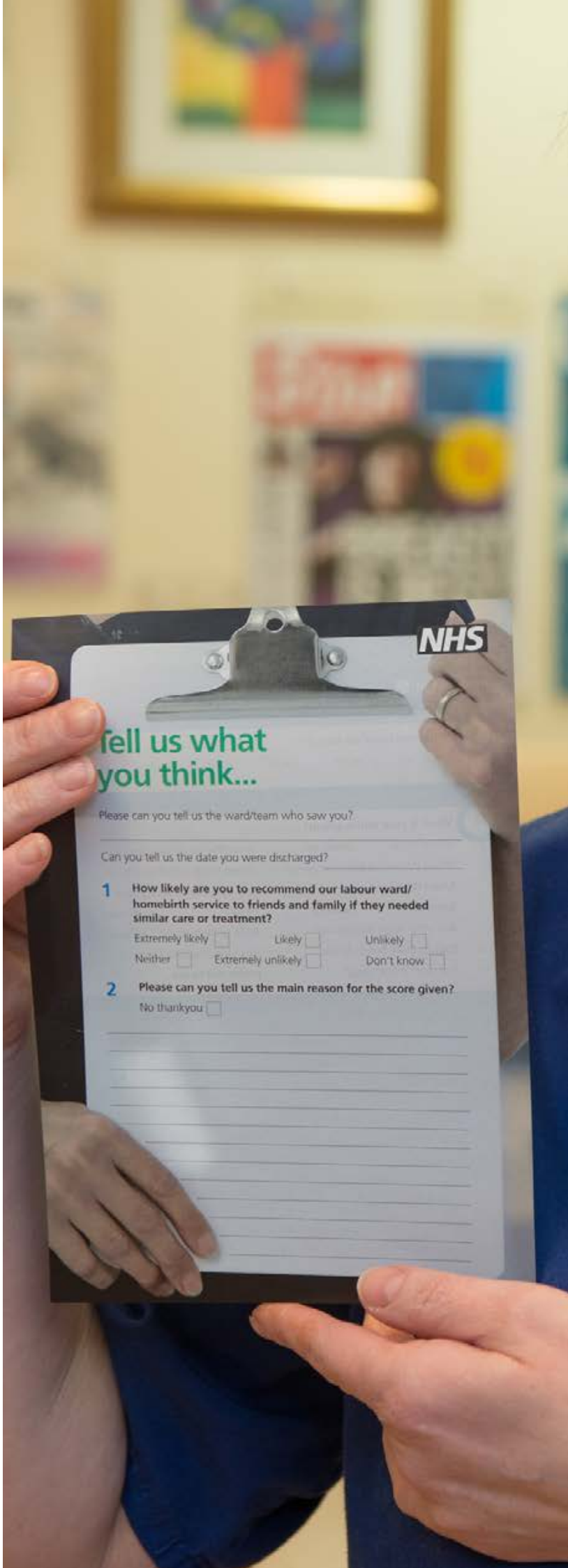
What further actions need to be undertaken?

- To continue to maintain a high focus on the Quality Priority - effective outcomes for women and baby
- To progress the improvements via the NHS Improvement SGA Group and additional working groups as appropriate
- To implement the plan for increased sonography service provision
- To finalise the review and updating of the Reduced Fetal Movement Guideline and embed into practice
- To ensure accurate data is reported to the Perinatal Institute
- Progress of the Better Births and Place Plan to deliver achievements of the 7 Key Lines of Enquiry (KLOEs) including smoking cessation – a number of key actions are progressing for this line of enquiry which will also support in reduction of small for gestational age babies
- Monitoring and oversight of priority actions and improvement trajectory via the Clinical Governance Committee and Quality Assurance Committee.
- Executive support.

3.1.3 Additional information about how we provide care

Friends and Family Test

The Trust continues to use the Friends and Family Test as one method of gaining feedback from patients and their families. The data is anonymised and reported to NHS England who publish the data each month. The latest data is for February 2019 and shows the Trust has approval ratings comparable to acute trusts across England. The 40% target for the response rate for inpatient areas is not being achieved in some areas, however the Trust continues to explore ways for increasing the completion rate. Whilst A&E response rates nationally are significantly lower than inpatient areas, the Trust remains an outlier. This is being addressed as a quality priority for 2019/20.



TRFT FFT results compared to England February 2019*

Service	Rate of return	% recommending	% not recommending
A&E			
TRFT	0.4%	71.4%	23.8%
England	12.2%	85.0%	9.0%
INPATIENTS			
TRFT	42.0%	96.8%	1.6%
England	24.6%	96.0%	2.0%
OUTPATIENTS			
TRFT	n/a	98.2%	0.8%
England	n/a	94%	3%
MATERNITY SERVICES			
ANTENATAL			
TRFT	65%	100%	0%
England	1.54%	95%	2%
BIRTH			
TRFT	25.0%	98.1%	1.9%
England	22.2%	97%	1%
POSTNATAL WARD			
TRFT	79%	100.0%	0%
England	1.41%	98%	1%
POSTNATAL COMMUNITY			
TRFT	46%	100%	0%
England	1.21%	98%	1%
OVERALL COMMUNITY SERVICES			
TRFT	4.40%	94.6%	1.1%
England	6.70%	96%	2%

*Please note February is the latest published data by NHS England.
(Source: NHS ENGLAND Friends and Family Test data)

Friends and family Test Positive scores 2017 / 2018 (1st April 17 - 31st March 2018)

	Target	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Inpatients	95%	97.5%	97.5%	97.5%	97.5%	96.3%	96.0%	97.2%	97.3%	95.8%	95.3%	96.3%	96.7%
Day Cases	95%	98.9%	99.5%	98.5%	100.0%	99.5%	99.0%	99.5%	99.7%	97.7%	99.4%	99.1%	99.1%
Urgent & Emergency Care Centre	85%	83.7%	91.2%	95.5%	91.4%	97.0%	93.7%	92.7%	93.7%	93.1%	99.1%	99.1%	92.8%
Maternity Service	95%	99.6%	98.9%	98.2%	97.3%	97.4%	98.9%	99.7%	100.0%	98.4%	96.7%	98.4%	98.5%
Outpatients	95%	98.0%	98.0%	97.2%	95.2%	98.1%	97.6%	98.2%	95.6%	97.9%	97.2%	97.0%	98.0%
Community Services	95%	98.0%	99.0%	98.1%	96.8%	99.0%	99.5%	98.1%	96.3%	98.4%	97.9%	98.1%	98.8%

Data Source TRFT data capture system.

Friends and family Test Positive scores 2018 / 2019 (1st April 18 - 31st March 2019)

	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Inpatients	95%	98.4%	98.0%	97.5%	97.0%	97.0%	95.3%	97.3%	98.2%	97.6%	97.5%	96.8%	97.4%
Day Cases	95%	99.4%	99.5%	98.6%	99.2%	98.4%	99.5%	99.0%	99.3%	99.7%	99.8%	99.4%	98.7%
Urgent & Emergency Care Centre	85%	97.5%	94.3%	97.8%	94.5%	94.1%	88.5%	93.1%	93.9%	95.8%	82.7%	71.4%	95.8%
Maternity Service	95%	99.7%	99.3%	98.1%	98.1%	99.0%	99.0%	98.4%	100.0%	99.6%	100.0%	99.6%	100.0%
Outpatients	95%	97.1%	97.8%	98.3%	96.2%	97.6%	97.3%	96.7%	97.4%	97.0%	97.8%	98.2%	97.3%
Community Services	95%	95.2%	96.8%	95.9%	97.8%	99.1%	97.8%	92.8%	97.6%	97.0%	99.8%	94.6%	96.7%

Data Source TRFT data capture system.

The Rotherham NHS Foundation Trust - Indicator Scorecard - Friends and Family - 2018/19

Friends and Family Test 2018-19		Quarter 1 (2018-19)					Quarter 2 (2018-19)						Quarter 3 (2018-19)						Quarter 4 (2018-19)					
	% Response Rate	Target	Quarter to date	Apr 18	May 18	June 18	On target	Target	Quarter to date	July 18	Aug 18	Sept 18	On target	Target	Quarter to date	Oct 18	Nov 18	Dec 18	On target	Target	Quarter to date	Jan 19	Feb 19	Mar 19
Response Rate	Inpatients & Daycases	40 %		54 %	54%	52%		40 %		57 %	48%	59%		40 %		55 %	53%	53%		40 %		52 %	50%	56 %
	Urgent & Emergency Care Centre	15 %		2.8 %	2.7 %	2.2%		15 %		2.6 %	2 %	2.7 %		15 %		4%	6 %	2.4 %		15 %		0.8 %	0.4 %	0.4 %
	Maternity Service	40 %		49 %	48%	50%		40 %		69 %	46%	34%		40 %		40 %	40%	37%		40 %		32 %	46%	45 %
	% Positive Score	Target	Quarter to date	Apr 18	May 18	June 18	On target	Target	Quarter to date	July 18	Aug 18	Sept 18	On target	Target	Quarter to date	Oct 18	Nov 18	Dec 18	On target	Target	Quarter to date	Jan 19	Feb 19	Mar 19
Positive Score	Inpatients	95 %		98.4 %	98%	97.5 %		95 %		97.0 %	9 7	95.3 %		95 %		97.3 %	98.2 %	98%		95 %		97.5 %	96.8 %	97.4 %
	Day Cases	95 %		99.4 %	99.5 %	98.6 %		95 %		99.2 %	98.4 %	99.5 %		95 %		99%	99.3 %	99.7 %		95 %		99.8 %	99.4 %	98.7 %
	Urgent & Emergency Care Centre	85 %		97.5 %	94.3 %	97.8 %		85 %		94.5 %	94.1 %	88.5 %		85 %		93.1 %	93.9 %	95.8 %		85 %		82.7 %	71.4 %	95.8 %
	Maternity Service	95 %		99.7 %	99.3 %	98.1 %		95 %		98.1 %	9 9	99%		95 %		98.4 %	100 %	100 %		95 %		100 %	99.6 %	100 %
	Outpatients	95 %		97.1 %	97.8 %	98.3 %		95 %		96.2 %	97.6 %	97.3 %		95 %		96.7 %	97.4 %	97%		95 %		97.8 %	98.2 %	97.3 %
	Community Services	95 %		95.2 %	96.81 %	95.9 %		95 %		97.8 %	99.1 %	97.8 %		95 %		92.8 %	97.6 %	96.9 %		95 %		99.8 %	94.6 %	96.7 %

Mixed-sex sleeping accommodation

The Trust has a zero tolerance to using mixed-sex sleeping accommodation and, since CQC inspection in 2015 and 2018 there have been zero occurrences within inpatient wards. In addition, the Trust is also required to monitor patients who are stepping down from High Dependency Unit (HDU) level 2 care to base wards. Internal standards require reporting at 4 hours and 6 hours; an external report is made at 8 hours. There have been four instances of an external report in the last 12 months. This has been due to bed capacity in the correct specialty.

Additionally, there is also an internal process for monitoring and reporting 'pass by' breaches of mixed sex accommodation. In 2017/18 there were no reported breaches for pass-by of toilet facilities. When a bed area is reallocated to a different gender, the associated toilet facility and side room are also reallocated. This is monitored at ward and department level. The trust is part way through a programme of refurbishment of wards and development of more toilet facilities within bays.

Never Events

The process for identification of a Never Event starts with the incident being identified on Datix. The Datix incident form has a specific section which identifies the list of Never Events which are on the NHS Improvement (NHSI) Never Events policy and framework.

All Datix incidents are checked daily by the Patient Safety Team so any incident reported which hasn't been identified as a Never Event would be amended by the team.

Any incidents reported as Never Events are also reviewed daily to ensure they meet the criteria. Any incidents incorrectly reported as Never Events are amended and the reporter is informed of the changes.

All Never Event incidents are investigated as Serious Incidents and as such once these have been identified are presented at the weekly Serious Incident Panel for confirmation with the panel that this does meet the NHS Improvement criteria.

During 2018/19 the Trust has reported four Never Events within the following categories:

- Wrong Site Surgery – three events reported
- Misplaced naso- or oro-gastric tubes – one event reported

Although there have been three incidents within the Wrong Site Surgery category, the circumstances and teams involved have been variable.

A robust Root Cause Analysis is carried out for each Never Event and an action plan is created with monitoring through Divisional Governance processes to ensure completion. The Patient Safety newsletter is used to ensure Trustwide sharing of the learning from these incidents to improve the quality of care for patient's and prevent future occurrences.

Patient-led assessments of the care environment (PLACE) 2018

The 2018 PLACE assessment was conducted in April 2018. Visits were made to 18 clinical areas at Rotherham Hospital and 2 at Breathing Space. The 2018 visits involved Governors, Healthwatch and Trust colleagues. The 2019 Assessment returns have been delayed until September 2019 as there is a current review of the process taking place nationally.

Trust results 2016 and 2017	Cleanliness		Food		Food (Organisational)		Ward Food	
	2017	2018	2017	2018	2017	2018	2017	2018
Breathing Space	98.52%	94.91%	92.69%	88.22%	86.78%	86.94%	93.36%	89.50%
Hospital	98.72%	97.13%	83.36%	85.36%	87.53%	88.27%	82.47%	84.56%

(Source: The Health and Social Care Information Centre)

Trust results 2016 and 2017	Privacy Dignity and Wellbeing		Condition Appearance and Maintenance		Dementia		Disability	
	2017	2018	2017	2018	2017	2018	2017	2018
Breathing Space	90.91%	100%	90.48%	86.48%	88.35%	70.99%	84.02%	76.36%
Hospital	72.08%	80.13%	93.07%	92.11%	62.49%	66.47%	73.93%	74.52%

(Source: The Health and Social Care Information Centre)

Whilst organisational food and ward food scores have increased from 2017, work is currently being undertaken around the organisational questions and where improvements can be made.

Although there has been a slight decrease in the condition of the environment, there have been a number of areas refurbished this year, the assessment outcome is dependent on what locations are chosen for a visit on the day.

Inpatient Survey Findings

The results from the 2017 Adult Inpatient Survey were published by the Care Quality Commission in June 2018. The annual national inpatient survey (2017) showed an improving picture when compared to the 2016 survey but with further improvements still required to meet the targets set for the 2018 survey.

The CQC compare the Trust results with other organisations and classify whether Trusts are performing about the same as other Trusts, better than other Trusts or worse than other Trusts. The results showed there were three areas where the Trust significantly improved the score from 2016: privacy in the Emergency Department, the hospital specialist having the necessary information about the patient's condition/illness from the referrer and having sufficient privacy during discussions. The Trust has been rated worse than others in two areas: Doctors talking in front of patients as though they were not there and the perception of having sufficient nurses on duty to provide care.

A summary of how the Trust has responded to the findings is described below:

- Following a review of the report at the Patient Experience Group, the previous action plan was updated to incorporate new areas of concern.
- Every month members of the Patient Experience Group have conducted interviews with inpatients to discuss their experiences. This has contributed to overall Trust reports but has also provided an opportunity to resolve issues in real time and provide localised, area specific feedback.
- The Trust Catering Group has continued to make good progress in addressing a number of areas to improve the quality of food. Regular reviews of the quality of food are held, with Governor involvement and feedback is provided to all concerned regarding the findings.
- Wards are reviewed daily by senior nurses to ensure the most appropriate deployment of nurses.

Governance – Monitoring and Compliance

- The Action Plan is monitored via the Monthly Patient Experience Group.
- Findings from the National Inpatient Survey are triangulated against other sources of patient feedback including concerns and complaints, Friends and Family Test, Governor's Surgeries and feedback from Healthwatch and other websites. This is analysed and reported within the quarterly Patient Experience Report.
- During 2018/19 there has been a quality priority in relation to Learning from the Views of Inpatients. The monthly local inpatient survey is used to inform this with questions based on previous results from the National Inpatient Survey. Findings are fed back in real time to Ward Managers and via reports to the Patient Experience Group, Clinical Governance Committee and Quality Assurance Committee. Further information on this quality priority can be found on page 77.

Healthcare Associated Infections

The Director of Infection Prevention and Control (DIPC) published the annual infection prevention and control report in May 2018. The 2018/19 annual report will be published in June 2019.

Throughout the year detailed updates on the incidence of healthcare associated infections have been provided to the Infection Prevention and Control and Decontamination Committee which reports to the Clinical Governance Committee. The Executive Medical Director was the DIPC at the commencement of the year and this changed to the Chief Nurse.

Locum Consultant Microbiologists worked during the year alongside the Associate Specialist in Microbiology pending the appointment of the new substantive Consultant Medical Microbiologist in September 2018.

Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C-difficile) are both alert organisms subject

to annual improvement targets. The MRSA bacteraemia target for 2018/19 was 'zero preventable cases' which was not achieved due to the one case in April. The C-difficile trajectory was 25 cases to year-end and the Trust achieved better than trajectory with 8 cases for 2018/2019.

Number of reported cases of MRSA bacteraemia Target = 0	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1	1	0	0	0	0	0	0	0	0	0	0	0

(Source: Trust Winpath System)

Number of reported cases of C.diff Target = <24	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	8	0	1	0	2	1	0	2	0	1	0	0	1

(Source: Trust Winpath System)

All cases of hospital acquired Clostridium difficile (C. difficile) were reviewed in depth by the Infection Prevention and Control (IPC) team. Shared ownership of completion of the Root Cause Analysis (RCA) investigation with the clinical divisions has greatly improved with any enquiries into other care aspects being referred to the relevant team when identified. e.g. to the vascular access team regarding line care, the continence team regarding urinary catheter care, the patient safety team if there is any query regarding falls, pressure ulcers or prolonged length of stay, the antimicrobial subgroup regarding antimicrobial prescribing. Multi-disciplinary Team (MDT) meetings with the relevant Division take place in the following two weeks where a full review of the RCA is undertaken.

A post-infection review (PIR) is carried out each month with the Lead Nurse for Infection Prevention and Control for NHS Rotherham Clinical Commissioning Group (CCG). The PIR scrutinises not only the Infection Prevention practices but also examines if there is any other lapse of quality of patient care identified during the whole patient care pathway.

In 2018/19 four cases have been classed as unavoidable with no lapse

in quality of care identified, one case from March 2019 is still under investigation but three cases did have an identified lapse in quality of care. The lapses identified were:

- Not all appropriate samples obtained and antimicrobial prescribing
- Lack of communication of previous C.difficile history provided on handover between clinical teams
- Delay in stool sample being obtained and lack of stool chart completion

All samples of C-difficile are sent for Ribotyping at the Leeds reference laboratory in order to determine the exact identity type of the organism. In the event that any samples have the same Ribotype the epidemiology is examined further to determine if there could be any link in time and place between the cases, if such a link is possible enhanced DNA fingerprinting is requested via the Leeds reference laboratory which identifies if the cases are indeed linked and thus caused by cross infection or not.

National mandatory reporting for Gram-negative bacteraemia commenced in April 2017, Gram negative bacteraemia includes E.coli, Pseudomonas aeruginosa and Klebsiella species. All CCGs have been given a 10% reduction goal for E.coli however numbers of hospital acquired cases, those that occur after 48 hours from admission, are low and no reduction target has been specified for acute hospitals. The Infection Prevention and Control Team are working jointly with the Lead Nurse for Infection Prevention and Control at the CCG to review all cases and looking for any themes that may help with future reduction including following NHS Improvement updates.

The intravenous (IV) access care provision has been incredibly successful in enhancing IV antibiotic therapy in the community. The Vascular Access Team in collaboration with the District Nurses and other stakeholders have been instrumental in the delivery of this service which has reduced admission and length of stay for many patients.

Recent updates to the vascular access database that allows the capture of data (including Central Line Associated Blood Stream Infections (CLABSI) data) has resulted in gaps within the data. However, daily surveillance and twice daily 'huddles' continue to focus on the topic of CLABSI. Based on the data we have available and the clinical picture that is regularly reviewed by the Vascular Access Team we are maintaining our low levels of CLABSI. We are currently working with the Meditech and Sepia teams to identify integrated technological solutions so that we will no longer rely upon standalone IT systems to control the data. In addition, we are developing administrative solutions that will assist with the identification and analysis of suspected CLABSI incidents.

The winter of 2018/19 has been challenging with numbers of cases of Influenza in line with the national picture which appears relatively low compared with the previous season however acuity of patients has been much higher with many admissions into critical care. The point of care (POC) machine has been used for the first full season and has helped to support the rapid identification of flu results which assists the emergency department team to discharge with diagnosis and advice and for those admitted a more accurate use of individual rooms that support flow through the hospital. The use of POC had led to some under reporting to the voluntary sentinel trust scheme which only reports against laboratory confirmed cases.

Cases of Norovirus and Rotavirus gastroenteritis have been at low levels and have been well managed to reduce further cases and with a number of beds closed where indicated to reduce onwards transmission risk whilst maintaining the operational flow of movement across the site.

There have been additional challenges during 2018/19 of infections with potential public health impact, this has included an increase in cases of Measles in the UK, with outbreaks reported in parts of Yorkshire and some cases diagnosed in Rotherham. The very rare incidence of Diphtheria identified and subsequent contact screening and vaccination, involving large co-ordination between various health colleagues locally and in the region.

Post-operative surgical site infection (SSI) surveillance following Caesarean section continues and is led by a Consultant Obstetrician working in conjunction with the IPC team with all ladies being followed up and their wound reported upon by the community midwifery team.

Post-operative surgical site infection (SSI) surveillance is mandatory for one quarter per year of Orthopaedic lower limb procedures (either hip or knee replacement). This surveillance has occurred during 2018/19 to include continual local surveillance of all lower limb arthroplasty. The results of the surveillance were provided to the Orthopaedic Governance Group. The Consultant for Podiatric Surgery completes continual SSI surveillance via the speciality national database and has had zero post-operative infection.

In summary, whilst the Trust was disappointed that a case of MRSA bacteraemia occurred, the Trust is pleased with infection prevention in other areas such as central line associated blood stream infections, rates of C difficile against trajectory and the low SSI rates in podiatric surgery. Norovirus, Rotavirus and Influenza infections have been well managed. More patients are being treated in the community with I/V antimicrobials which means that patients are prevented from hospital admissions or discharged earlier.

Reducing the incidence of Falls with Harm

A fall in hospital can be devastating. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also affects the family members and carers of people who fall, and has an impact on quality of life, health and social care costs. Falls represent significant cost to trusts and the wider healthcare system, with annual total costs to the NHS alone from falls among older people estimated by the National Institute for Health and Care Excellence (NICE) in 2015 at £2.3 billion.

The current rate of falls per 1,000 bed days

	2016-17	2017-18	2018-19
Falls	611	675	668
Bed Days	144,505	145,153	132,557
Falls Rate per 1000 Bed Days	4.23	4.65	5.04

(Source: Datix / Bed Days are Figures taken from KH03)

Monitoring of all falls is undertaken daily by the Patient Safety Team and the clinical areas are provided with data using a falls performance dashboard from Datix. Falls prevention and improvement is also monitored through the Trusts Falls Group who report into the Patient Safety Group.

The Trust continues to participate in the mandatory National Inpatient Falls Survey. Further actions for 2018/19 have been designed as a result of the National Survey. The Falls Group have also commenced a yearly audit against NICE Quality Standard 86 (Falls in Older People) – (quality statements 4–6) (National Institute for Health and Care Excellence, 2017) which identify how a patient is managed following a fall. This will help identify areas of weakness and improve the care of these vulnerable patients. The Trust is also reviewing its current falls assessment documents to ensure appropriate risk factors are identified and appropriate actions are put in place throughout a patient's pathway and the Trust's Falls policy has been reviewed to reflect all changes to the way falls are managed.

Duty of Candour

'Duty of Candour' requirements are set out in the Health and Social Care Act Regulation 20: Duty of Candour (Health and Social Care Act (2008)). The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report (Midstaffspublicenquiry.com, 2015) into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory duty of candour be introduced for health and care providers, to ensure a more honest and open culture in the NHS. From October 2014 there was a statutory requirement for Trusts to implement the Duty of Candour requirements.

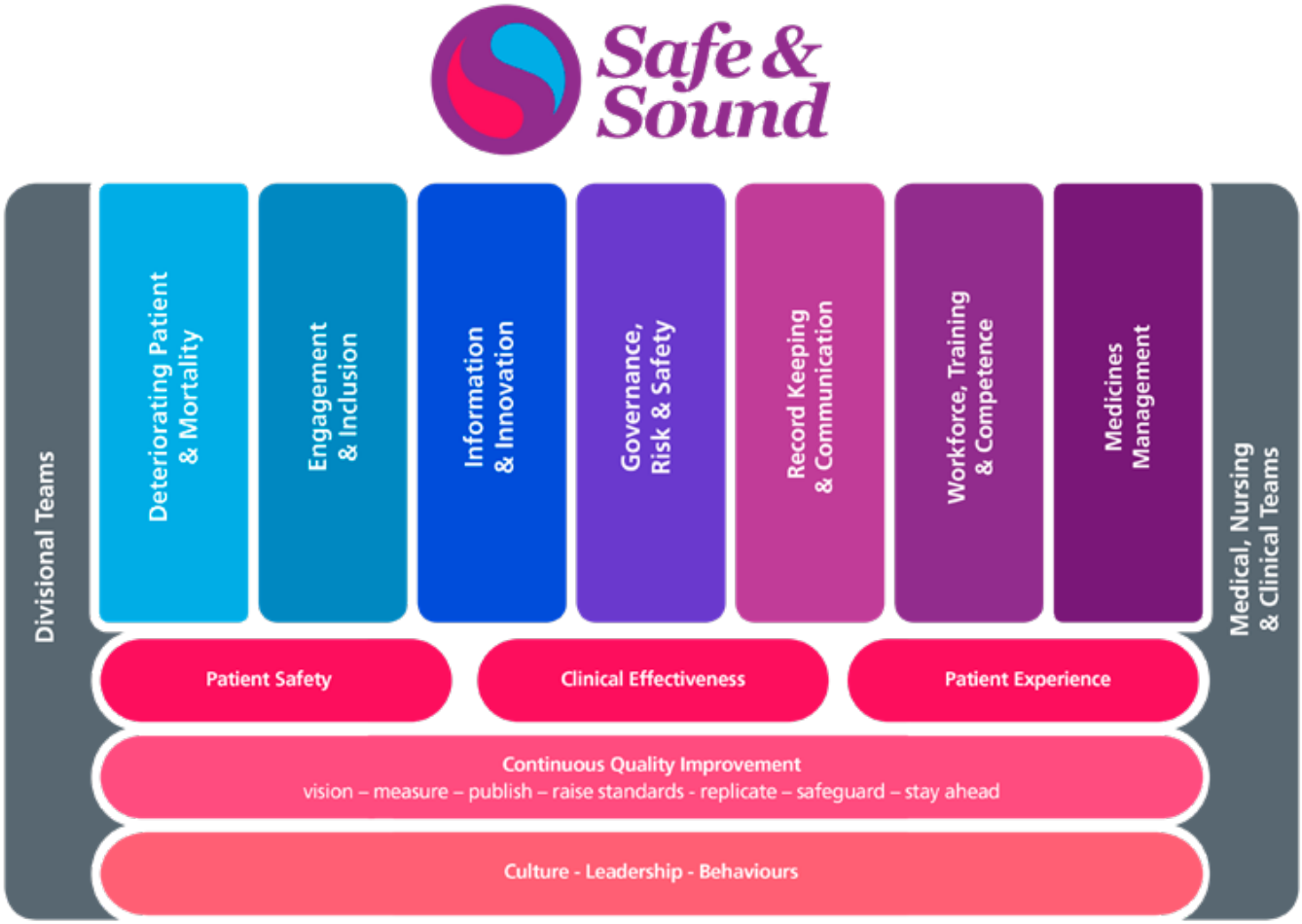
An audit was undertaken by the Trusts internal audit service in March 2017 (reported April 2017). The review assessed the extent to which the Duty of Candour Policy requirements were being adhered to and that there was a culture of openness and transparency within the Trust. The results showed reasonable assurance with compliance with the Trust's policy.

During 2017/18 we introduced the use of stickers within the patients notes to help identify specific conversations with patients/relatives and carers which demonstrate compliance with the Duty of Candour. We have also introduced a Serious Incident Database within the electronic Datix system where all Duty of Candour compliance is recorded and monitored. A further internal audit of Duty of Candour completed in 2018 identified some additional training needs which have commenced in January 2019. The Patient Safety Team will continue to monitor compliance with all the requirements identified in the initial audit and a further audit will be carried out in 2019. This work will continue to be monitored through the Patient Safety Group.

Safe and Sound Framework

The Trust is committed to delivering consistently safe care and taking action to reduce harm. Following on from the national Sign up to Safety campaign in recent years, TRFT has now developed a bespoke framework to support high quality, safe patient care.

The Chief Nurse and Interim Medical Director have developed the Safe and Sound Framework to deliver the Quality Improvement Strategy and Quality Improvement Plan. The Framework is based around 7 key areas, each of which has an executive lead.



Safeguarding Vulnerable Service Users

The Trust is committed to ensuring Safeguarding is an absolute priority. The Chief Nurse is the Trust's Executive Lead for safeguarding. The Chief Nurse is supported by the Assistant Chief Nurse, Interim Head of Midwifery Nursing and Professions and the Interim Head of Safeguarding, who manages the Safeguarding Team. The Safeguarding Team provides specialist input and advice regarding Adult and Children's Safeguarding. The Team also includes a Lead Nurse for Learning Disabilities.

In relation to adult vulnerability, the work and support by the team includes the Mental Health Act, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The year has seen a continued increase in activity across all work streams with continued challenges posed by the introduction of the Care Act 2014, and the Supreme Court 2013 judgement with regards to the Deprivation of Liberty Safeguards (DoLS).

The team also includes one Paediatric Liaison Nurse Specialist and one Paediatric Liaison Nurse who provide specialist input and support in relation to children's safeguarding within the Emergency Department, the Children's Ward and Community Services, including General Practitioners.

In addition to the integrated and co-located team there are also safeguarding colleagues based in services outside of the Trust:

- A Trust Safeguarding Nurse Advisor is based in the Multi-Agency Safeguarding Hub (MASH) at Riverside – this team responds to all children safeguarding referrals
- A Specialist Child Sexual Exploitation (CSE) Nurse is based in the Evolve Team in the Eric Mann building which provides services for survivors of Child Sexual Exploitation cases and is aligned to the Family Health Division

The Trust continues to be an active partner in the Rotherham Local Safeguarding Children Board (RLSCB), the Rotherham Local Safeguarding Adult Board (RLSAB) and the Health and Wellbeing Board. In addition, robust governance structures are in place to ensure The Rotherham NHS Foundation Trust has representation on a large number of external Safeguarding Strategic and Operational Groups. This ensures partnership working is embedded across the wider Rotherham Health and Social care economies.

The Adult Safeguarding Team continues to work in partnership with the Rotherham Metropolitan Borough Council (RMBC) to provide 'health' input for safeguarding investigations. This involves offering support to the RMBC Adult Safeguarding Team around investigations and preparations for Outcomes Meetings – even where there is no TRFT involvement. This highlights the Trust's continued commitment to partnership working. The Trust provides representation from both Adult and Children's practitioners at the Multi Agency Risk Assessment Conference (MARAC) meetings.

There has been significant activity, in partnership with the TRFT Learning and Development Team and Heads of Nursing, to review the competency levels required by individual job roles to align them with the Safeguarding Adults Intercollegiate document.

A full review of Safeguarding Children Training has also been

undertaken in conjunction with colleagues from the Trust Learning and Development Team. This was to ensure all colleagues have the correct level of training aligned to their specific role and recorded via the Electronic Staff Record. Training compliance is monitored via Safeguarding Key Performance Indicators and reviewed at the Safeguarding Operational Group reporting to the Strategic Safeguarding Group.

The method of recording training has been reviewed to ensure a more complete reflection of compliance across the Trust in ensuring accurate information is contained in the Electronic Staff Record (ESR). From this work e-learning training has been provided to colleagues to improve access and availability of appropriate training.

On-going training is being provided to support practice in respect of the 2013 Cheshire West Ruling and the changes to the implementation of the MCA and DoLS procedures. The MCA forms have been developed, agreed and are now embedded throughout the Trust. A template which replicates this form has been developed and is available for practitioners on SystmOne.

A robust training programme is in place for Prevent, which is included in the Trust induction programme and is part of the Mandatory and Statutory Training offering. Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved in/or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity. TRFT is represented at the Channel meetings, where all cases of those suspected of being exploited are heard.

The Trust's Safeguarding Vulnerable Service Users Strategy is embedded in the organisation and key performance indicators against which safeguarding performance is monitored are in place and reported to the Clinical Governance Committee quarterly. In addition, a number of safeguarding standards are in place and monitored externally via NHS Rotherham Clinical Commissioning Group. The Trust has two specific Safeguarding meetings; a monthly Safeguarding Operational Group chaired by the Named Nurse Adult Safeguarding and a quarterly Safeguarding Strategic Group chaired by the Assistant Chief Nurse, Interim Head of Midwifery Nursing and Professions. A quarterly Safeguarding Report has been provided to the Board of Directors and presented by the Chief Nurse. In addition, quarterly performance reports are provided to the Local Safeguarding Children Board and Local Safeguarding Adult Boards Sub Groups.

Responsibilities of all staff employed by The Rotherham NHS Foundation Trust (TRFT) for safeguarding vulnerable people are documented in TRFT Safeguarding Policies.

An annual work plan is in place and monitored by the Trust Safeguarding Operational Group to ensure all plans progress.

The Trust will continue to strive to develop and further improve safeguarding systems and processes in order to protect vulnerable children, young people and adults.

Macmillan Cancer Information Support Service

The Macmillan Cancer Information Support Service (MCISS) provides awareness, information, signposting and first line support to anyone affected by cancer, face to face contact, drop in, telephone, email, direct and indirect referrals from clinicians and other health professionals. The MCISS works in alignment with the national charity Macmillan Cancer Support. The current and future aims of Rotherham MCISS are to:

- Extend the hospital based MCISS into the community of Rotherham to ensure equity of service provision and accessibility.
- Expand engagement with the MCISS both geographically and along the cancer journey working across Rotherham and other aligned organisations such as the MCISS within Barnsley, Sheffield, Doncaster and Chesterfield.
- Work in alignment with Macmillan Cancer Support to raise the profile of the service.
- Maintain the annual revalidation of the Macmillan Cancer Support Quality Environment Mark (MQEM).
- Maintain the National Macmillan Cancer Support 'Quality in Information and Support Services Standard' (MQUISS).

During 2018 a total of 5301 patients have accessed the service and prevented the need for:

- 6 A&E visits.
- 349 GP appointments.
- 25 Consultant contacts.
- 338 Nurse Specialist contacts.
- 445 other contacts, such as District Nursing and Social Care.

The MCISS works with primary care, Rotherham Metropolitan Borough Council, voluntary, charitable and statutory provider services. MCISS consults with these other agencies to ensure collaborative planning of services and to avoid duplication. MCISS works to improve accessibility for patients, carers and the general population from diagnosis through to discharge and/or transition to palliative care.

'Drop in Centres' are being established across the locality alongside the:

- Future development of community engagement.
- Future development of an extensive training programme.
- Current expansion and consolidation work to foster closer links and collaborative working practices with:

    - The South Yorkshire Cancer Alliance.
    - Living With and Beyond Cancer Project.
    - Rotherham Health Watch.
    - Voluntary Action Rotherham through their social prescribing programme and the Be cancer Safe project.
    - Rotherham Hospital Health Information Services and key stakeholders to deliver healthy living and cancer awareness campaigns to the local population.

The MCISS have developed Volunteer Services since 2015 and they continue to support the service in its entirety whilst also supporting the Macmillan walk and talk cancer support group. This year the service was nominated and shortlisted for 2 Trust Proud awards in Caring and Outstanding Volunteer, to which the volunteer nominated received an award.

Dementia Care

The Trust continues to review the strategy for the provision of care supporting people living with dementia within a context of person-centred care across the organisation. This is consistent with national drivers.

The frailty team is now well established, providing nursing leadership for dementia care within the Trust. All wards have dementia link nurses and bi-monthly meetings have commenced to provide further support, development and training for these roles.

The Trust has started to review the ongoing provision of training to support people living with dementia. Currently this training is delivered through e-learning, however it is felt that face to face training would be more effective, therefore, the first person centred care training day, led by the frailty team, commenced in April 2019, which incorporated Tier 2 dementia training. The dementia training design and delivery audit tool will be used to monitor the effectiveness of the training.

The frailty team are now also supporting dementia screening for the trust, which has recently improved to 90% compliance. The two senior members of the team are undertaking their non-medical prescribing courses which will further enhance their service and the quality of care provided to patients living with dementia. The lead nurse is also currently in the process of securing a place on the Kings Fund Older Persons Fellowship, which, if successful, will include a quality improvement project to further improve care for patients living with dementia.

Learning Disability

The Rotherham NHS Foundation Trust is committed to improving the experience for people who have learning disabilities and/or Autism. A specialist nurse is employed to focus on all aspects of patient care and experience at the hospital, whether people attend as an outpatient, planned inpatient or are admitted through the Emergency Department.

- There is an electronic flagging system in place to identify that a person has a learning disability. This then populates a live database for the Lead nurse in learning disabilities to access. This enables them to have an overview of inpatients with a learning disability.
- Championing the use of the Health Passport system, a person centred assessment tool for people with learning disabilities and Autism that helps staff to learn about how to care appropriately for each individual.
- Providing training that supports staff to improve their skills and knowledge. Developing a training package that is service user lead and talks about actual patient experience to help to change professional practice and behaviours.
- Continue to build links with established organisations to support learning, such as Speak Up, CHANGE organisation, Health Education England and Royal Mencap.
- Facilitating a programme of mentorship for Learning Disability Nurse/Generic social work students at Sheffield Hallam University. Providing shadowing and training opportunities to the Trust's Trainee Nurse Associates.
- Providing bespoke training for the Undergraduate Adult branch nurses at Sheffield University.
- Facilitating a learning disability/autism sub group, which has members from community learning disability teams, care providers for people with learning disability, such as Mencap, Voyage and Exemplar Health care and the local authority. This enables the Trust to learn from patient experience to change and alter practice/systems and pathways.
- Working closely with the volunteer coordinator at the Trust to mentor and support our volunteers in the Trust who have a learning disability/Autism.
- Working closely with colleagues within the Trusts community teams, such as Community Matrons, Fast Response and district nurses to ensure community care plans are in place for people with a learning disability and or Autism to minimise frequent admissions to hospital services.

Future plans:

- To work with the CCG and Local authorities to look at an electronic flagging system to identify people with Autism with an electronic flag on their medical records, with obtained patient consent.
- To have secured funding for a Trainee Nurse Associate Specialising in Learning Disabilities to be based within UECC and AMU areas to assist with the urgent and emergency care pathway into hospital for a person with a learning disability.
- Continue to encourage the role of the Learning Disability champion on all wards and departments.
- To work with service user focus groups to help the Trust adapt and change the environment of the hospital to be accessible for people, for example the signage around the Trust.
- Applying guidance from the Accessible Information standard (2015) to ensure all patients have information about their care/treatment/appointments in a format that they are able to understand.
- To work with the Trust Equality and Diversity Steering group, to look at how the Trust can actively encourage people with Learning Disabilities and/or Autism to take on voluntary or paid roles at the Trust.
- Focusing on specific care planning tools for people with Learning disabilities and/or Autism, to help improve individual patient pathways and responsiveness of the Trust.
- The lead nurse in Learning disabilities and/or Autism is commencing the Non-Medical Prescribing course to assist with timelier discharges and a more evidence based treatment plan for that individual patient pathway.
- To plan towards the Trust obtaining an 'Autism Friendly Award', which is accredited by the National Autistic Society.

Engaging with Colleagues

The Trust remains committed to continue its journey of continual improvement. It recognises that staff are fundamental to delivery of quality patient services and care. Every staff member counts and to this end despite the challenges faced in the NHS both financially and to the workforce the Trust continues to seek out opportunities to involve and empower the workforce to shape the future both in local services and as part of the transformation agenda.

The NHS Annual National Staff Survey

The annual NHS National Staff Survey (NSS) gives colleagues in the Trust an opportunity to tell the organisation what it is like to work at the Trust. It also gives an opportunity to reflect on and help to prioritise the focus and actions to support continual improvement. The Trust response rate to the survey saw a small decline to 38% from the previous year (41%).

Nationally the results of the 2018 NHS Staff Survey still show a service struggling to provide care against increasing demands and the Trust mirrors this position. Since the last survey the Trust has seen an improvement in staff recommending the Trust as a place to work but this is not where the Trust wants to be. There has also been a small improvement in staff being treated fairly when involved in errors.

Staff have reported that the Trust needs to do more to support their health and wellbeing and again this mirrors the national position. The challenges remain in the following areas; Colleagues being happy with the standard of care if a relative or friend needed treatment, patient care being the Trust priority, communication between senior managers and staff being effective and having supplies and equipment.

A new question measuring morale reported a score of 6.1 (out of 10) nationally. The Rotherham NHS Foundation Trust scored 5.8 compared with similar combined acute and community trust organisations scoring 6.2 (average).

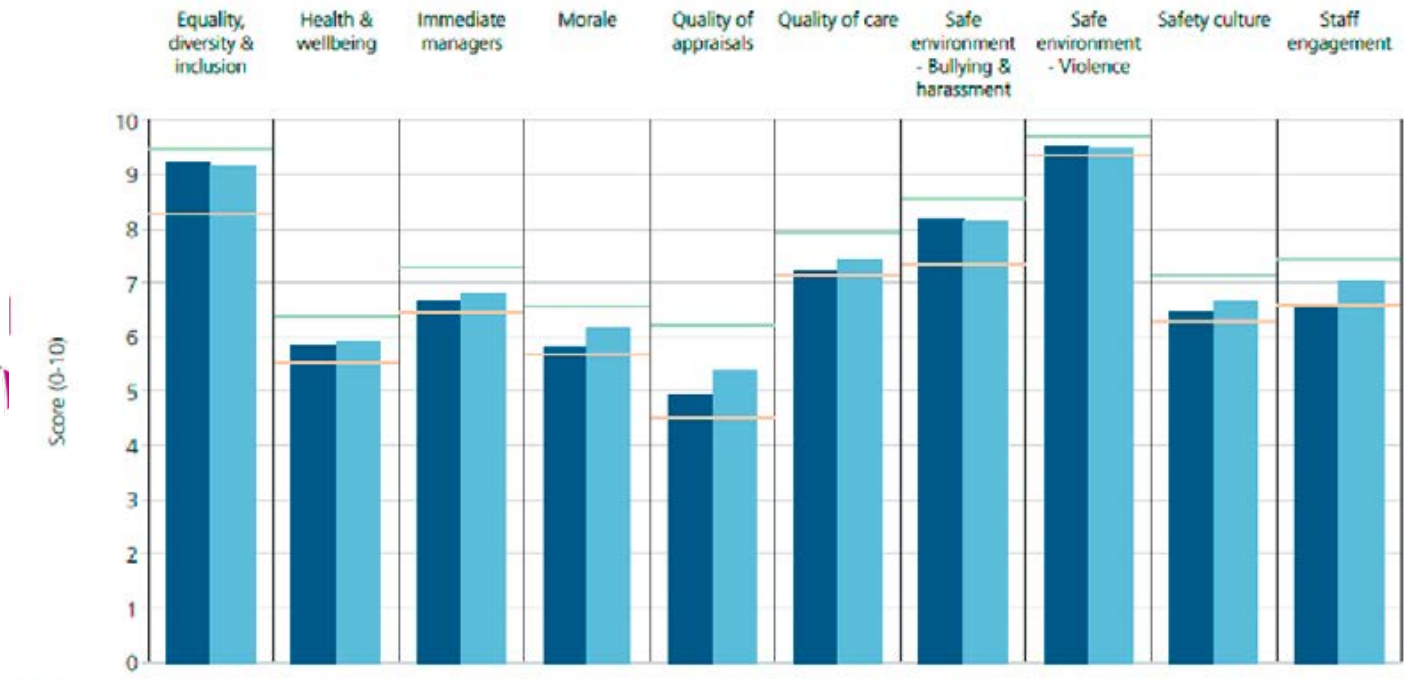
The Trust has made staff engagement an organisational priority over the next 2 years.

Focus will be placed on working to improve colleague wellbeing in particular how the Trust supports staff with maintaining good mental health and work to improve muscular skeletal injury as a result of work.

In quarter 3 2018/19 steps were taken to implement an Employee Assistance Programme. Working with the new provider to promote and analyse the wider colleague requirements to optimise colleague health. Data will be regularly available to support programmes and underpin our focus.

Themes

This year the National Staff Survey results have been themed rather than key findings. The graph below shows this year's results.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.5	6.4	7.3	6.5	6.2	7.9	8.6	9.7	7.1	7.4
Your org	9.2	5.8	6.7	5.8	4.9	7.2	8.2	9.5	6.5	6.6
Average	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0
Worst	8.3	5.5	6.5	5.7	4.5	7.1	7.4	9.3	6.3	6.6
Responses	1,561	1,581	1,581	1,555	1,448	1,319	1,546	1,545	1,572	1,609

Of the ten themes in the survey the Trust is slightly above average on 3 key themes:

- Equality diversity and inclusion.
- Safe environment- bullying and harassment.
- Safe environment-violence.

The Trust performs significantly below average on:

- Quality of appraisal.
- Morale.
- Staff engagement.

The chart below summarises the Trust findings from the national staff survey 2018, carried out by Picker who were also commissioned by 19 similar Acute and Community Trusts. The chart represents the results in comparison to those organisations.

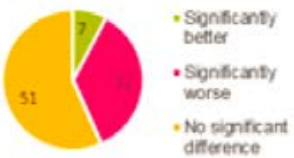
A total of 90 questions from the survey be positively scored. 82 of these can be compared historically between NSS17 and NSS18. Your results include every question where your organisation had the minimum required 11 respondents.

4353	4232	38%	40%	41%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (1628)	Average response rate for similar trusts	Your previous response rate

52%	Q21c. Would recommend organisation as place to work
54%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
66%	Q21a. Care of patients/service users is organisation's top priority

Historical comparison*

Comparison with average*



Picker

*Chart shows the number of questions that are better, worse, or show no significant difference

The following eight questions from the staff survey indicate a significant improvement compared to previous Trust performance:

- Staff satisfied with the recognition for good work.
- Staff satisfied with the amount of responsibility given.
- Staff satisfied with the extent the organisation values their work.
- Staff satisfied with levels of pay.
- In the last three months staff not coming to work when not feeling well enough to perform duties.
- Staff not seeing error/near miss or an incident that could hurt staff, patients or service users.
- The organisation treats staff involved in errors fairly.
- Would recommend organisation as place to work.

The following four questions show significant deterioration:

- Adequate materials, equipment and supplies to do your work.
- Do not work any additional paid hours for the organisation over and above contracted hours.
- Organisation definitely takes positive action on health and wellbeing.
- Last month have not seen errors/near misses that could hurt patients.

The tables below show the top 5 scores, improvement and deterioration including the least improved.

Performance against priority areas

The Trust has maintained its commitment to undertaking key projects, activities and approach to engagement. Whilst the results of the staff survey are disappointing, increased focus on meaningful staff engagement will be a priority for the Trust over the next two years. This will include revitalising the Wellbeing offering focusing on stress, mental health and musculoskeletal (MSK). The Trust will also seek to continue with Together We Can engagement methodology building on last year's work with an aim for services to own and utilise change methodologies. The ambition last year was to undertake 10 engagement events using Together We Can, this has been exceeded during the year. Examples of teams include: Understanding the challenges of the surgical wards and recognition of areas of high performance; development of patient friendly sheets to aid bed making and maintain good pressure areas; Executive led sharing of the results of the 2017 staff survey; Finance - planning the year ahead with the team; developing a 24 hour community service. Each of these focused on putting staff at the heart of service development and improvement in working practices.

The Trust performed well against the Influenza vaccination programme. Achieving 80% of frontline workers vaccinated. The Trust was shortlisted for a NHS employers award for its work around Flu.

	Top 5 scores (compared to average)
95%	Q19a. Had appraisal/KSF review in last 12 months
72%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours
86%	Q16a. In last month, have not seen errors/near misses/incidents that could hurt staff
76%	Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
45%	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours

	Bottom 5 scores (compared to average)
54%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
41%	Q4f. Have adequate materials, supplies and equipment to do my work
66%	Q21a. Care of patients/service users is organisation's top priority
52%	Q21c. Would recommend organisation as place to work
33%	Q9b. Communication between senior management and staff is effective

	Most improved from last survey
68%	Q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work
52%	Q17a. Organisation treats staff involved in errors fairly
54%	Q5a. Satisfied with recognition for good work
41%	Q5f. Satisfied with extent organisation values my work
52%	Q21c. Would recommend organisation as place to work

	Least improved from last survey
41%	Q4f. Have adequate materials, supplies and equipment to do my work
27%	Q11a. Organisation definitely takes positive action on health and well-being
44%	Q13d. Last experience of harassment/bullying/abuse reported
74%	Q16b. In last month, have not seen errors/near misses/incidents that could hurt patients
72%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours

Picker

Staff Friends and Family Test

The Trust invites colleagues to participate in the staff friends and family test. Data is collated from colleagues each quarter, asking two key questions;

- How likely are you to recommend The Rotherham NHS Foundation Trust to friends and family as a place to work? The table below shows the responses collected during the year.

	Quarter 1 2018/19		Quarter 2 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	14.4	24	23.6	34
Likely	33.5	56	31.3	45
Neither likely or unlikely	21.6	36	14.6	21
Unlikely	15.0	25	11.8	17
Extremely Unlikely	15.5	26	18.0	26
I don't know	0	0	0.7	1
No response	0	0	0	0
	Quarter 3 2018/19*		Quarter 4 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	11.8	184	9.2	6
Likely	39.8	620	36.9	24
Neither likely or unlikely	30.8	479	9.2	6
Unlikely	12.1	188	15.4	10
Extremely Unlikely	5.5	85	26.2	17
I don't know	0	0	3.1	2
No Response	0	0	0	0

- The second question asked, how likely are you to recommend The Rotherham NHS Foundation Trust to friends and family if they needed care or treatment?

	Quarter 1 2018/19		Quarter 2 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	17.2	29	28.3	41
Likely	40.8	69	40.0	58
Neither likely or unlikely	23.1	39	9.0	13
Unlikely	11.8	20	4.8	7
Extremely Unlikely	7.1	12	13.8	20
I don't know	0	0	4.1	6
No response	0	0	0	0
	Quarter 3 2018/19*		Quarter 4 2018/19	
	Response %	Response Count	Response %	Response Count
Extremely likely	11.5	178	6.3	4
Likely	42.4	655	48.4	31
Neither likely or unlikely	29.9	462	14.1	9
Unlikely	12.0	186	10.9	7
Extremely Unlikely	4.2	65	18.7	12
I don't know	0	0	1.6	1

(Source: TRFT Survey Questions)

Monitoring Arrangement and future priorities and how they will be measured

The Trust is currently developing its new engagement and wellbeing strategy to ensure it continues to improve the approach to staff engagement. The key underpinning principles include ensuring the Board is cited on the Trust position in terms of how staff feel and that staff drive this. In response to this the Board have developed the Operational Plan which includes the following engagement priorities:

- Introduce PULSE surveys: with a continuous improvement in participation each quarter and improved baseline results.
- Implement staff inclusion networks: with a minimum of 2 networks established (BAME, Disability).
- Establish new Together We Can teams: with agreed deliverables and outcomes across a range of priority areas, targeting 10 teams.

Freedom to Speak up (FTSU) Guardians

The FTSU Guardian (FTSU) role was first introduced at the Trust in July 2015 in response to the Francis report, with the appointment of six FTSU Guardians. In September 2016 a Lead Guardian was appointed, which enabled the separation of the FTSU Guardians from the HR functions of the organisation. Subsequent to this appointment six further FTSU Guardians have been recruited to ensure that all Divisions have representation. All of the FTSU Guardians have a suitability interview and undertake the role on a voluntary basis in addition to their substantive post. A new FTSU lead was appointed in January 2019, covering 0.1WTE. As the post holder is already a trust employee this time is spread over the week to increase staff access to the FTSU lead.

Since the appointment of the National Guardian, Dr Henrietta Hughes, there has been increased direction from the National Office regarding the role of FTSU Guardians. The regional network meets every two months and there are biannual national events which our FTSU Guardians have been supported to attend. In June 2018 TRFT hosted the Regional Meeting which was attended by a representative from the National Guardians Office. October 2018 was national FTSU month where the Trust ran a joint promotion with South Yorkshire Police to raise awareness of hate crime and FTSU. The FTSU Guardian month aimed to raise the profile of FTSU Guardians across the Trust and saw several events including the launch of a monthly drop in clinic at each of our sites.

The FTSU Guardian Lead has direct access to the Chief executive and other board members and is now line managed by the Chief Nurse. They formally meet quarterly, together with the Senior Independent Director and Executive Director of Workforce.
In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up. Staff at TRFT can raise concerns with their Trade unions, line managers, colleagues or other supervisors, health and safety, security manager, Human Resources, professional regulator, trust chaplains and to any of the FTSU team via face to face, telephone (including voicemail linked to e-mail address), e-mail, drop in clinic once a month at each site and anonymously via letter to the FTSU Lead.

All concerns are responded to within 5 working days. If colleagues wish to meet with a guardian to discuss their concerns, meetings are arranged at a time and venue convenient to the complainant. All staff who raise a concern with the FTSU team are contacted three months after a concern is raised to see if they have suffered a detriment as a result. The wellbeing check also requests feedback from concern raisers on the service provided by the FTSU Guardians. To date feedback has been mainly positive with colleagues finding it easy to contact a FTSUG and pleased with the support that has been received.

In 2018/19 the FTSU Guardians received 26 concerns. The concerns have related to attitudes and behaviour (nine), with colleagues being directed to HR or union support for further advice. Of the remainder, nine related to quality and safety of patient care, two to policy and procedures, and six to patient experience. An increased number of concerns have been raised to the FTSU guardians over the past 12 months, compared to the previous 12-month period. This may be due to The Rotherham NHS Foundation Trust being one of the only trusts nationally to have FTSU as a MAST subject. This training ensures staff are aware of FTSU and what to do if they suffer a detriment and how to escalate it, if it does indeed occur. Robust reporting systems are in place through which the FTSUG Lead reports biannually to the Audit Committee and Board of Directors with regular reporting to the Operational Workforce Committee.

Key learning from the issues raised over the last 12 months, includes the development of a new Freedom to Speak Up strategy, in line with national guidance. National reviews and cases raised locally have informed the content of the strategy. It was also evident that the process for escalation of concerns was not robust whereas there are now formal routes into the serious incident investigation process, when required, and into Trust governance processes.

Proud Awards: recognising the contribution of colleagues at The Rotherham NHS Foundation Trust

On 8 November 2018, The Rotherham NHS Foundation Trust's annual Proud Awards took place to celebrate dedicated and caring colleagues who help ensure patients receive the care and compassionate treatment they deserve.

Held at Magna and hosted by Heart Yorkshire's Dixie, the event saw more than 250 colleagues, partner organisations and guests alongside the shortlisted nominees.

This year, more than 460 nominations were received, including a fantastic response from patients and members of the public who submitted over 150 entries for the Public Recognition category alone.

Chief Executive Louise Barnett was joined by the Chairman, Martin Havenhand, the Executive Team as well as the Deputy Mayor and Mayoress of Rotherham. The Health Reporter from the Rotherham Advertiser, Dave Doyle, was also in attendance to help present the Public Recognition Award.

Proud AWARDS 2018

The 2018 winners and runners-up are:

Strategic Objectives Award - Patients
Winner: Immunisation and Vaccination Team, 0-19 Service

Strategic Objectives Award - Colleagues
Winner: Dr Kim Russon, Day Surgery

Strategic Objectives Award - Governance
Winner: Derek Stowe, Information Governance

Strategic Objectives Award - Finance
Winner: Lynette Evans, Dermatology

Strategic Objectives Award - Partners
Winner: The Winter Beds Project Team, Care Coordination Centre, CCG, Private care homes

Values Award - Ambitious
Winner: Paediatric Acute Rapid Response Outreach Team, Children's Community Nursing

Values Award - Caring
Winner: Jennifer Turedi, Learning Disabilities

Values Award - Together
Winner: Sitwell Ward, Urology

Outstanding Volunteer
Winner: Samina Nawaz,
Macmillan Cancer Information and Support Service

Learning and Development
Winner: Mary Dougan, Chief Nurse Team

Unsung Hero
Winner: Janet King, Labour Ward
Runner up: Allen Blore, Estates

Our Top Leader
Winner: Sandra Whiting,
Community Occupational Therapy Single Point of Access

Team of the Year - Clinical
Winner: Acute Medical Unit

Team of the Year - Non-Clinical
Winner: Pharmacy Stores and Procurement Team

Public Recognition Award
Winner: Kelly Guest, Early Attachment Service
Runner up: Alcohol Liaison Service

Shining Star Award
Winner: Samantha Pritchard, Wentworth South District Nurses

Innovation Award
Winner: Joanne Cook and Midwives, Maternity

Chief Executive's Award
Winner: Radiology Team, Clinical Support

Chairman's Award
Winner: Alison Cooper, Anaesthetics

Lifetime Achievement
Winner: Dr Dave Harling, Critical Care

Three Rotherham community nurses receive prestigious award

Three community nurses working for The Rotherham NHS Foundation Trust have been recognised for their commitment to nursing at a ceremony held in London in June 2018.

Sharon Hunter, District Nurse; Paula Boyer, Community Matron and Sharron Roberts, Advanced Nurse Practitioner and Community Matron have been given the prestigious title of Queen's Nurse by community nursing charity The Queen's Nursing Institute. Between them, they have nearly 60 years' nursing experience.

The title is not an award for past service, but indicates a commitment to high standards of patient care, learning and leadership. Nurses who hold the title benefit from developmental workshops, bursaries, networking opportunities, and a shared professional identity.

Chris Morley, who was the Trust's Chief Nurse at the time, said: "It is fantastic news that Sharon, Paula and Sharron have been awarded the title of Queen's Nurse and testimony to the quality of the care that they provide. I have had the privilege of seeing first-hand the difference that these nurses make to the health and wellbeing of their patients. This is a prestigious award and I am very proud of their tremendous and well deserved achievement."

Dr Crystal Oldman CBE, Chief Executive of the Queen's Nursing Institute said: "On behalf of the Queen's Nursing Institute I would like to congratulate Sharon, Paula and Sharron, and welcome them as Queen's Nurses. Queen's Nurses serve as leaders and role models in community nursing, delivering high quality health care across the country. The application and assessment process to become a Queen's Nurse is rigorous and requires clear commitment to improving care for patients, their families and carers. We look forward to working with all Queen's Nurses who have received the title this year."

In their roles, Sharon, Paula and Sharron work collaboratively across a number of partner organisations, ensuring patients with complex and long term conditions receive high standards of care and helping to reduce the number of hospital admissions.

Sharon Hunter has been a nurse for 14 years and has been working in the community since 2009. In 2015, she became a Community Practitioner Specialist (District Nurse).

Paula Boyer has spent her nursing career in the community since qualifying in 2004. She has been a Community Matron since February 2017.

Sharron Roberts has been working in the NHS for 30 years and is an Advanced Nurse Practitioner as well as a Community Matron.

Abiola excels in World Skills competition

A talented Rotherham health worker scooped the silver medal at the UK finals of the World Skills competition in November following his successes in the regional heats earlier in the year.

Abiola Lugboso, aged 29 and lives in Brinsworth, works as a Therapy Support Worker at The Rotherham NHS Foundation Trust and helps provide rehabilitation treatment for elderly patients and those requiring intermediate care following a stay in hospital.

Abiola, who works at a variety of locations across the Rotherham community, including Lord Hardy Court and Davis Court care homes, is undertaking training with Rotherham College as part of an apprenticeship course.

During the regional heats and the finals, Abiola took part in a variety of healthcare based scenarios in which his skills, knowledge and ability to deliver excellent quality care was assessed by a panel of judges. Abiola said: "Being involved in this process has allowed me to learn new skills and broaden my knowledge which I can now use in my role.

"I've got a passion for what I do, work with a supportive team, and I get lots of satisfaction knowing that I am able to help people get the rehabilitation they need to regain their independence and live at home. The recognition I've received is great as it has reaffirmed that I am doing the right thing for my patients."

Angela Wood, Chief Nurse at The Rotherham NHS Foundation Trust, said: "We are all very proud of Abiola's achievements and getting so far in the competition. He has a great passion for the work he does and it is great to see his hard work and dedication recognised in this way as he strives to do the best for his patients."

Two teams shortlisted for Clinical Support Services award

Two teams from the Trust were shortlisted for the Clinical Support Services category at the Health Service Journal (HSJ) Value Awards in June 2018. The teams were:

- Rotherham Dietetic Led Nutrition Prescribing – 10 years of improved patient care
- Occupational Therapy Single Point of Access

The Dietetic team, working in partnership with Rotherham CCG, has improved patient care over the last 10 years by changing the way nutritional prescribing is carried out. Across the country, the norm is for the Dietitian to carry out an assessment, decide on the supplements, enteral feeds, specialist baby milks or gluten free products needed and contact the GP for a prescription. However, in Rotherham the Dietitians do the prescriptions themselves, saving time for consultants and GPs and reducing the wait time for the patient from 2-3 months to 2-3 weeks.

The team also looked at the incidence of pressure ulcers in care homes. Pressure ulcers are linked with nutrition, and in the same period as the team have been doing the prescribing, the incidence of pressure ulcers has fallen.

Over the last 10 years, this model, now known nationally as the Rotherham Model, has saved the CCG around £5.6 million, with prescribing costs reducing while the rest of the country has seen them increase 99.3%.

In the last year, three CCGs have implemented the Rotherham Model while some others have partially implemented it. The team have also been contacted by others interested in the model. The work of the team has also been recognised by the British Dietetic Association who used the Rotherham Model as a case study to support their case to the Department of Health and Social Care for Dietetic Led Nutritional Prescribing nationally.

The Occupational Therapy team developed a pilot where a Community Occupational Therapist was based within the Adult Social Care Single Point of Access team to assist the Wellbeing Officers to provide prompt and appropriate advice to people phoning the service. The pilot expanded and reduced the waiting list for Community Occupational Therapy referrals, and is now a permanent team.

The whole Occupational Therapy team remained committed and adapted to change quickly and efficiently throughout the pilot. Engagement and support from the Single Point of Access Team and Social Care Managers has been vital to the success of integrated working.

The team have previously been recognised in the Proud Awards and boast the RMBC Employee of the Year.

While both teams entered into the HSJ Value Awards missed out on the top prize, it is still a huge achievement to be shortlisted as finalists. It also highlights their successes on a national stage and shows some of the Trust's dedicated and hard-working colleagues working in different areas of the Trust.

Dietetic led Rotherham Enteral Tube Feeding (RETF) Service

Rotherham Enteral Tube Feeding Service (RETF) was created in February 2018 with support from the Consultant Nurse in Endoscopy and Interventional Radiology and the Innovation and Improvement team. Data has been collated; for the first 6 months, RETF have:

- Prevented 28 A&E/ AMU visits and 18 hospital admissions (reducing pressure in A&E and a saving of approximately 126 bed days based on historic data of an average hospital stay of 7 days per admission).
- Prevented 30 GP/District Nurse Visits.
- Established a robust out of hours pathway via Care Coordination Centre (CCC) which has further prevented hospital admissions.
- Established Parenteral and Enteral Nutrition (PEN) Multi Disciplinary Team (MDT) meetings which has ensured decisions on the most appropriate mode of feeding were made in collaboration with all clinicians involved in the patient care. This process has dramatically reduced the waiting time for patients needing a Gastrostomy placement (from 3-4 weeks to within a week). This has also reduced length of stay. In addition there has been a 50% reduction in use of Parenteral Nutrition due to reduced inappropriate referrals and prompt availability of alternative feeding options.
- Developed relevant governance paper work e.g. patient information material, referral documents and care plans, Rotherham wide Guidelines, competencies packs, pathways of care and emergency protocols.
- Established a programme of training and education for staff, patients and carers.
- Performed audits to assess current performance and implement changes to improve the service.
- Included Gastrostomy tubes, ancillaries and syringes in the Enteral Feeds and Supplements contract which has ensured further saving on these items.

Patient satisfaction survey conducted at the end of the 6 months has shown a 28% increase of patient confidence in the service and 29% increase in patient satisfaction.

The team have received several compliments and also a nomination for TRFT 'Public Recognition Proud Award'.

Dietetic led Enteral Tube Feeding service facilitates patients to access the right care, in the right place at the right time.

Electronic Observations (e-obs)

The Trust launched electronic observations (e-obs) on Meditech in January 2018 to mark the beginning of an exciting new digital era for TRFT. The Practice Development Team (PDT) have supported the launch alongside Health Informatics Team and IT, ensuring staff are trained on how to input patient observations and vital signs electronically.

All ward areas will have launched e-obs by the end of April 2019.

Undertaking nursing observations electronically is more efficient, safer and will save time in the long run. It also allows patients' observations to be accessed from anywhere in the hospital. Meditech is already being used by the Trust so there has been no extra expense incurred by installing a new system.

Deputy Chief Executive Chris Holt said: "The roll-out of electronic observations is a real benefit to the Trust and helps provide teams with real time information and visibility on patient acuity from any network connected device in the Trust."

Additionally, the PDT have also been supporting the Critical Care Outreach Team with the training of ward colleagues on NEWS2, which was launched at TRFT at the end of March 2019.

NEWS2 (National Early Warning Score) is a revised scoring system which will reliably detect deterioration in adults and trigger escalation of care when appropriate. NEWS2 replaces the MEWS scoring system previously used to record a patient's vital signs. It will help to improve the identification and management of sepsis and other serious conditions, and also includes a new plan for escalation.

Band 2 Health Care Support Worker Competency Package

In 2018 the PDT introduced a new competency package for all Band 2 Health Care Support Workers to ensure equity and consistency in the standard of care delivered across TRFT.

The package, which was launched in February 2018, consists of a competency log book alongside a one day workshop which all Band 2 Health Care Support Workers (HCSWs) working at the Trust must attend. The log book covers twenty competencies which are divided into two types: professional skills and core clinical skills.

These competencies are linked to the Care Certificate Framework, the Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England and the 6 Cs of Nursing.

The competency workshop is designed to reinforce the value of the Healthcare Worker in a modern healthcare setting. Attendees are provided with their own log book at the end of the workshop, which is to be completed and then signed off by their Ward Manager within 12 weeks. Colleagues are issued with a certificate of completion.

So far over 100 HCSWs have attended one of the workshops and the feedback has been extremely positive.

Laboratory Medicine

Following initial inspection in July 2017 and subsequent closure of findings raised during the inspection, Laboratory Medicine received notification in September 2018 of Accreditation to the International Standard ISO15189 (Medical laboratories – Requirements for quality and competence). In January and February 2019, Laboratory Medicine received their first surveillance visit as part of accreditation to ISO 15189 and subject to closure of findings raised during the visit, the department has been recommended for maintenance of accreditation. Excellent feedback was received for all departments. The assessment team unanimously commended the competence and quality of service observed and the development and improvements since the visit in 2017. Assessors also commented on the excellent knowledge and competence of staff.

Service Developments - Maternity

Continuity of Carer – New Model commenced in March 2019

As set out in Implementing Better Births: Continuity of Carer (CoC) means each woman has consistency in the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour, and the postnatal period. In order for the Rotherham Maternity Services to provide this continuation the following actions and plans have developed and progressed led by the Midwifery Lead for Community and supported by the Associate Head of Midwifery.

The Maternity Service have commenced the new model of one team comprising 8 whole time equivalent Midwives that have been identified as a pilot.

The Team is a gradual transition to community for those midwives who are moving from the hospital but the team will be fully operational from June 2019 and undertaking births from September 2019. The Team are planning to have annualised hours during the pilot. Each midwife will build up their caseload over the year aiming for a ratio of 1:35. The team will provide on call from August or early September to start to cover those women with an expected date of delivery in September 2019. Community Colleagues have decided to name their teams after trees, the first team is called The Willow Team. This Team will be caring for women on a standard maternity pathway hoping to increase the home birth rate, providing assessment at home when women go into labour.

There have been a number of documents that have been developed to provide good strong governance regarding this care provision including the development of an inclusion criteria, an information leaflet for women and a Standard Operating Procedure (SOP) for labour and delivery. Further Teams are planned including a high risk team focusing on twin pregnancy, diabetes and vaginal birth after caesarean section.

Personalised Care Plans (PCPs) – Commenced March 2019

The Trust has piloted a new Personalised Care Plan (PCP) from 1 March 2019 and this will help women to choose and make decisions in relation to their care and place of birth. The Trust will continue to evaluate this and are working with other providers across the Place within the LMS and with the Maternity Voices Partnership (MVPs). This links and supports Continuity of Carer to make care more personalised and woman centred.

Maternity Voices Partnership (MVP)

As part of Better Births each service has to work with local service users to create services that are woman centred. The Trust has developed its MVP and work in partnership to deliver service improvements. They are part of the trusts Better Births Governance Group. We will be evaluating Continuity of Carer and plan to devise an evaluation for women and staff. The Maternity Voices Partnership are also involved in the evaluation process and plan to undertake some focus groups with women for both the Personalised Care Plans and our Continuity of Carer later in the year.

Rotherham First Contact Physiotherapy service

The First Contact Physiotherapy (FCP) service has been established to deliver a high quality assessment service for primary care patients with musculoskeletal (MSK) conditions. MSK pain is a very common reason for patients to present to primary care clinicians. The NHS England Long Term plan (NHS England, 2019) prioritises MSK conditions as part of its vision; including expanding the role of other healthcare professionals within the general practice team to meet the growing demand. The FCP service offers patients the opportunity to attend an appointment with an Advanced Physiotherapy Practitioner rather than their General Practitioner (GP), allowing patients to have access to earlier MSK intervention and reducing the demand on GPs.

The FCP service within Rotherham consists of six advanced physiotherapists, who possess advanced clinical knowledge and expertise to accurately assess, diagnose and treat MSK conditions. The practitioners are based in various GP practices across the Rotherham borough and any registered GP patient can access an appointment with one of the FCP practitioners. The patient accesses an appointment via an agreed care navigation process. Patients receive expert advice on the management of their MSK problem; the FCP practitioners have an enhanced understanding of the MSK pathways and also have access to relevant diagnostics tests if required.

The Rotherham FCP is currently one of the largest in the country; both in terms of population served and number of FCP practitioners employed.

Neonatal Outreach Team (NOT)

The neonatal outreach team was launched in September 2018 to support some of the Trust's most vulnerable patients and their families. Admission to Special Care Baby Unit (SCBU) is not a planned part of a family's pregnancy journey and the time spent on Special Care Baby Unit can be frightening and daunting. These feelings are experienced again when being discharged home from SCBU. The development of NOT supports baby's and families following the discharge from SCBU by having experienced neonatal practitioners to support them in the community setting. The creation of earlier discharge pathways allow parents to take their babies home earlier receiving oxygen and/or naso-gastric tube feeds supported by the NOT. The NOT are able to undertake procedures that previously families would have had to return to outpatients for. In the short space of time this service has been running it has been invaluable for families and is well supported by colleagues in the Trust.

Paediatric Acute Rapid Response Outreach Team (PARROT)

The service was launched in October 2017. The vision of the service was to provide care closer to home, reduce duration of inpatient stay, minimise hospital readmission, empower parents to manage their ill children in the home environment and enhance the patient experience. The team initially commenced working with Children's Ward and Children's Assessment Unit and this has also been successfully rolled out to the Urgent and Emergency Care Centre with referrals directly from the UECC, this reduces hospital admission through safe and supported care in the community. This has been received exceptionally well by colleagues in all areas and by patients and their families. The service is to be developed so that General Practitioners will be able to refer directly to the PARROT service to reduce the number of UECC attendances and referrals to the CAU

Paediatric Practice Development Team – In place from February 2019

Ensuring that high quality standardised training and education is provided across the Trust for paediatric nurses is essential in delivering high quality safe patient care. The practice development Team commenced in February 2019 and provides support and training across the Trust both acute and community perspective.

Enuresis Service – March 2019

This service was commissioned by the Rotherham CCG due to a gap in service provision following the retendering of the 0-19 service. Enuresis problems for children and young people can be extremely distressing and lead to isolation. This service is launched at the end of March 2019 and supports children/young people and their families through structured pathways to provide intervention, education and support.

Speech and Language Therapy Children's Service

The Speech and Language Therapy children's service has a thriving and growing traded service. This is predominately mainstream schools buying in a Speech and Language Therapist for a set time each week to improve speech and language levels across the school. Most schools are purchasing the service through pupil premium money which is a payment made to schools by central government to help raise the educational levels for children who fit the eligibility for free school meals. Schools are generally using their Speech and Language Therapy (SLT) time to: screen all children entering school at Foundation stage level (nursery and reception), targeting certain year groups or groups of children for intervention groups, training staff in school to identify

children with SLT needs and improve the general communicative environment in classrooms and training teaching assistants to run language groups.

Two of the Trust's highly specialist Speech and Language Therapists started a 3 day a week secondment in September 2018 to RMBC's Virtual schools team. This team has oversight of all Rotherham children in the Looked After Children (LAC) and Previously Looked After Children (PLAC) (post adoption) services. The aim of this post is to help raise educational attainment levels for this group of children and to ensure that a looked after child does not have unmet speech and language needs. As a result of this newly commissioned service every child who is taken into care will have a Speech and Language screening assessment. Children with identified needs will where possible be signposted to local NHS core SLT services wherever the child is placed or receive intervention from the 2 therapists if local services are not accessible

for any reason. Many LAC children have had missed opportunities for SLT assessment and intervention before they come into care or have unidentified needs because Social Emotional and Mental Health or learning difficulties are masking an underlying language difficulty. There are over 600 children monitored by the virtual schools team. The first year's priorities are to assess every new Rotherham child coming into care wherever they are geographically placed and also to target a cohort of Year 3 children (7-8 year olds) who have been identified as performing significantly behind their peers in literacy in their end of Key stage 1 SATs tests. The SLTs will also be working closely with the Educational Psychologists in the team to provide joint training for schools, foster carers and parents. This is a very exciting project that puts the Trust's SLT's at the forefront of joint working with local council services for this very vulnerable group of children.

Implementing the priority clinical standards for 7 day hospital services

The Trust has agreed the need to develop a 7 Day Services plan following the national guidance and local requirements. It is linked to the operational plan and the key work is around providing 7 day services with the acute facilities, ensuring that pathways are available 24/7. The initial priority in relation to this is the development of:

- Weekend board rounds.
- Consultant reviews.
- 7 day Hospital at night services rolled out to 24 hours at weekends.
- 7 day cover of the Ambulatory service.
- 7 day Consultant cover within the AMU.
- Increased Ratting services (pilot commenced).
- Further roll out of the Advanced Nurse Practitioner (ANP) model to support 7 day working in ED AMU Hospital at Night teams.
- Review complete of outreach and Hospital at night teams business case produced to increase 7 day coverage.

The national focus is still only on four of the 10 clinical standards:

Standard 2: Time to initial consultant review.
Standard 5: Access to diagnostic tests.
Standard 6: Percentage of diagnostic interventions available.
Standard 8: Ongoing daily consultant reviews.

The Trust participates in the national 7-Day Services Survey and compares well to the national picture. The May 2018 survey was completed and shows compliance with the 4 national standards. The January survey was completed and the national team are feeding back initial findings from the results nationally. The Trust will be taking the learning and feedback from this into the formal self-assessment due in July 2019.

Management of Rota Gaps – Doctors in Training

Gaps in Junior Doctor rotas can occur for a number of reasons, most commonly vacancies but also due to sickness absence and doctors training on a less than fulltime basis. The current vacancy rate for training grades is 13.7%; the equivalent of 20 posts out of an establishment of 146 across all training grades and specialties. Rotas are issued to individuals at least 6 weeks in advance and there are a number of shifts, designated Red Flag Shifts, that must be filled, e.g. Medical Registrar On-Call. In addition, minimum staffing levels have been set for ward areas to ensure sufficient junior doctors are available to maintain patient care and safety.

Management of gaps occurs on a daily basis with Rota Co-ordinators taking a pro-active approach to ensure gaps are filled in a timely manner. If a gap is not filled by a substantive member of staff, the process is to look to fill from the Trust's Internal Bank or via Agency if internal cover cannot be sourced. Other staff can also be utilised, such as an ANP for a F1 gap. Rota design also plays an important part to ensure optimum cover is provided; any change to rotas fully involves the junior doctors in the design of the rota and their agreement to undertake the revised work pattern. The Trust has also adopted Good Rostering Guidance, produced jointly by NHS Employers and the BMA in May 2018.

External Agency Visits, Inspections or Accreditations

During 2018/19 there have been 19 external agency visits. Details of these visits are included in Appendix 3 (page 136). Action plans are developed, where required, and monitored through the Clinical Governance Committee.

3.2: Performance against relevant indicators

The Trust is required to report performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement, for 2018 /19 these are:

i. The Risk Assessment Framework
ii. The Single Oversight Framework

For the purposes of this Quality Report, only the indicators that appear on both the lists above, are required. For The Rotherham NHS Foundation Trust therefore, the five following indicators are reported:

1. Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway.
2. A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge.
3. All cancers: 62-day wait for first treatment from:
   · urgent GP referral for suspected cancer
   · NHS Cancer Screening Service referral
4. Cancelled Operations.
5. C.Difficile.
6. Delayed Transfer of Care.

18 weeks from point of referral to treatment (RTT)

Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

% of patients waiting less than 18 weeks Target >=92%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	95%	95.00%	96.00%	95.50%	96.00%	95.20%	95.40%	95.90%	94.90%	95.41%	94.23%	93.42%	93.24%
2018/19	93.99%	94.35%	94.57%	94.32%	94.82%	95.07%	94.07%	94.43%	94.37%	93.80%	93.10%	92.01%	92.98%

(Source: Meditech)

The criteria for this indicator are defined in NHS guidance. These are used by TRFT and for ease of reference these are:

"The percentage of patients waiting to start non-emergency consultant led treatment who were waiting less than 18 weeks at the end of the reporting period. Numerator is the number of incomplete pathways within 18 weeks at the end of the reporting period. Denominator is the total number of incomplete pathways at the end of the reporting period. Indicator is numerator/denominator expressed as a percentage.

RTT (referral to treatment) consultant-led waiting times only apply to services commissioned by English NHS commissioners and for those patients that English commissioners are responsible. Therefore, RTT pathways commissioned by non-English commissioners are excluded from the calculation."

A number of TRFT specialties are currently excluded from 18 weeks RTT report. These are excluded because (as per national guidance) TRFT do not provide these services or they are non-consultant led activity.

The Trust continues to maintain performance against the Referral to Treatment time indicator with a strong performance throughout the year. With 94% performance in year which is above the 92% target.

The A&E four hour waiting time target

% of A&E attendances seen within maximum waiting time of 4 hours from arrival to admission/transfer/discharge

Target >=95%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	84.98%	87.15%	88.08%	87.20%	81.15%	82.41%	81.79%	85.50%	81.36%	85.64%	87.10%	87.70%	83.10%
2018/19	85.65%	83.54%	89.92%	92.09%	86.43%	87.54%	84.66%	88.71%	88.85%	84.32%	80.63%	76.75%	84.16%

Standard data from the Trust's Meditech system as reported to SUS (Source: Meditech patient information system)

The criteria for this indicator are defined in NHS guidance. These are used by TRFT and for ease of reference these are:

'A&E attendances and emergency admissions data reported through a central return are split into two parts. These are A&E Attendances which collects the number of A&E attendances, patients spending greater than 4 hours in A&E from arrival to discharge, transfer or admission and the number of patients delayed more than 4 hours from decision to admit to admission and Emergency Admissions which collects the total number of emergency admissions via A&E as well as other emergency admissions (i.e. not via A&E). These are reported for type 1, 2 and 3 department types.'

This data was subject to External Audit assurance. (A)

The maximum wait time of 4 hours standard has proven difficult to achieve throughout the year as reflected in the national picture. There has been an increase in attendance numbers and the acuity of the patients. TRFT along with other acute providers have not managed to hit the 95% standard for admitted patients although the Trust has on a large number of occasions hit the non-admitted target. Reinforcing the ability of the Urgent Care Centre and Emergency Department team to treat patients in a timely manner, highlighting the issues with the admitted patients who are reliant on flow through the hospital and community facilities for beds.

In a major report published in March 2019, Professor Stephen Powis, the Clinical Director of the NHS, found a number of flaws with the current four-hour waiting target in A&E, specifically that it does not measure total waiting times or take account of the patient's actual condition. TRFT has been asked to field-test measuring the waiting time from an initial clinical assessment and measuring the average waiting time. The Trust will be working with NHS England/NHS Improvement over the first half of 2019/20.

Cancer National Waiting Times

Trust performance against national waiting times for cancer services 2014/15, 2015/16, 2016/17, 2017/18 and 2018/19:

Metric	Target	2014/15	2015/16	2016/17	2017/18	April 2018 to Sep 2018
Cancer 2 week wait from referral to date first seen, all urgent referrals	93%	94.90%	95.12%	95.89%	95.1%	93.4%
Cancer 2 week wait from referral to date first seen, symptomatic breast patients	93%	94.70%	97.43%	94.98%	90.9%	81.4%
Cancer 31 day wait from decision to treat to first treatment	96%	99.40%	98.82%	99.21%	97.6%	98%
Cancer 31 day wait for 2nd or subsequent treatment - surgery	94%	100%	98.67%	96.85%	98.8%	98.5%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100.00%	100%	100	100%
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	92.70%	88.46%	86.93%	84%	85%
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	100%	98.20%	96.28%	90.8%	98.9%
Consultant Upgrade	TBC	TBC	94.72%	91.95%	92.8%	89.4%

(Source: Infoflex/Open Exeter)

The criteria for this indicator are defined in the Cancer Waiting Times rules. These are used by TRFT and for ease of reference these are:

'Maximum two months (62 days) from Urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first treatment (62 day classic).

Cancer Standards 62 Day 2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	89.7%	89.1%	88.9%	86.4%	87.5%	91.3%	76.4%	86.8%	80.2%	74.4%	80.5%	88.9%
Numerator	30.5	41	112.5	28.5	31.5	47	40.5	52.5	40.5	45	31	48
Denominator	34	46	126.5	33	36	51.5	53	60.5	50.5	60.5	38.5	54

Cancer Standards 62 Day 2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target >=85%	81.8%	87.1%	83.5%	85.7%	85.2%	86.2%	80.0%	86.6%	75.7%	69.8%	75.7%	74%
Numerator	54	57.5	43	57	54.5	53	50	51.5	39	44	40.5	35.5
Denominator	66	66	51.5	66.5	64	61.5	62.5	59.5	51.5	63	53.5	48

* (Figures October 2018 to March 2019 are provisional at the time of production of this report. Final figures will not be available until 5 June 2019 which is after the production of this report.)

Performance Against Targets

	Quarter1	Quarter 2	Quarter 3	Quarter 4
62 day	No	Yes	No	No
Screening	Yes	Yes	Yes	No

Screening:
Achieving screening targets can be challenging due to the small numbers of patients within the screening programme which only allows for 2 breaches per quarter. We have achieved 3 out of the 4 quarters this year, which is an improvement on last year.

62 Day Cancer Waiting times:
Performance has overall deteriorated throughout the year. With the trust only achieving this target in Q2. This has been attributed to the following reasons:

- An increase on 2ww referrals
- Difficulty in recruiting consultants which has impacted on capacity
- Increase in COSD data requirements

Steps have been put into place to ensure better working relationships between cancer services and the divisions. Cancer action plans to cover all areas have been developed and cancer recovery meeting which has been set up and runs bi-weekly. The trust has recruited additional support within Cancer Services to review and manage the PTL.

This data was subject to External Audit assurance. (A)

Delayed Transfer of Care

Delayed Transfer of care	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	6.78%	7.50%	6.88%	5.74%	6.13%	5.34%	2.37%	2.80%	2.56%	2.49%	2.14%	3.02%
2018/19	3.10%	2.26%	1.82%	2.52%	4.42%	3.16%	4.24%	2.80%	2.61%	4.06%	1.78%	1.90%

(Source: Trust Information System)

The criteria for this indicator are defined in NHS guidance and details are on the NHS Digital indicator portal. These are used by TRFT and for ease of reference these are:

'Delayed Transfer of Care (DTOC) from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when a clinical decision has been made that patient is ready for transfer AND a multidisciplinary team decision has been made that patient is ready for transfer AND the patient is safe to discharge/ transfer.'

Current position:
Since October 2018 the Team have adopted and rolled out within the Trust a Single Referral Process. This new process replaces several previous referral processors within the IDT, now being a Single Point of Access for Discharge Planning and access to Discharge Pathways.

This has supported the Team to continue to achieve Delayed Transfers of Care figures within the National Standard, despite the pressures in winter and the increased acute and non-acute beds.

The Integrated Discharge Team will continue to be in a phase of development and endeavour to continue to improve practices and processes to sustain current DTOC performance within National Standard.

Cancelled Operations

Cancelled Operations 2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target <=0.80%	0.71%	0.89%	0.64%	0.65%	0.78%	0.43%	1.02%	0.84%	0.82%	1.10%	1.10%	1.15%
Numerator	19	27	20	19	24	13	33	26	20	33	30	33
Denominator	2684	3017	3147	2927	3061	3053	3234	3096	2448	3005	2728	2859

Cancelled Operations 2018/19	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target <=0.80%	1.18%	1.10%	0.71%	0.89%	0.64%	0.89%	0.49%	0.54%	0.67%	0.71%	0.73%	0.79%
Numerator	35	34	22	27	19	25	16	17	17	21	20	23
Denominator	2960	3094	3086	3042	2968	2802	3294	3149	2542	2963	2742	2903

(Source: Trust Information System)
This data was subject to the External Audit assurance (A)

Cancelled operations data is reported quarterly through a central return however, the information is also reported monthly to the Trust Board to show the Trusts 'performance against the <=0.80% target. The indicator applies to all admitted patients planned for surgery who get their operation cancelled at the last minute due to non-clinical reasons i.e. on the day of arrival in hospital, or after admission to hospital, or on the day of surgery. The Trust then has the responsibility of getting the patients re scheduled within 28 days of the original cancelled operation date. Should for whatever reason the Trust cannot comply with this national rule, the Trust has to fund the patients treatment at the time and hospital of the patients choice. The source of the information is the Trusts electronic system (Meditech). The numerator is the number of patients cancelled by the hospital for non-clinical reasons i.e. lack of equipment and the denominator is the number of operations carried out.

The standard applies to all planned or elective admissions where an OPCS-4 operation code procedure was to be carried out. This includes patients admitted for day surgery. Invasive X-ray procedures carried out on inpatients or day cases are counted as an operation for the purpose of monitoring this standard.

Some common non-clinical reasons for cancellations by the hospital, highlighted by NHS England, could include: ward beds unavailable; surgeon unavailable; emergency case needing theatre; theatre list over-ran; equipment failure. However, this list is by no means exhaustive.

Any patient who is cancelled on the day of their procedure, for non-clinical reasons, must be offered an alternative date within a 28 day period.

The total full year performance for 17/18 was 0.84%, which is slightly outside the agreed target of 0.80%. The total performance for 18/19 YTD is 0.78% which is within the agreed standard.

Should any services not meet the target then the contributing factors are investigated as part of their governance processes and could be questioned at service level performance meetings, which take place monthly. There is a robust validation process in place in order to ensure services are reporting accurately and any themes or learning can be shared.

The importance of achieving this target is well understood within the service, as cancelling patients on the day of their surgery provides a very poor experience for those individuals.

Incidence of C.difficile

Number of reported cases of C.diff

Target = <24	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	15	0	0	0	2	0	2	2	0	3	2	1	3
2018/19	8	0	1	0	2	1	0	2	0	1	0	0	1

(Source: Trust Winpath System)

The Trust improved its performance on C difficile compared to the previous years and was well under the trajectory of 25 that it had been set.

All cases of hospital acquired C-difficile are reviewed in depth by the Infection Prevention and Control (IPC) team. Shared ownership of completion of the Root Cause Analysis (RCA) investigation with the clinical divisions has continued. Multi-disciplinary Team (MDT) meetings with the relevant Division take place in the following two weeks where a full review of the RCA is undertaken with any identified actions being reported via the relevant governance meeting.

National and local priorities and regulatory requirements:

The Trust is assessed through the submission of wide range of data.

Measure	Department of Health	NHS Improvments	2016/17		2017/18		2018/19	
			Year-end position	National Target	Year-end position	National Target	*Year-end position	National Target
Number of cases - clostridium Difficile infection (C-difficile)	x	x	19	>24	15	>26	8	>26
Number of cases - MRSA	x	x	1	0	3	0	1	0
Delayed transfers of care	x	x	3.41%	3.50%	4.61%	3.50%	1.9%	3.50%
Infant health & inequalities: breastfeeding initiation	x	x	57%	66%	57%	66%	66.5%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	96.89%	95%	95.92%	95%	96.1%	95%
Maximum time of 18 weeks from point of referral to treatment in aggregate, ADMITTED PATIENTS, NON ADMITTED PATIENTS and INCOMPLETE PATHWAYS.								
Admitted	x	x	84%	90%	84%	90%	84.4%	90%
Non - Admitted	x	x	96%	95%	95%	95%	95.4%	95%
Incomplete	x	x	95%	92%	95%	92%	95.01%	92%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	2.40%	Less than 1%	0.60%	Less than 1%	0.49%	Less than 1%
Patients waiting less than 4 hours A&E	x	x	88.63%	95%	84.95%	95%	85.65%	95%
Cancelled operations for non-medical reasons	x		0.76%	0.80%	0.73%	0.80%	0.8%	0.80%
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		92%	90%	91.34%	90%	93.6%	90%
Patients who spend at least 90% of their time on a stroke unit	x		85%	80%	75%	80%	81%	80%
Higher risk TIA cases who are scanned and treated within 24 hours	x		66%	60%	81%	60%	70%	60%
Elective Adult patients 18years and over readmitted to hospital within 28 days of discharge from hospital	x		5%	6%	2.06%	6%	1.53%	6%
Non Elective Adult patients 18 years and over readmitted to hospital within 28 days of discharge from hospital	x		13.60%	12.50%	11.86%	12.50%	12.45%	12.50%
Elective patients 0-17 years readmitted to hospital within 28 days of discharge from hospital	x		0.60%	3%	1.19%	3%	0.29%	3%
Non-Elective 0-17 years patients readmitted to hospital within 28 days of discharge from hospital	x		6.50%	10.40%	8.30%	10.40%	8.33%	10.40%
Ensuring patients have a positive experience of care (Pt survey overall score)	x	x	8	10	8.1	10	Not Published until June 19	10

Measure	Department of Health	NHS Improvments	2016/17		2017/18		2018/19	
			Year end Position	National Target	Year end Position	National Target	Year end Position	National Target
Patients waiting no more than 31 days for second or subsequent cancer treatment								
Anti-Cancer Drug Treatments - Chemotherapy	x		100%	98%*	100%	98%*	100%	98%*
Surgery	x		96%	94%*	98.80%	94%*	97.5%	94%*
Radiotherapy	x		n/a	94%	n/a	94%	n/a	94%
62-Day Wait For First Treatment (All cancers)								
From Screening Service Referral	x		95%	90%*	90.80%	90%*	94.7%	90%*
Urgent GP Referral	x		87%	85%*	84%	85%*	81.2%	85%*
31-Day Wait For First Treatment (Diagnosis To Treatment)								
All cancers	x		99%	96%*	97.60%	96%*	97.5%	96%*
Two week wait from referral to date first seen								
All cancers (%)	x		95%	93%*	95.10%	93%*	93.8%	93%*
For symptomatic breast patients (cancer not initially suspected)	x		98%	93%*	90.90%	93%*	85.6%	93%*
SHMI	x		112.06	100	103.13	100		100

Please note : the data for April 18 - March 19 is not published until August 2019
(Source: Various Information Systems including InfoFlex/Open Exeter and Trust Information System)

For further details of readmission rates see Appendix 2.


Safe &
Sound

Annex 1: Statements from Commissioners, the local Healthwatch organisation and the Overview and Scrutiny Committee

Statement on behalf of the Council of Governors

The comprehensive Quality Account Report which details the progress and delivery of quality improvement initiatives is welcomed by the Governors.

We believe that the report is an accurate and true reflection in terms of actions taken by the Trust during the year and indicates both the significance and the emphasis placed on safety, quality, patient experience and clinical effectiveness by the Trust.

During the year, the Trust welcomed the Care Quality Commission who carried out inspections at the Trust, including the Trust's first CQC 'Well Led' review. This document provides substantial detail with regard to the CQC findings and follow up actions being taken.

Whilst improvement was seen in some areas, the overall rating for the Trust remains as 'requires improvement'. This was to be expected, partly because of changes to the inspection procedures whereby fewer areas are inspected meaning that it is difficult for the rating to move upward within one inspection cycle. However, it is without doubt, both disappointing and concerning, that services from our flagship Urgent and Emergency Care Centre were awarded an 'inadequate' rating by the CQC and that within their findings, the domains for safety and caring had both deteriorated since the last inspection.

The Council of Governors is assured that a substantial amount of work has been and will continue to be carried out by the Trust to remedy this and the other areas where improvement is required. The Council of Governors also wishes to thank colleagues for the unending compassion, strength, resilience and professionalism shown by them before, during and after the CQC visits.

The CQC identified digital progress as an area of outstanding practice across the Trust, not only in terms of the systems used but also in the level of clinical involvement and in the use of data to monitor and drive performance. The extended use of digital technology continues to support improvements in patient care. This includes the deployment of E-observations across inpatient and UECC areas, and the Trust continues to plan for Trust-wide implementation of E-prescribing in autumn 2019.

It has been a demanding year for the NHS in general, and the Trust has not been immune to system wide and local challenges. Whilst it is disappointing that some local standards were not met, such as the four hour A&E access standard, and some cancer standards, there is still some satisfaction with the strong performance in areas such as infection control, hip fracture best compliance, and reduced length of stay.

In January 2019 the Council of Governors chose cancelled operations as the local indicator to be audited by the Trust's External Auditors. The Council was pleased to note that the Trust's performance for 2018/19 had improved compared to 2017/18 and was within the agreed national standard.

The Governors are assured that the continual improvement in the quality of care delivered to the citizens of Rotherham is of the highest priority for the Trust. The Council of Governors will continue to question and challenge appropriately within the discharge of their statutory duties, in order to support the Trust in this endeavour. As Lead Governor I can attest to the open and honest dialogue and the high level of engagement the Trust leadership has with the Governors, and it is appreciated.

The Trust continues to work closely with partners throughout the South Yorkshire and Bassetlaw Integrated Care System, and the Rotherham Integrated Care Partnership. Governors are supportive of proposed arrangements, which, if taken forward and carried out successfully, will bring benefits for our patients in the future.

We look forward with interest to the next steps in these initiatives and hopefully, many further years of collaborative, joined-up working, leading to improved quality of health and social care in Rotherham and across the region.

Gavin Rimmer

Lead Governor, The Rotherham Foundation Trust.

Statement from NHS Rotherham Clinical Commissioning Group

Throughout 2018/19, The Rotherham NHS Foundation Trust (TRFT) have worked with NHS Rotherham Clinical Commissioning Group (RCCG) to secure continuous improvements in the three domains of Patient Experience, Patient Safety and Clinical Effectiveness through engagement from TRFT clinicians and executives at contractual meetings and other key committees between the two organisations. The joint Contract Quality Meeting has had particularly strong representation during the latter part of 2018/19 with regular attendance from both the Chief Nurse and Interim Medical Director. The level of assurance provided at this forum in relation to actual and potential quality issues within the Trust has been robust and transparent.

RCCG are particularly keen to highlight the achievements of TRFT in relation to a number of areas which are detailed below.

RCCG recognises the significant improvements that have been made in clinical coding during 2018/19 resulting in TRFT being rated in the top quartile nationally for depth of coding and achieving the highest grade Level 3 for the Information Governance Audit. Depth of coding is important for Providers and Commissioners in ensuring that the complexity of patients is captured appropriately and accurately and supports in the planning of services to ensure patients' needs can be met.

TRFT's Infection Prevention and Control team and the lead Infection Prevention and Control Nurse for RCCG work in collaboration to attempt to prevent, manage and reduce the healthcare associated infections in Rotherham. Flu cases have been a particular challenge during 2018/19 however this has been managed well by the introduction of point of care testing within the Urgent and Emergency Care Centre which has helped to support rapid identification and admission avoidance.

TRFT provided RCCG with full assurance on the review process and governance arrangements for risk assessments and sign-off in relation to the quality impact assessments of cost improvement plans. Of particular importance was that for the 2018/19 cost improvement schemes these were either approved at Divisional Level having being assessed as having no risks to quality or safety, or discounted at concept stage, as having an impact on quality and safety to pursue. RCCG have noted the potential change to the QIA process for 2019/20 and will look forward to receiving the same level of assurances for the forthcoming year.

RCCG and TRFT participate in an annual programme of clinically led visits. The purpose of these visits is to facilitate assurance about quality and safety of healthcare services; providing an opportunity for commissioners to inspect facilities and engage directly with patients, clinicians and management to hear any concerns and ideas for improvement under a guarantee of anonymity. For 2018/19, there was a joint agreement to change the way that visits were conducted with a focus on the patient journey and full end to end pathway. Two visits have taken place during 2018/19, these being maternity and learning disabilities. Overall the two visits concluded with positive feedback from RCCG clinicians with a series of recommendations for improvement to be implemented. Also of particular note was the positive feedback from the patients during these visits. A programme of visits is in the process of being agreed for 2019/20.

TRFT's current registration with the Care Quality Commission (CQC) is 'registered with conditions' due to a number of conditions placed upon the Trust during 2018. The latest inspection in September and October 2018 gave the Trust an overall rating of requires improvement and subsequently a comprehensive action plan has been developed to address the inspection findings. TRFT have committed to sharing updates against these actions with RCCG and RCCG recognises the hard work that has been put into not only developing the plan but addressing the immediate concerns raised by the CQC. RCCG will continue to work in a supportive manner with TRFT as well as seeking assurance on delivery of the plan and identifying notable improvements.

TRFT have experienced challenges during 2018/19 with regards to medical staffing vacancies recognising that this is a national issue. RCCG have been assured that processes are in place to manage this.

RCCG is supportive of the Trust's key quality priorities for 2019/20 and is pleased to note that priorities have been agreed following a consultation process involving colleagues, governors, patient and members of the public. In particular, the focus on enhancing patient feedback and public engagement is welcomed.

Dr Anand Barmade
GP Executive Lead – TRFT Contract
NHS Rotherham CCG

Sue Cassin
Chief Nurse
NHS Rotherham CCG

11 April 2019

Statement from Rotherham Healthwatch

Healthwatch Rotherham continues to have an excellent co-operative working relationship with The Rotherham Foundation Trust.

Having read the Quality Accounts it is good to see Patient Experience included in the quality priorities for 2019/20, focusing on improving End of Life recognition, improved patient discharge and enhancing patient feedback and public engagement. Healthwatch Rotherham attend the Patient Experience Group meeting and feeds back any complaints, compliments or concerns that have arisen during the month. A snapshot of comments from social media channels are fed back to the group and we ensure that all comments in the feedback section of our website are responded to by the Head of Patient Experience.

A representative from Healthwatch Rotherham attended the PLACE assessment during April 2018, assessing privacy and dignity, food, cleanliness and general building maintenance. It is good to see that The Rotherham Foundation Trust are taking on board areas where improvements can be made.

Any information received by Healthwatch Rotherham via our engagement work from local residents is passed onto The Rotherham Foundation Trust. The majority of comments continue to be from residents who have received excellent care, and are praising the individuals involved. Any concerns or complaints received at these events are raised in the agreed way.

Healthwatch Rotherham looks forward to continuing to grow and develop a good working relationship with all at The Rotherham Foundation Trust.

Tony Clabby
Healthwatch Rotherham CEO

Statement from Rotherham Health Select Commission

The TRFT sub-group from the Health Select Commission (HSC) held a detailed discussion on progress on the quality priorities in January 2019. This was then followed by a similar session in April 2019, with Members also having had the opportunity to consider the draft Quality Account. Members value being presented with this information and asked questions in both sessions with regard to challenges, performance and delivering further quality improvements.

Clearly the HSC was concerned by the findings from the recent CQC inspections, in particular with regard to the Urgent and Emergency Care Centre and the Safe and Well-led domains, internal communications and safeguarding referrals. They held an in depth session on the CQC report in February and probed into the key issues and how these would be addressed. 47 Must Do actions have been incorporated in a comprehensive action plan and HSC expects to see these actions being taken to ensure the CQC report is acted upon. Members are keen to see that improvements lead to better relationships between managers and staff and improved staff morale. Scrutiny of progress with the action plan will be included in the Select Commission's work programme for early autumn.

It is positive to see the progress made on the quality priorities during the year, in particular with electronic results reporting in radiology and future expansion into other areas, and further progress on both End of Life Care and Mental Capacity Act compliance, which are difficult areas. Further work on discharge planning and increasing pre-noon discharge is welcomed by the HSC and it is hoped that the roll out of e-prescribing will facilitate this, for example with people not having to wait for take home medication to be dispensed. It is also envisaged that e-prescribing will enable further progress on medicines management overall and reducing medication omission errors.

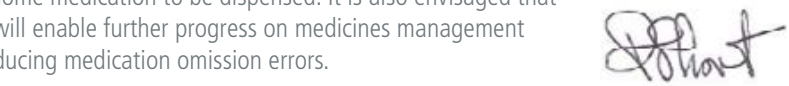
As Vice Chair I would like a continued focus on staff training on safeguarding to ensure all children and young people are protected and that signs of possible abuse are correctly recorded and concerns passed on to partner agencies.

Workforce challenges have been an ongoing issue for a few years with national shortages of nurses and doctors in various specialties. The Trust is being proactive on this issue with a number of initiatives to ensure the right skills mix and to encourage existing staff members to develop their careers at the hospital. Visits to local schools and colleges to talk to students about career opportunities and pathways are a positive move.

It was disappointing to see that the percentage of patients reporting that they were not bothered by noise at night had decreased and hopefully additional measures will be considered to improve this.

Overall there is a lot of work to do but Members are very supportive of the introduction of the new Safe & Sound Framework being developed by the Chief Nurse as the overarching means of delivering the long term changes needed and to embed a quality improvement culture. It is pleasing to hear that within this framework the Trust is planning to strengthen its approach to listening to the views of staff, patients and their families and carers.

The Health Select Commission appreciates the willingness of the Trust to engage regularly with Members, by attending meetings and providing information, as well as taking on board their comments and concerns. The Commission expects this to continue and looks forward to working closely with the Trust again in 2019-20.



Cllr Peter Short
Vice Chair, Health Select Commission
16 April 2019

Annex 2: Statement of Director's Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2018 to 31 March 2019.
    - papers relating to quality reported to the board over the period April 2018 to 31 March 2019.
    - feedback from commissioners dated 18/04/2019.
    - feedback from governors dated 14/05/2019.
    - feedback from local Healthwatch organisations dated 08/05/2019.
    - feedback from Overview and Scrutiny Committee dated 17/04/2019.
    - the trust's complaints report published under regulation18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/04/2019.
    - the national patient survey 13/06/18.
    - the national staff survey 26/02/2019.
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 16/05/2019.
    - CQC inspection report dated 31/01/2019.
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- the performance information reported in the Quality Report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controzzls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Martin Havenhand
Chairman
22 May 2019

Louise Barnett
Chief Executive
22 May 2019

Post script
Regulation 5 statement

The draft Quality Report was sent to stakeholders within the timeframes stipulated by the guidance and regulations.

Since receipt of the responses which are provided on pages 117-120, the Trust has undertaken further work to enhance the content of the document regarding the layout of the sections in the document and updating information which was not available at the time.

Independent Auditors' Limited Assurance Report to the Council of Governors of Rotherham NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Rotherham NHS Foundation Trust to perform an independent assurance engagement in respect of Rotherham NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to our limited assurance conclusion are (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) ("NHSI"):

Specified Indicators	***Specified indicators criteria*** (exact page number if possible, or title of section where criteria can be found)
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	See pages 106 & 107 of Quality Report
Percentage of patients with a maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	See pages 108 & 109 of Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing the limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period;
- Feedback from the NHS Rotherham Clinical Commissioning Group dated 11/04/2019;

- Feedback from Governors dated 14/05/2019;
- Feedback from Rotherham Healthwatch dated 08/05/2019;
- Feedback from the Overview and Scrutiny Committee dated 17/04/2019
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/04/2019;
- The latest national patient survey dated 13/06/2018;
- The latest national staff survey dated 26/02/2019;
- Care Quality Commission inspection report, dated 31/01/2019; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16/05/2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Rotherham NHS Foundation Trust as a body, to assist the Council of Governors in reporting Rotherham NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Rotherham NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;

- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures;
- assessing the access controls in place surrounding the Meditech system; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

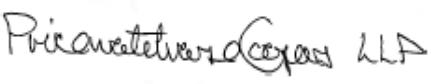
The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Rotherham NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.



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29th May 2019

The maintenance and integrity of the Rotherham NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendices

Appendix 1: Review of Local Clinical Audits

Review of Local Clinical Audits

The reports of 95 local clinical audits were reviewed by the provider in 2018-19 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
A&E	Paediatric Priority 2 audit	The priority of children within the department to be reviewed and discussed in huddles and Consultant meetings. The paediatric escalation policy will be reviewed and amended.	R955
A&E	Documentation 2017/18	Discuss the documentation in patient notes of when x-rays and blood results have been reviewed in staff huddles, display information on the department notice board and include in department information bulletin.	S1627
AMU	Investigations for cancer in unprovoked VTE as per NICE guidelines	Present the results in hospital weekly teaching sessions and display posters in the ambulatory care area.	S1689
Anaesthetics	Ventilator Tidal Volumes	Improve number of patients receiving lung protective ventilation by ensuring patient's weight and height are correctly documented and documenting target tidal volumes.	R1037
Anaesthetics	MRX Operational Check Audit (Rolling audit)	No actions required.	R984
Anaesthetics, General Surgery	Post appendicectomy analgesia in children	To ensure that all children will have an overall experience of no pain or mild pain, alter the dose of Ibuprofen on the Paediatric analgesia guideline. Ensure anaesthetists and recovery are aware of updates.	S1292
Community Adult Services	Quality of Radiographs taken in Doncaster Community Dental Service 2017	Feedback the results of the audit at the Doncaster Community Dental Service Staff Meeting and offer individual results to operators. Re-iterate to dentists that all radiographs taken must be graded for quality and that reasons for Grade 2 & 3 radiographs must be recorded. Re-iterate to all operators that Radiation Protection Supervisor (RPS) checks must be done quarterly i.e. 4 x per year or 3-monthly and to record collimator use and if not, the reasons why. Implement the buddy system for RPS checks as soon as practicable.	R951
Community Adult Services	Quality of Intra-oral Radiographs taken in 2017 in the Rotherham Community Dental service	To discuss at staff meeting and Clinical Governance Group that the standard of justifying and reporting of all radiographs should be done on the software of excellence custom screen and that all dentists/operators log all radiographs in the Ionising Radiation (Medical Exposure) Regulations practitioners' files as well as complete the x-ray custom screen for each radiograph taken.	R977
Community Adult Services	Compliance with NICE guidelines for referral for cochlear implant	Standardise the patient assessment to ensure all appropriate cases are identified and recorded.	S1720
		Develop a relevant information leaflet to provide to patients for whom cochlear implant is an option for use in clinic.	
Children and Young People (CYP) Service	SCBU discharge letters	To update the IT system "BADGER" with weekly summary.	R1050
CYP Service	Re-audit of CYP Multidisciplinary Documentation (April 2018)	To develop a poster to share audit results with the multidisciplinary team. To ensure documentation standards are included in trainees induction.	R1051

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service	Quality of paperwork provided at Looked After Children (LAC) clinic	Arrange a meeting with the appropriate people around the table to address escalation and implement 'No paperwork, No LAC appointment'.	R1069
CYP Service	Audit of recording of admin v clinical time in Speech & Language Therapy (SLT) children's SystmOne unit	All new starters to be given bespoke SystmOne training by a SLT SystmOne super user.	R942
CYP Service	Quality of assurance of initial health assessment for looked after children	Remind all registrars to record decision on how to allocate between consultants. Remind all registrars to record time frame for next appointment. Discuss with relevant registrar if recording of dental details on form not done. If child not registered with Dentist, remind registrars to include on action plan and inform foster carer/social worker.	R961
CYP Service	Asthma Management in Children's Outpatients 2017	Add information regarding the proforma stickers to training programme for Registrars. Place stickers on clinic desks to enable everyone to remember to use stickers. Email all doctors a summary of the audit findings and reminder to use checklist stickers.	S1602
CYP Service	Readmissions of term babies with jaundice to TRFT	Identify other causes that may affect the development of jaundice with the aim of identifying how to reverse such causes. Assess feeding within the first 24 hours for babies readmitted for the treatment of jaundice. Develop better information booklet for parents and implement 'Informed of signs of jaundice' sticker in Red Book, if any signs or risks of jaundice present on discharge.	S1667
CYP Service	Paediatric Acute Rapid Response Outreach Team referrals (PARROT)	Update referral guidelines to Include section on when would be appropriate to refer to PARROT.	S1804
CYP Service, Safeguarding	Audit of revised midwife to health visitor handover pathway	Standardise the use of the Midwife to 0-19 Service template for hand over from Midwife to 0-19 Practitioner in SystmOne (electronic health record) by re-affirming the SOP. Train staff in compliance with an open reciprocal share between the midwifery and the 0-19 Units on SystmOne. Improve communication with Midwifery teams that serve the borders of Rotherham Borough by requesting notification from Bassetlaw, Barnsley and Sheffield hospitals of new mothers booking.	R849
CYP Service, Safeguarding	Safe sleep assessment re-audit (2017)	Promote and review the Trust Safe Sleep Policy in both midwifery and 0-19 service to include undertaking repeat assessment when risk identified. Identify Link Health Visitor's within each locality to lead on safe sleep. Review the midwifery to 0-19 service handover template process for requesting repeat visit. Review reports on how many safe sleep assessments have been completed by 0-19 service to identify areas for further investigation. Develop safer sleep awareness campaigns in Rotherham by developing displays for Community clinics supporting the Yearly National Safer Sleep Week plan.	S1582

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service, Safeguarding	Documentation of names and relationships of adults attending with children to children's ward and out patients within child health	Review and amend Multi-Disciplinary Team (MDT) documentation proforma, enabling Medical and Nursing staff to be more aware of family structure. Share results at safeguarding training days in April and through team brief to ward staff. Discuss with medical and nursing staff the feasibility of use of Meditech (EPR) documentation template to record: • Family names, relationships, dates of birth, addresses. • Accompanying adults. • To be checked and updated every admission. • Printable so can form part of paper record for that admission. 0-19 service to review their documentation to include the names and relationships of accompanying adults, household contacts as part of their audit of SystmOne. Doctors to collect family names and relationships of household contacts carers and siblings at first new patient COPD attendance on OPD proforma (clerking sheet).	S1709
CYP Service, Safeguarding	Audit of child protection medical reports	Email all trainees and consultants to check that start and finish time of CP medical is always documented, as well as Persons present for history and during examination; to remember that Chaperone is essential for examination, and desirable during history taking, and to ensure that the full name and professional role of the chaperone is documented fully in CP medical reports; to ensure each report has a separate opinion section, and opinion should be clear, based on balance of probability as to likelihood of abuse and risk of significant harm; each report also to include differential diagnosis, reference and limitation if any; to remind everyone that A Police Protection Order (PPO) does not confer parental responsibility, and if it is known that a parent objects to the medical then legal advice should be sought before proceeding, as an Interim Care Order may be needed with a court direction to allow the medical examination. To write and implement guidelines for Child Protection Medicals.	S1708
Dermatology	An audit of initial assessment and discharge of patients undergoing phototherapy	Develop the current flowchart to have space for the doctor initiating phototherapy or the nurse leading the patient education session to list the full patient's medications. To redevelop the discharge letter to include a tick box confirming that a patient has been informed about accessing their GP for re-referral, a tick box that advises the GP to commence regular surveillance for changing skin lesions and dermatology referral if concerns arise and encourage staff to fill out the follow up section of a discharge letter template.	R1061
Dermatology	An audit of initial assessment and discharge of patients undergoing phototherapy	Develop the current flowchart to have space for the doctor initiating phototherapy or the nurse leading the patient education session to list the full patient's medications.	R1061
Dermatology	Excision Vs biopsy	A surgery list to be complied by a Consultant and Specialist Nurse of the procedures each medic and nurse are able to undertake.	R980
Dermatology	Audit of compliance with guideline: checking vitamin D levels in all newly diagnosed melanoma patients	The action regarding measuring vitamin D levels at diagnosis to be added to the skin cancer work programme and relevant clinicians emailed regarding the measurement of vitamin D. A proforma to be devised for the recording of vitamin D levels. A patient's GP to be contacted following identification of suboptimal vitamin D levels for treatment to be arranged.	S1598
Dermatology	British Association of Dermatologists national clinical audit on the management of bullous pemphigoid	Record blood pressure and blood tests in notes for all patients commencing on systemic treatments for bullous pemphigoid. Osteoporosis risk should be documented for all patients and all patients considered for bone protection when commencing on high dose steroids.	S1695

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Endoscopy	Colonoscopy Completion Rate (October 2016 - March 2017)	Increase lists for low volume endoscopists by identifying those permanent members of staff, or locums with low case numbers. Continue to monitor completion rates & provide upskilling training. Educate endoscopists to record discomfort rates, polyp detection and retrieval rates in appropriate part of Infoflex (database). Report polyp detection and retrieval rates by Endoscopist. Update Infoflex to add sedation score as a mandatory field and add rectal retroversion rate, colonoscopy withdrawal time & rectal retroversion, midazolam dose by age groups to ensure auditable outcomes are captured.	S1571
General Surgery	Audit of the adherence to the rib fracture pathway	Rib fracture pathway analgesia to be re-audited in more detail.	S1696
General Surgery	Audit of the adherence to the rib fracture pathway - analgesia	Improve rib fracture pathway with a multidisciplinary team approach between pain team, general surgery, physiotherapy & anaesthesia.	S1800
General Surgery	VTE Prophylaxis	VTE Risk assessment to be reviewed as part of the Post Take Ward Rounds on the Acute Surgery Unit.	S1807
Genitourinary (GU) Med	FSRH Emergency Contraception National UK Benchmarking audit 2018 (faculty of sexual and reproduction healthcare)	Provide teaching on Emergency contraception in weekly training sessions, including documentation of information on copper intrauterine devices (Cu IUDs), advice on Sexual Health, and advice on contraception. Suggest revision to the template on IT system 'Inform' to record when information and advice given.	R1036
GU Med	Audit of Contraception in women living with HIV	Review the 4 patients in whom drug interactions have been highlighted in MDT, to see if there are alternative antiretroviral (ARV) regimens. Establish on going team teaching sessions to educate team on guidelines to enable women to personalise their contraceptive choices better.	R940
Haematology	Documentation Audit 2018/19	Discuss the results at the Haematology governance meeting, highlighting the need for the ward location of the patient to recorded at each entry in the notes.	S1764
Laboratory Medicine (Lab Med)	Competency compliance of staff administering blood components and completion of pre-transfusion bedside checklist	Hospital Transfusion Team (HTT) to attend clinical areas that did not meet the 100% target for the presence of the checklist. Communication to be sent to all staff and relevant ward managers regarding the presence and completion of safe bedside checklist. HTT to review the integrated care pathway (ICP) document to make more user friendly and facilitate the mandatory checklists effectively for the staff using it.	R1035
Lab Med	Audit on the use of the Pre-Prescription Checklists for Chemotherapy	Prescribers and Checkers made aware of the need to ensure Pre-Prescription Checklist is signed by Biomedical Scientist (BMS) in Blood Bank when patient commences systemic anti-cancer therapy where components with special requirements required. Identify appropriate central location to be identified to retain copy of form to ensure access by all relevant staff an at all times.	R1059
Medicine	Adult Bronchoscopy	Leaflets regarding the bronchoscopy procedure to be made available on the medical wards, especially A1 and A7.	S1617
Medicine	Documentation 2017/18	Explore the possibility of a teaching session on the importance of documentation to Junior Doctors.	S1622
Medicine	Documentation 2017/18 (AMU)	Results to be discussed at the Acute Medical Unit (AMU) governance meeting, highlighting the areas where improvements are required.	S1628
Medicine	National Core Diabetes audit 2017	Improve HbA1c levels, by reducing the number of patients with levels between 58-86 by increasing follow up clinics for patients on insulin pumps.	S1658

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Medicine	Retrospective audit of Admissions to Stroke Unit via A&E	A re-audit to be undertaken which focusses on the improvements made in the previous audit.	S1675
Medicine	Audit of management of pulmonary embolism	A proforma to be developed for the assessment and management of pulmonary embolism, including pulmonary embolism severity index (PESI). Further discussions to be had amongst clinicians regarding the consideration of use of direct oral anticoagulant (DOAC) alone without need for Tinzaparin.	S1684
Medicine	Blood Glucose monitoring in diabetic inpatient	Create a blood monitoring (BM) chart which includes an action plan for completion when BM is >11 in type 1 diabetes mellitus patients. Consider the causes for the significant variation in BM levels during admission. Blood ketone machines to replace urine ketone machines to enable point of care testing for ketones on the wards.	S1688
Medicine	To improve first 24 hours acute care in Decompensated liver failure patients	To arrange an education session with junior doctors regarding the implementation of the cirrhosis care bundle. Undertake a quality improvement project with the aim of improving ascitic tap procedures performed within 24 hours of admission to AMU.	S1759
Medicine	Documentation Audit 2018 (Acute Medical Unit)	No actions required.	S1778
Neuro-rehabilitation	The National Service Framework Neurological Disability and Rehabilitation audit	A plan to be generated for therapeutic activities between formal therapy sessions. Continue with work already begun with equipment and real estate improvements. Review documentation of need for slow stream rehabilitation and nursing care following discharge. A similar audit to be undertaken with outpatient clinic and community patients subscribing to Rotherham Integrated Neurological Conditions Service (RINCS).	R1041
Obstetrics and Gynaecology (O&G)	Depth of Cervical loop biopsy and outcomes by individual colposcopists	Re-audit 2017-18 performance and monitor results by Quality Assurance process.	R1052
O&G	Compliance with legal completion of HSA1 form	Implement Surgical Termination of Pregnancy (STOP) and Evacuation of uterus preparation form checklist and Day Surgery Unit staff to check completion of forms before procedure. To raise awareness through training with Day Surgery team to ensure DSU return yellow forms and case notes to Pregnancy Advisory Service for submission.	R1054
O&G	Re-audit of Massive post-partum haemorrhage	To revise Datix review / audit proforma to include Drugs in Labour, whether Bimanual compression was applicable, whether all audit criteria documented at time of haemorrhage (consultant/ anaesthetist present).	R716
O&G	Ongoing audit of severe pre-eclampsia and eclampsia cases through the unit	Create poster and display outcomes of audit on notice board in Labour ward. Add definitions of hypertensions into mandatory training.	R833
O&G	Repeat antenatal membrane sweep audit	No action required.	R837
O&G	Case notes of babies unexpectedly below 10th centile (small for gestational age - SGA)	Approve business case for the Family Health ultrasound sonography for serial scans to delivery for women at risk of fetal growth restriction. Continue to review babies born below the 10th centile which were unexpected on a monthly basis. NHSI work stream -Multi-disciplinary task and finish group to explore the pathway of Small Gestational Age at Trust and an obstetrician to be part of the project.	R925

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
O&G	Urinary retention post vaginal surgery	Write a comprehensive guideline to standardise bladder care post gynaecology surgery.	S1589
O&G	Enhanced Recovery after Caesarean Section	Create poster for Wharncliffe to congratulate staff on achievement. Discuss with Pharmacy Lead in respect to provision of prepared packs on Wharncliffe ward of common "to Take Out" (TTOs) to reduce waiting time for discharge.	S1591
O&G	Care of women in non-obstetric setting	Develop a simple educational programme to cover early and late pregnancies to provide regular educational programmes in ED on the pregnant woman attending. Revise Guideline for care of pregnant women attending ED or admitted non obstetric area and Signpost the guideline on the intranet. Modify Modified Early Obstetric Warning System (MEOWS) flowchart and add postnatal patients to guideline. Laminate flowchart and display in hospital. Develop and display a poster of care of pregnant women outside of obstetric unit.	S1597
O&G	Outcomes after TVT	Ensure patients are referred to Multidisciplinary Team prior to invasive procedures for Urinary incontinence. Ensure all Urogynaecology surgeons are registered for access to British Society of Urogynaecology (BSUG) database and enter patients into database for better follow up information. All patients to be assessed pelvic floor tone at initial appointment and refer to Women's' Health physio if required.	S1690
O&G	Obstetric Documentation Audit 2018	Reprint of labour ward booklet, to have spaces for stickers on every page.	S1777

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
O&G	Re-audit of Induction of Labour	Check with network whether to include pre-labour rupture of membranes in the classification of induction of labour Introduce mechanical induction of labour to optimise patient flow and bed occupancy. Introduce patient leaflets. Continue using stickers to capture counselling for induction of labour in notes, and incorporate as mandatory in Meditech.	S1781
O&G	Review of surgical site infections in C Sections	Review local studies to seek evidence for increased dose of antibiotics for prolonged operation. Discuss at labour ward forum to review C section guideline re. increased duration of antibiotics. Make staff aware of protocol for reduced theatre traffic. Implement use of PICO ® Negative Pressure Wound Therapy dressing for BMI >45 agreed and add to guidance.	S1825
O&G, Safeguarding	Re-audit of Perinatal domestic Abuse Screening (Safeguarding)	Request template change on IT system SystmOne to reflect screening questions in booking and antenatal follow up templates. Request Meditech changes to reflect screening questions, to include free text to record reason if question not asked. To introduce seeing women on their own in Greenoaks at 12-week appointment for screening.	R1042
Oral and Maxillofacial Surgery (OMFS)	Re-audit of assessment and treatment of A&E patients: Are we keeping to the 4 hour rule?	Formal teaching session on what constitutes a good handovers as per Royal College of Surgeons (RCS) guidelines to be included as part of induction.	R1038
OMFS	Quality of histopathology request forms submitted by OMFS department	Ensure all clinicians are aware of the details required on a histopathology form.	R1063
OMFS	Assessment and treatment of A&E patients: are we keeping to the 4 hour rule?	Allocation of cupboard in A&E to permanently house OMFS equipment and use an itemised list of equipment to be re-stocked by on call Dental Core Trainee on Friday and Monday. Review and confirm that the clinical need to take precedence when prioritising on call task by educating how to triage effectively during on call. Investigate provision of on call IPad to allow Instantaneous review of Bassetlaw and DRI images.	R938
OMFS	Custom-made Medical Devices Prescription Compliance	Educate Orthodontic clinical staff of their responsibility to correctly complete Custom-made Medical Prescriptions.	R957
OMFS	Compliance with performing investigations for patients admitted with orofacial infection	Dental Core Trainees to be re-educated about importance of performing these investigations.	S1560
OMFS	Venous thromboembolism (VTE) risk assessment: quality of completion	To investigate what factors are contributing to a lack of compliance by monitoring completion of VTE assessment for every inpatient every day by checking VTE status at each ward round and document findings in clinical notes. Provide education on VTE and VTE assessment completion for Dental Core Trainees with a teaching session from a specialist nurse.	S1685
OMFS	Compliance with performing investigations for patients admitted with orofacial infections (re-audit)	Educate new Dental Core Trainees of which investigations need to be performed and why.	S1745

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
OMFS	Do all A&E patients receive a timely follow up in the OMFS departments at Rotherham & Mexborough Hospitals for hard tissue injuries - a re-audit	Improve appointment bookings at Mexborough Montagu Hospital by Dental Core Trainees confirming and recording Mexborough slots for the next week every Friday.	S1746
OMFS	VTE Risk Assessment: Quality of completion	New cohort of DCTs educated on VTE prophylaxis during induction.	S1782
Ophthalmology	Medical Retina local guidelines Implementation	No action required.	R1039
Ophthalmology	Astigmatic Keratotomy	No action required.	R1048
Ophthalmology	Retinopathy of Prematurity Audit	To consider introduction of local protocol for retinopathy of prematurity (ROP) and revise the referral form to clearly show date to ensure referral made one week before screening window overdue. To liaise with Special Care Baby Unit (SCBU) in investigation into cases of missed screening.	S1661
Ophthalmology	Cataract Pre-operative assessment audit	Liaise with opticians and nurse practitioners to obtain post-operative refraction data.	S1671
Ophthalmology	Intraocular pressure and gonioscopy changes after yttrium-aluminium-garnet laser (YAG) peripheral iridotomy	No action required.	S1694
Ophthalmology	Cataract surgery outcomes (TRFT 2018)	Nurse practitioners to auto refract 1st eye at appointment for 2nd eye surgery to measure differences.	S1698
Ophthalmology	Follow up against discharge guidelines	Review existing discharge guidance & ensure guidance available in each clinical room.	S1700
Ophthalmology	Emergency clinic re-audit	Morning clinics to be booked for same day referrals. Slots to be made available for patients with more than 2 follow ups. Guidelines for referral urgency of ophthalmic urgent care to be updated and distributed to doctors and nurses running casualty clinic, A&E and GPs to ensure appropriate referrals based on appropriate grading and follow up timescales.	S1701
Ophthalmology	Health risk from corneal Perforation due to peripheral ulcerative keratopathy in rheumatoid arthritis	Colleagues to be alert to condition and refer to Rheumatology as the condition could be considered as a predictor of impending serious medical problems.	S1703
Ophthalmology	Documentation Audit 2018/19	Remind & monitor colleagues on use stamps to ensure that correct details are documented per entry, and focus on legibility of documentation.	S1772
Ophthalmology	Out of hours patients follow up via HUB email	To ensure that confirmation of continuity of care is sent to the hub, clearly nominate the person responsible for checking the emails on daily basis and have cover in case of absence.	S1785
Orthopaedics	Duration of hospital stay after hip and knee arthroplasty surgery	None (re-audit).	R1072
Orthopaedics	Fluroscan Documentation	To develop local guidelines for radio graphic doses for wrist surgery.	R982

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Orthopaedics	Best practice for management of distal radius fractures	Implement virtual fracture clinic to give priority for distal radius fracture on [illegible] to ensure that surgical intervention planned for distal Radius fracture, this should be performed within 72 hours of injury for intra-articular fractures and within one week for extra-articular fractures.	S1794
Orthopaedics	Compliance with consent form 4	Increase awareness on consenting and capacity evaluation.	S1824
Pharmacy	Are PGDs compliant with NICE Medicines Practice Guidelines (MPG2) PGDs 2013 recommendations standards 1.5.2 and 1.5.7?	Leads for the Patient Group Directions (PGDs) to be sent a copy of the PGD policy and inform them of where this can be located on the intranet. To add a paragraph to the ratification letter to PGD leads as a reminder regarding obtaining staff signatures on the PGD and having a paper copy of the latest PGD accessible in clinical areas.	S1718
		A checklist to be produced and disseminated to all PGD leads on the process to follow after a PGD has been approved by the Rotherham Medicine Optimisation Group (RMOG).	
Radiology	Ultrasound DVT audit	To re-write the deep vein thrombosis (DVT) pathway with regards to imaging.	R1040
Radiology	Polytrauma CT audit	Meet with Emergency Department colleagues to discuss the results in relation to the concerning number of major trauma patients and delays in access times to CT. Present the results at TRFT meetings and arrange to present at the trauma network meeting.	R830
Safeguarding	Re-audit of compliance with the TRFT Health Records Policy	To recirculate the briefings across the Trust to remind all colleagues to record the name and contact details of the person/people accompanying the patient to a clinical consultation. Heads-of-service to be notified regarding the outcome of the audit so that they may decide what further action is necessary.	R962
Safeguarding	Quality of information and sections completed on the Multi Agency Risk Assessment Conference (MARAC) Research forms	To update MARAC guidance that is available to practitioners on IT system SystmOne. To email updated SOP guidance out to all 0-19 and midwifery practitioners who undertake completion of MARAC research. To complete training sessions with practitioners that undertake MARAC research forms.	R963
Safeguarding	Audit of Local Authority Designated Officer (LADO) meetings, looking at actions for safeguarding,	To inform the RMBC Local Authority Designated Officer (LADO) panel that TRFT do not need to be invited or attend LADO meetings, unless it directly involves a TRFT employee. Named Nurse to discuss with Deputy Chief nurse safeguarding Lead at next 1:1 session.	R964
Safeguarding	A comparative audit of Deprivation of Liberty Safeguards (DoLS) requests made by TRFT staff in Q2 of 2017 - 2018 and Q2 2018-2019	Promote a timely identification of patients requiring a DoLS, the team administrative support will continue to visit the wards 1 – 2 times a week to identify with the nurse in charge, in a timely manner and identify patients with extended admissions on a weekly basis. The team will continue to monitor the quality and number of DoLS for each ward area noting themes and trends by undertaking a re-audit.	R966
Therapy Services & Dietetics	Therapies and dietetics documentation audit (2017/18)	The results have been discussed and reviewed at team meetings and at the Therapy Services & Dietetics Clinical Effectiveness meeting. Areas where improvements are required in respect of documentation in paper notes and systm1 records, have been highlighted to staff and ongoing, regular reviews undertaken, where appropriate, within team meetings and supervision sessions.	S1588
Therapy Services & Dietetics	Is the process used for delivery of snacks and supplements as per dietetic recommendation effective?	Escalation and Involvement of senior nursing team and chief nurse to help support uptake of snacks being provided e.g. back to the floor days. Support catering team to update Catering Service Level Agreement (2015) and disseminate to all.	S1715

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Therapy Services & Dietetics	A review of the referrals received from Care homes for the elderly - to review if they are following the process advised by RNDS	Review the referral pathway and first line treatment plan and update the current care home pathway. Share results with the council to improve training.	S1716
Trust wide	Adherence to Trust Duty of Candour Policy	Governance leads in all areas to promote the Duty of Candour requirements and timescales and embed the use of the Duty of Candour Trust sticker in patient's records.	S1639
Urology	Intravesical Botox injection (re-audit)	To ensure that all staff involved in treatment of Over Active Bladder (OAB) patients follow the local protocol: Intra vesical Botulinum Toxin A injection is considered as third line treatment for Over Active Bladder patients; All female patients should be referred to Urogynaecological Multi-Disciplinary Team before offering Botox; All patients listed for Botox 100 or more; Units should be offered International Continence Society (ISC) training; the dosage of Botox recommended is as per NICE guidelines; Botox as a fifth line off label medication for Bladder Pain Syndrome should only considered after Multi-Disciplinary Team (MDT) discussion.	S1711

(Source: Audit Trust Database)


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Appendix 2: Readmissions within 28 days

Re admissions within 28 days of discharge from Hospital	1st April 2017 - 31st March 2018	1st April 2018 - 31st January 2019
Age 0- 15 years	8.33%	6.79%
Age 16 years and above	11.84%	10.85%

Data source: TRFT Data Warehouse SQL Server Reporting Services - Re admissions

The latest update available from NHS Digital is for the period 2011/12. Therefore, the internal TRFT data Warehouse is used for all reporting of re admissions for the performance reports for the Board, the Divisions, the clinical support units (CSU) and for the Service Line Monitoring (SLMs) reports.

Appendix 3: External Agency Visits, Inspections or Accreditations

The table opposite details the external agency visits undertaken during 2018/19.

Detail of Visits	Date of Visit
PLACE inspection (hospital site)	2 May 2018
PLACE inspection (Breathing Space)	4 May 2018
Getting it right first time visit to Orthopaedics	13 June 2018
Public Health England Antenatal and Newborn Screening Programme Quality Assurance visit	19 June 2018
CQC unannounced Inspection of UECC, Children's Ward and A1	17 July 2018
CQC Unannounced Inspection	25 to 27 September 2018
External Audit of Pharmacy Technical Services Unit	27 September 2018
NHS Improvement Use of Resources assessment	28 September 2018
Police Counter Terrorism team review of Category Level 3 (CL3) containment facility in Laboratory Medicine	4 October 2018
Jonathan Slater, the Permanent Secretary for Education re: use of apprentices	8 October 2018
CQC unannounced inspection Children's and Young People's services in the community and wards A1 & A5	16 to 18 October 2018
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	22 to 23 October 2018
CQC Well-led assessment	22 to 24 October 2018
Health Select Scrutiny Commission visit to Health Village, the Care Co-ordination Centre and Single Point of Access	13 November 2018
Getting it right first time visit to Dermatology	11 December 2018
National Children's & Young People Diabetes Quality Programme Peer Review visit	9 January 2019
Getting it right first time visit to Endocrinology	17 January 2019
United Kingdom Accreditation Service (UKAS) ISO 15189 accreditation 1st surveillance visit	30 to 31 January 2019 and
5 February 2019	19 February 2018
Getting it right first time visit to Ophthalmology	28 February 2019
Police / Environment Agency visit (EA) to Medical Physics department	12 March 2018
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	12 – 13 March 2018
GIRFT ENT	20 March 2018
NHSE deep dive on Cancer as part of the Cancer Alliance	28 March 2018

References

Care Quality Commission (2016) National Inpatient Survey

Department of Health (2011) GAfREC - Governance Arrangements for Research Ethics Committees: a harmonised edition

Health and Social Care Act (2008) Regulation 20: Duty of Candour available at http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

Leadership Alliance for the Care of Dying People (2014) One Chance to Get it Right. Publications Gateway Reference 01509

Midstaffspublicinquiry.com. (2015). Final report | Mid Staffordshire NHS Foundation Trust Public Inquiry. [online] Available at: http://www.midstaffspublicinquiry.com/report [Accessed 2 May 2018]

National Institute for Health and Care Excellence (2017). Quality Standard 86(Q586) – Falls in Older People

NHS Improvement. SAFER patient flow care bundle [online] Available at: https://improvement.nhs.uk/resources/rapid-improvement-guide-safer-patient-flow-bundle/ [Accessed 2 May 2018]

NHS England Long Term plan (NHS England, 2019)

(Source: Trust Database)

Acronyms

A&E	Accident & Emergency Department
AMD	Associate Medical Director
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CGC	Clinical Governance Committee
CHID	Clinical Health Informatics Development Group
CHKS	Comparative Health Knowledge System
CLABSIs	Central Line Associated Blood Stream Infections
CoC	Continuity of Carer
CSE	Child Sexual Exploitation
C-difficile	Clostridium Difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CYP	Children and Young People
Datix	Computer software used by health services for risk management and reporting incidents
DIPC	Director of Infection Prevention and Control
DNACPR	Do not attempt cardio-pulmonary resuscitation
DoLS	Deprivation of Liberty Safeguards
DR (AGFA)	Digital Radiology
DSPT	Data Security and Protection Toolkit
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Estimated Date of Discharge
EMR	Electronic Medical Record
ENT	Ear Nose and Throat
EPR	Electronic Patient Record
FCP	First Contact Physiotherapy
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GAfREC	Governance Arrangements for Research Ethics Committees
GAP	Growth Assessment Protocol
GP	General Practitioner
GU	Genitourinary
HbA1c	HbA1c is your average blood glucose (sugar) levels for the last two to three months
HCSW	Health Care Support Worker
HDU	High Dependency Unit
HGD	High Grade Dysplasia
NHS DIGITAL	Health and Social Care Information Centre
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
IDT	Integrated Discharge Team
IG	Information Governance
IT	Information Technology
IV	Intravenous
Lab Med	Laboratory Medicine
LAC	Looked After Children
LOS	Length of Stay
MARAC	Multi Agency Risk Assessment Conference
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act 2005
MCISS	Macmillan Cancer Information Support Base
MDT	Multi-Disciplinary Team
MDTM	Multi-Disciplinary Team Meeting
MEWS	Modified Early Warning System
MQEM	Macmillan Cancer Support Quality Environment Mark
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MVP	Maternity Voices Partnership
NELA	National Emergency Laparotomy Audit
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NRLS	National Reporting and Learning System
O&G	Obstetrics and Gynaecology
OMFS	Oral and Maxillofacial Surgery
PAR	Patient at Risk chart
PCPs	Personalised Care Plans
PDSA	Plan, Do, Study, Act
PDT	Practice Development Team
PIR	Post Infection Review
PLAC	Previously Looked After Children
PLACE	Patient-led Assessment of the Care Environment
PROMS	Patient Reported Outcome Measures
QAC	Quality Assurance Committee
RCA	Root Cause Analysis
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
RIS (AGFA)	Radiological Information System
RLSAB	Rotherham Local Safeguarding Adult Board
RLSCB	Rotherham Local Safeguarding Children Board
RMBC	Rotherham Metropolitan Borough Council
SAU	Surgical Assessment Unit
SCBU	Special Care Baby Unit
SGA	Small for Gestational Age
SHMI	Summary level Hospital Mortality Indicator
SI	Serious Incident
SLT	Speech and Language Therapy
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
STOP	Surgical Termination of Pregnancy
TRFT	The Rotherham NHS Foundation Trust
TTOs	To Take Out
YTD	Year To Date
VTE	Venous Thromboembolism
WNB	'Was Not Brought'

Glossary of Terms

AGFA
Agfa Healthcare.

CHANGE organisation
Is a human rights organisation led by Disabled People, working to build an inclusive society where people with learning disabilities are treated equally.

Clinical Coding
The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.

Comparative Health Knowledge System (CHKS)
A web based performance benchmarking system, utilised by many Trusts

Commissioning for Quality and Innovation (CQUIN)
A series of nationally and locally agreed improvement targets, linked to a proportion of Payment by Results funding as an incentive to achieve agreed outcomes.

Data Quality Index
A composite indicator reflecting data quality, provided by CHKS.

Datix
An Incident reporting system used by many NHS Trusts.

Exemplar Health Care
Exemplar is one of the UK's leading providers of specialist nursing care and neurorehabilitation for adults with complex needs.

FFFAP
Falls and Fragility Fracture Audit Programme, led by the Royal College of Physicians, gathering and analysing data on serious harms across the NHS.

HbA1c
HbA1c is your average blood glucose (sugar) levels for the last two to three months.

Healthcare Resource Groups (HRGs)
HRGs are standard groupings of clinically similar treatments which use common levels of healthcare resource.

HRGs help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

HRGs are currently used as a means of determining fair and equitable reimbursement for care services delivered by providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the service.

Presently, the Trust complies with HRG4 to code clinical activity.

Healthwatch
The independent consumer champion that gathers and represents the public's views on health and social care services in England.

Mencap
Mencap is a UK charity for people with a learning disability. Mencap also support their families and carers.

Monitor
Sector regulators for health services in England.

Mortality Rate
The rate at which patients die in a hospital. Data is collected nationally by HSCIC and enables Trusts to look at trends in Mortality Rates and make comparisons with other hospitals.

Mortality is generally measured in one of two ways: The HSMR measures the actual number of deaths occurring in a hospital compared to the number of deaths that might have been expected. The SHMI is a ratio of the actual number of patients who die against the number who would be expected to die on the basis of average England figures. The SHMI ratio includes those patients who die within 30 days of discharge from hospital.

Never Event
Defined by the DoH as a very serious, largely preventable, patient safety incident that should not occur if appropriate preventative measures have been put in place.

NHS Digital
Provider of data for the NHS; formerly known as the Health and social care information centre (NHS DIGITAL).

NHS Improvement
NHSI was launched on 1 April 2016. It was formed from the two previous regulators, Monitor and the Trust Development Authority (TDA).

OPCS-4
The OPCS Classification of Interventions and Procedures (OPCS-4) is a Fundamental Information Standard which is revised periodically. The classification is used by Health Care Providers and national and regional Organisations.
OPCS-4 is used to support operational and strategic planning, resource utilisation, performance management, reimbursement, research and epidemiology. It is used by NHS suppliers to build/update software to support NHS business functions and interoperability.

Patient-led assessments of the care environment (PLACE)
PLACE is a new way of assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. They look at how the environment supports patient privacy and dignity, the meeting of dietary needs, cleanliness and general building maintenance.

Results from the annual assessments are reported publicly to help drive improvements in the care environment; they show how the Trust is performing by comparison with other Trusts across England.
For more information visit www.england.nhs.uk/ourwork/qual-clin¬lead/place.

Ribotyping
Ribotyping is a molecular technique that takes advantage of unique DNA sequences to differentiate strains of bacteria.

Risk Assessment Framework
This document sets out Monitor's approach to making sure NHS Foundation trusts are well run and can continue to provide good quality services for patients in the future.

Safeguarding
A process used to identify adults and children at risk and provide protection against further harm.

Safety Thermometer
The expanded national patient safety improvement initiative, promoting 'Harm Free Care' and linked to National CQUINs.

The Secondary Uses Service (SUS)
The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Voyage
Voyage Care supports thousands of people with learning and physical disabilities, brain injuries, autism and other needs across England, Scotland and Wales.
They offer person centred care and support in a range of settings and have experience of supporting people to move from one type of service to another as their needs change or they become more independent.

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Accountability Report

Directors' Report

This report is presented in the name of the directors of the Board of Directors who occupied the following positions during the year:

Name	Position	In year changes
Martin Havenhand	Chairman	
Louise Barnett	Chief Executive	
Gabrielle Atmarow	Non-Executive Director	
Joe Barnes	Non-Executive Director and Senior Independent Director	
George Briggs	Chief Operating Officer	From 01 April 2018
Cheryl Clements	Director of Workforce	To 08 July 2018
Heather Craven	Non-Executive Director	
Mark Edgell	Non-Executive Director	
Paul Ferrie	Acting Director of Workforce	From 09 July 2018
Callum Gardner	Interim Medical Director	From 03 September 2018
Lynn Hagger	Non-Executive Director and Vice Chair	
David Hannah	Non-Executive Director	
Chris Holt	Deputy Chief Executive Director of Strategy & Transformation and Deputy Chief Executive	From 14 September 2018 From 01 April 2018 to 13 September 2018
Barry Mellor	Non-Executive Director	
Simon Sheppard	Director of Finance	
Conrad Wareham	Medical Director	To 02 September 2018
Angela Wood	Interim Chief Nurse Chief Nurse	From 01 October 2018 From 01 February 2019
Directors who served during the year, but who had left before year-end		
Chris Morley	Chief Nurse	To 30 September 2018

Directors' biographies can be found within the Governance Report beginning on page 169, together with details of Directors' attendance at Board and Board Committees.

Directors' Register of Interests

The Directors' Register of Interests is available to view on the Trust's website (http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Our_Board_of_Directors/) or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec, Company Secretary
General Management Department, Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

Under the NHS Act 2006, NHS Improvement has directed The Rotherham NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction.

The Directors are responsible for preparing the accounts on an accrual basis, which gives a true and fair view of the state of affairs of The Rotherham NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Directors are required to comply with the requirements of NHS Improvement's *NHS Foundation Trust Annual Reporting Manual 2018/19* and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed
- Disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy, and
- Prepare the financial statements on a going concern basis.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Directors are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors of The Rotherham NHS Foundation Trust confirm that as far as they are aware there is no relevant audit information of which the Trust's Auditor is unaware.

The Directors have taken all steps they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's Auditor is aware of that information.

The Directors consider that the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Cost Allocation and Charging Guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury. The Trust has participated in a national audit of the implementation of the national costing standards being run by NHS Improvement.

Political Donations

There are no political donations to disclose.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid, verified invoice, whichever is later. However, the Trust, in common with all sectors of the economy, has to primarily manage its cash flow according to the requirements of the organisation in order to ensure it has sufficient liquidity, prevent unforeseen bank charges and minimise the extent of interest payable on loan financing.

As can be seen in the table below during 2018/19 the Trust paid 71.75% (by number) of all of its bills within the 30-day target. This shows a marked improvement from the position in 2017/18 when the Trust paid only 13.78% (by number) of bills within the target.

	Number	Value £000's
NON-NHS		
Total Bills Paid in Year	53657	87542
Total Bills Paid Within Target	39530	52253
Percentage of Bills Paid in Target	73.67%	59.69%
NHS		
Total Bills Paid in Year	2222	11622
Total Bills Paid Within Target	563	967
Percentage of Bills Paid in Target	25.34%	8.32%
TOTAL		
Total Bills Paid in Year	55879	99164
Total Bills Paid Within Target	40093	53220
Percentage of Bills Paid in Target	71.75%	53.67%

In 2018/19 the Trust did not become liable to pay interest as a result of failing to pay invoices within agreed payment terms where obligated to do so.

Information on Fees and Charges

The Trust has nothing to disclose in relation to any individual service having full costs exceeding £1 million.

Income Disclosures required by Section 43(2A) of the NHS Act 2006 (as amended by the Health & Social Care Act 2012

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Rotherham NHS Foundation Trust meets this requirement.

As required by section 43(3A) of the NHS Act 2006, an NHS foundation trust must provide information on the impact that other income it has received has had on its provision of goods and services for the purposes of the health service in England.

The Rotherham NHS Foundation Trust has not received any income which was not for the purposes of the health service in England during 2018/19.

Disclosures relating to NHS Improvement's Well-led framework

During 2018/19, the Board of Directors commissioned an external Well-led review undertaken and completed in-year. This review identified some areas that needed to be focussed on.

The Trust also received an inspection from the Care Quality Commission (CQC) during 2018/19 and the CQC assessment of Well-led remained at 'requires improvement'.

The Trust developed an action plan to take forward the recommendations from both the external well-led review and CQC inspection. In addition, a review of the arrangements for risk management and quality governance was undertaken during the year with full implementation during 2019/20.

Patient Care

It has been a particularly busy year for the Trust with several service developments which positively impacted on patient care, such as the launch of the new Surgical Assessment Unit and the refurbishment of the Acute Medical Unit, Ambulatory Care Unit and Discharge Lounge.

The Trust managed to secure £3.4 million in external funding during the year, enabling investment in improvements such as the co-location and enhancement of assessment and ambulatory facilities. In addition, £2.1 million was invested in developing the Acute Surgical Unit. Funding was also awarded for improvements in the Trust's digital equipment and systems, including £750,000 for the implementation of electronic prescribing (ePMA).

The Trust has seen a continued and sustained improvement in the Hospital Standardised Mortality Ratio (HSMR) throughout the year and an improvement in the Standardised Hospital Mortality Index (SHMI). HSMR provides a rolling 12-month picture of mortality data for a time period ending 6 months previously at the time of publishing, or 12 months previously in the case of SHMI.

Throughout the next financial year, there will be continued focus on improving learning from deaths by ensuring that as many deaths as possible are retrospectively reviewed; by optimising the recognition of patients coming to the end of their life; and by ensuring that all such learning is triangulated with learning from adverse incidents and complaints. In addition, the Trust continues to run a monthly Mortality Group to review performance and learnings from deaths, which in turn reports into the Patient Safety Group and the Clinical Governance Committee, both of which are chaired by the Interim Medical Director.

Part of the Trust's new Safe & Sound Quality Framework will also see the introduction of an enhanced senior leadership structure under the Chief Nurse and Interim Medical Director, which will enhance Trust oversight and leadership across a number of quality domains, including patient experience, clinical effectiveness, and patient safety. This will include the introduction of two new Associate Medical Director posts: one for Patient Safety (which will include responsibility for leading on quality priorities such as sepsis and the deteriorating patient); and focusing on Clinical Effectiveness (which will include responsibility for leading on audit and mortality). Both of the Associate Medical Director roles will be overseen by the Interim Medical Director, who will personally lead on patient experience.

The Trust continues to focus on improving the timeliness and effectiveness of responses to deteriorating patients, including through the roll-out of electronic observations across the hospital and by ongoing focussed training and education. In addition, the Trust will be rolling out the new national observation scoring system, NEWS2, from April 2019, and is developing plans to launch a new and enhanced response team called the Acute Response Team (ART). The ART will function 24 hours a day, 7 days a week, and will replace the current Hospital at Night service, which only operates out of hours.

Good progress has been made in the identification and management of sepsis. Progress has included the introduction of the 'Sepsis 6' screening tool throughout the adult medical wards, as well as targeted training and education, including through mandatory training, posters in clinical areas, screen savers on computers, and about policies and procedures. Nevertheless, the Trust continues to report delays in the administration of antibiotics. As good sepsis outcomes are imperative, it is important that timely treatment is given, particularly as evidence would suggest that sepsis can worsen with delayed treatment. As a result, the Trust will continue to focus on the timely administration of antibiotics, along with other critical medications such as insulin and pain relief, and is committed to the roll out of electronic prescribing throughout the hospital site during 2019/20.

The Trust had an unannounced CQC inspection in July 2018, which focussed on non-invasive ventilation (NIV) and the paediatric Urgent & Emergency Care Centre (UECC) and which highlighted some key areas for improvement. The CQC then undertook an announced inspection in September 2018, following which the Trust was rated as 'Requires Improvement' overall, but 'Inadequate' for the Urgent and Emergency Service. Since both the unannounced and announced inspections, the Trust has been working closely with the CQC to provide them with assurance of the significant improvements made to date, particularly in the UECC, and enhanced, ongoing senior support has been provided by our Chief Nurse and Interim Medical Director. In addition, the Trust has proactively sought external support to help identify and drive

improvements, with the aim of becoming 'Good' by the time of the next CQC inspection.

Service Improvements

Health Informatics

During 2018/19 the Trust updated all computers on its wards to support very fast login to the Electronic Patient Record (EPR) system and deployed an electronic nursing observations IT system which automatically calculates NEWS and NEWS2[6] scores. NHS-WIFI was also implemented across all of the Trust's estate, allowing the public and colleagues secure access to high speed, NHS-branded Wi-Fi services.

During the year the Rotherham Health Record clinical portal went from strength to strength. A borough-wide publicity campaign was initiated and a microsite was launched (available at: http://rotherhamhealthrecord.org/), which gave members of the public the opportunity to opt-out of the system. In addition, Adult Social Service information became accessible within the Rotherham Health Record alongside GP records.

Estate Improvements

In September 2018 the Trust was successful in receiving £2.1M from NHS England to provide a 20 bed in-patient Acute Surgical Unit (ASU) on the Rotherham Hospital site. In order to create the ward space necessary for this work a series of smaller enabling schemes were developed that saw various areas refurbished to allow relevant departments to move in and free up the total space needed for the ASU.

Work began on the enabling schemes in late September 2018 and was completed by mid-November 2018 which then allowed full access to the space required.

The Acute Surgical Unit was completed on the 19 January 2019 and became operational on the 4 February 2019.

The estates work undertaken provided the following:

- New accommodation for the Speech and Language Therapy Team
- New accommodation for Phlebotomy Services
- Relocation of Administrative and Clerical teams
- Refurbishment of Ward B4
- Creation of a dedicated Medical Assessment Unit (MAU)
- Provision of a 20 bed Acute Surgical Unit complete with 10 assessment bays, ultrasound room and associated consulting and treatment rooms

Monitoring Improvements in the Quality of Healthcare

Improvements in the quality of care; progress made against local and national targets and the implementation of actions emanating from the CQC inspections in September and October 2018 are all monitored at a Trust-level by the Quality Assurance Committee (one of the Board Committees) and at the Clinical Governance Committee (operational level committee).

In addition, each of the clinical Divisions also monitors the quality of care it provides, achievement of its local and national targets and progress with its actions relating to the CQC inspections at their own Divisional meetings.

Board Committees seek evidence as to performance and compliance in order that they are able to provide assurance to the Board of Directors that quality objectives are being met. The Clinical Governance Committee is the highest level operational committee responsible for monitoring all aspects of the quality of the healthcare the Trust provides.

The Clinical Governance Committee, chaired by the Interim Medical Director and supported by the Chief Nurse, has a key role in overseeing the operational delivery of high quality healthcare through the work of a number of sub-groups including those relating to patient experience, patient safety and clinical effectiveness. The role and functions of these groups and their interface with the governance arrangements in the clinical Divisions has been the subject of an external review and the changes recommended by this review are being implemented.

CQUIN (Commissioning for Quality and Innovation)

As previously reported in the Performance Analysis section of this Annual Report, the Trust's performance against the four key health care targets during 2018/19 was mixed.

The Commissioning for Quality and Innovation (CQUIN) scheme includes locally agreed and nationally mandated goals for improving the quality of healthcare provided. The schemes agreed with NHS Rotherham Clinical Commissioning Group (Rotherham CCG) and the Trust's forecast year-end position against each scheme is detailed below. It should be noted that the final reconciled position will not be available until the end of May 2019 although provisional figures are provided opposite based on current data.

CQUIN Indicator Description	Forecast Year-end Position
NHS Staff health and wellbeing of NHS staff	Partial Achievement
Healthy food for NHS staff, visitors and patients	Achieved
Uptake of flu vaccinations for front line clinical staff	Achieved
Reducing the Impact of Serious Infections	Partial Achievement
Improving services for people with mental health needs who present to A&E	Achieved
Offering Electronic Advice and Guidance to General Practitioners	Achieved
Preventing ill health by risky behaviours - tobacco: Tobacco screening	Partial Achievement
Preventing ill health by risky behaviours - tobacco: Alcohol screening	Partial Achievement

[6]NEWS is a well validated track-and-trigger early warning score system used to identify and respond to patients at risk of deteriorating. NEWS 2 is an updated version of the system. Source: https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/news-frequently-asked-questions/#5-has-news2-been-mandated last accessed 21/3/19.


NHS
NHS

In addition, a number of local quality indicators were also agreed with Rotherham CCG and the Trust monitored progress against the delivery of a set of community service indicators. The indicators and the Trust's forecast year-end position against each scheme are detailed below:

Community Key Performance Indicator	Forecast Year-end Position
Community Services Benchmarking	Achieved
Personalised Care & Support Planning	Achieved
Community Services Key Performance Indicators aligned to admission avoidance and utilisation of Alternative Levels of Care	Achieved

Other quality indicators where the Trust sustained or improved performance were:

- MRSA and C.difficile rates
- Compliance against 18 week wait targets
- Best Practice Hip Fracture
- Dementia assessments

Service Improvements following staff or patient's surveys / comments and CQC reports

A number of service improvements have been undertaken as part of the Trust's Quality Priorities and following on from the Care Quality Commission inspection and recommendations and are described in the Quality Report section of this Annual Report.

New or significantly revised services

The Trust provided a full range of acute and community services during 2018/19.

During the year the organisation continued to build upon its transformation work programme aimed at reviewing clinical pathways across a number of areas including both acute and community services. A significant improvement in management of the District Nursing workload has been achieved through implementing a revised scheduling process for management of urgent and routine patients. This has resulted in better utilisation of staff capacity and a better patient experience.

The Trust continues to progress the locality based model of delivery for community services which brings together a range of disciplines caring for a patient in a multi-disciplinary approach to ensure the patient's overall clinical needs are understood and managed efficiently and effectively. The aim is to manage patients at home as much as possible and avoid expensive hospital admissions.

During 2018/19 the Trust has continued to reconfigure its wards and bed base. This programme of work is specifically aimed at co-locating specialty based wards to ultimately improve patient flow throughout the hospital.

On 01 February 2019 the Trust ceased to provide the Rotherham Wheelchair and Equipment Services (REWS) with this contract being awarded to a new provider following a rigorous tender exercise completed by NHS Rotherham Clinical Commissioning Group.

Patient/Carer Information

The Trust's Communications Team works closely with both clinical and non-clinical teams to update information for patients and visitors and every effort is made to ensure that the information on the Trust's website is in plain English, is concise and well presented to make the access to information as easy as possible.

As part of wider Informatics and Communications strategies, plans are in place to continue to make further improvements to the Trust's website to improve the information available and that will be a focus during the next year.

The Patient Information Group is responsible for the review of information developed by colleagues for patients across all areas of the Trust. During 2019/20 a new role of Engagement and Equality Officer is planned who will provide leadership for this group.

A significant amount of patient health information is also produced through third party organisations and where appropriate the Trust is seeking to utilise these resources to ensure the accuracy of information and minimise the reproduction and review costs associated with the development of in-house patient health information.

Information on Complaints Handling

The Trust recognises the importance of managing any concerns or complaints raised by patients or families on a patient's behalf, in a timely, effective manner.

During the year there has been focused work on encouraging more face to face meetings between patients with concerns and staff, this has resulted in 25% of complaints closed during 2018/19 being addressed through the Local Resolution process.

In addition, for those patients who would rather receive a written response, work has been undertaken to ensure that they receive that response within 30 working days. This work has resulted in the Trust improving its performance such that in June 2018, 100% of complaints were answered within the agreed timescale. The overall performance for the year was 90.45%. The Trust will continue to build on the progress made in the timeliness of responses to complaints.

Partnerships and Alliances

The Trust continues to work in well-established partnerships with Doncaster & Bassetlaw Teaching Hospital NHS Foundation Trust for the delivery of Ear, Nose & Throat and Oral Maxillofacial services. Management of these services across the sites is embedded and has been in place for a significant number of years. In addition to these services, the organisation works collaboratively with Doncaster to provide an out-of-hours gastrointestinal bleed rota.

The Trust continues to engage with other provider colleagues both within the South Yorkshire and Bassetlaw footprint and slightly further afield for example with Chesterfield and Mid Yorkshire provider organisations.

The Trust is a proactive member of committees and clinical networks for the Acute Federation, the Rotherham Place Plan and the wider South Yorkshire and Bassetlaw Integrated Care System.

Collaborative working with care homes continued during the year to provide early supported discharge for those patients who are medically fit but require a continued level of nursing intervention.

Through a range of transformational developments (including the community integrated locality model which supports more effective and efficient hospital discharge and effective usage of intermediate care capacity) the organisation has continued to work very closely with Rotherham Metropolitan Borough Council and other health and voluntary sector organisations to support delivery of its overall vision.

Development of services involving local agencies

The Trust has continued to actively engage with other local services across the health economy to further develop and/or enhance service delivery. In 2018/19 work continued with Social Care colleagues at Rotherham Metropolitan Borough Council (RMBC) on a digital initiative to facilitate multi-system, and streamline multi-disciplinary, working to support patients' clinical and social needs.

Active engagement with Public Health colleagues both at RMBC and at NHS England in supporting health awareness messaging has continued in year, as has work with the voluntary sector to provide support where appropriate.

The Trust continued to work extremely closely with RMBC and other agencies to address any safeguarding concerns identified within maternity and children's services. This resulted in significant improvements to systems, processes and communications across both organisations to support effective and timely management of concerns. This joint approach further facilitates a shared knowledge and understanding of issues relevant to both organisations allowing sharing of learning to support continued development.

The Trust also worked in partnership with Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) on the development and enhancement of joint working relationships for adults, older adults' mental health services and child and adolescent mental health services (CAMHS). The two Trusts have a Memorandum of Understanding regarding standard setting and shared responsibility for improving the mental health of patients.

A number of significant improvements were implemented via this joint working including: support and implementation of a CAMHS Interface Liaison Nurse; development of shared pathways of care for children; improved communication; and support for adults and older adults through the location of the mental health liaison team within the Emergency Department and the ongoing assessment of patients should they be admitted to an inpatient bed.

As part of the Rotherham Place-based Plan the Trust worked with RDaSH to provide an integrated point of contact for physical and mental health referrals via its Care Coordination Centre, providing a 24/7, 365 days a year dedicated referral line for patients experiencing mental ill-health and living with learning disabilities.

The service provides a better patient experience as those in need and their health professionals are able to contact one location for physical and mental health needs to be considered holistically. It is also more efficient since it reduces the number of contact points being staffed across the borough.

Within Rotherham work with partner agencies including health, social care, mental health, primary care and private/charitable organisations continued in-year. This provided excellent opportunities for delivering a full and rounded care package for patients with agreed referral pathways understood by all organisations. This has proved successful in formulating children's services, facilitated through multi-agency reviews, to 'make every child count'. This focuses on developing agreed, individualised care packages for the child and family with clear sign-posting to other agencies in place. This multi-agency approach allows early indications of safeguarding concerns to be identified and further enhances shared knowledge and shared learning across organisations.

The development of the locality based model continued during 2018/19 enabling direct links to general practice teams. Regular multi-disciplinary case reviews of adult patients allowed health, social and emotional needs to be identified and an individualised package of care to be established to support the patient.

During 2018/19 the Trust worked more closely with Connect Healthcare, a Federation of General Practitioners in Rotherham which came together to identify how they could work more collaboratively to meet the needs of the local population. A model of 'Physio 1st' was introduced during the year with senior physiotherapists in a designated number of GP practices being the first point of contact for patients with musculoskeletal conditions. The aim of this service was to manage patients in the community, prevent onward referral to outpatient services and to free up GP appointments. Whilst this continues as a pilot, early indications suggest the scheme is delivering benefits.

These multi-disciplinary, multi-agency approaches have brought significant benefits for patients and allow valuable exchange of knowledge within and across organisations. Ultimately such approaches support the shaping of streamlined services which are patient focused, with the aim of improving clinical outcomes and providing a better patient experience.

Consultation with local groups and organisations

The Rotherham NHS Foundation Trust views consultation as important. During 2018/19, representatives from the South Yorkshire and Bassetlaw Integrated Care System (ICS), held consultation sessions for Trust colleagues and members of the public. This was an opportunity for people to find out more information about the Hyper Acute Stroke consultation and how they could share their views.

In September 2018, the Quality Priorities showcase for colleagues, patients, public and stakeholders took place. This allowed the Quality Priorities for the Trust to be shared with those present to make suggestions for how the improvements could be made.

The Trust has strong links with the local authority, and representatives from the Trust often attend meetings of the local Health Select Commission in order to provide an overview on arising health care matters.

Public and Patient Involvement Activities

Patient and public involvement has become an integral part of health care with its emphasis on including and empowering individuals and communities in the shaping of health and social care services. The importance of engaging patients and the public at all levels of health

systems is widely recognised and organisations have acknowledged the value of engaging them. The potential benefits of doing this include the establishment of policies that include their ideas and address their concerns, the improved implementation of policies, improved health services, and better health.

The Trust has ensured that patients and members of the public were able to take part in activities across its services during 2018/19. These included:

- **Child Development Service Review** - The Trust's work with local Parent Carer Forum has been highlighted as an example of good practice, specifically how this was co-produced with parents. Parents were involved in the working group right from the start and were widely consulted every step of the way on 'what good looks like'. Their views will now be reflected in the updated service specification for the Child Development Service
- **World Osteoporosis Day** - The Bone Health, Falls and Fracture Liaison Service celebrated World Osteoporosis Day in the main entrance of the Hospital on 19 October 2018 in conjunction with the National Osteoporosis Society, with displays and information leaflets for staff and patients
- **Perinatal forum** - A new perinatal 'get together' has been established as a forum for people with experiences from Light, an organisation which provides pre- and post-natal support. The launch event took place on 24 October 2018 and was well attended
- **Ophthalmology** - The Ophthalmology Service runs bi-annual open days which alternate between cataract and age related macular degeneration (AMD). More than 40 people attended the year's event in spring 2018 (with a further 30 participating via written responses) where past and present patients were invited to discuss the care they receive with nurses, consultants, support colleagues, volunteers and patient representatives
- **The Rotherham Maternity Voices Partnership** – A forum to provide a voice for service users to give their opinions and be involved in decisions related to service development, patient information and patient education. This service has recently been commissioned by the local CCG. It replaces the previous provider, 'Forging Families'
- **Research** - The Trust's research team held a series of events throughout the year to promote the research that takes place within the Trust and how people can get involved. One of these events was for Clinical Trials Day during May 2018

The Rotherham NHS Foundation Trust has ensured that patients and members of the public were able to take part in activities across the Trust during 2018/19.

2018 was a year of celebration for not only the NHS in its 70th year, but it was also the 40th anniversary of the opening of Rotherham Hospital. To celebrate these milestones, a series of events took place throughout the year which involved patients, members of the public and colleagues across the Trust. This included tea parties, presentations and a showcase event in the main entrance of the hospital where people could find out more about our services and how they have changed over the last 40 and 70 years.

A showcase event was held in September 2018 for members of the public to share their view on the development of the Trust's Quality Improvement Priorities for 2019/20. There was an opportunity to speak to those involved in developing the priorities as well as being able to vote for the final nine Trust priorities.

The annual Self-Care Week took place in November. This saw teams from across the Trust and partner organisations including Be Cancer Safe, the Rotherham Fibromyalgia group and Shared Lives promoting their services and offering advice and support to members of the public.

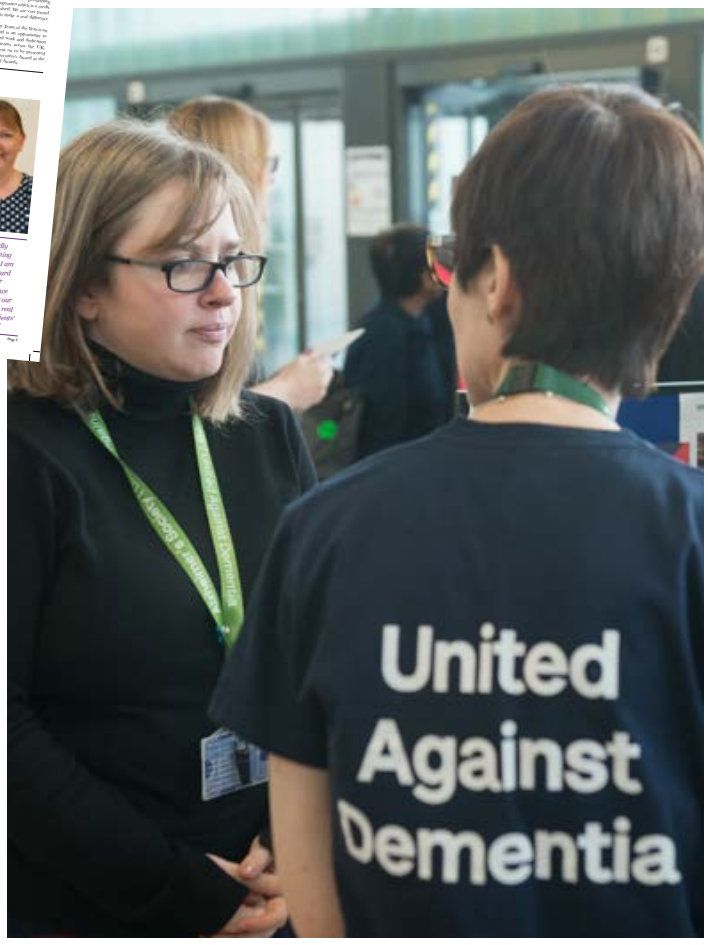
As part of the Trust's annual Proud Awards, where colleagues from across the Trust are recognised for their hard work and achievements, members of the public were encouraged to submit entries for their healthcare heroes. In the 'public recognition' category, supported by the Rotherham Advertiser, over 150 nominations were received.

Throughout the year, 260 promotions were held in the Trust's Community Corner and Health Information areas within the main entrance to the hospital. These events took place with support from colleagues within the Trust, from partner organisations and volunteers to highlight heath campaigns, lifestyle changes and fundraising. Events during the year included: Breast feeding awareness month; Learning disabilities week; Safeguarding Awareness Week and Mental Health Awareness Day.

In January 2019, the Trust joined forces with social movement Camerados to install a temporary public living room, in the form of a tepee in the main entrance of the hospital for three months. This served as a place where patients, visitors and colleagues could go to relax, chat and look out for each other during what can be stressful times.

In February 2019, the Trust launched a new quarterly publication 'Your Health - Rotherham Hospital and Community News'. This new publication, which is available online, within the Trust and included within the Rotherham Advertiser, provides members of the public with the latest news and updates from across the organisation along with health advice and details of events and activities they can get involved in.

The Trust has strong links with the local authority, and representatives from the Trust are often invited to attend meetings of the local Health Select Commission in order to provide an overview on arising health care matters.



Remuneration Report

Annual Statement on Remuneration from the Chair of the Remuneration Committee (not subject to audit)

I am pleased to present the Remuneration Report for the financial year 2018/19 on behalf of the Board of Directors' Remuneration Committee with regard to executive directors, and the Council of Governors' Nomination Committee with regard to Non-Executive directors.

In accordance with the requirements of the HM Treasury Financial Reporting Manual (FReM) and NHS Improvement, we have divided this report into the following parts:

- The Directors' Remuneration Policy sets out the Trust's senior managers' remuneration policy; and
- The Annual Report on Remuneration which includes more detailed information and governance details.

Major decisions taken on senior managers' remuneration, 2018/19

In detailing below, the definition for 'senior managers' as contained in the FReM has been applied and refers to executive and Non-Executive directors only, i.e. those who influence the decisions of the Trust as a whole, rather than the decisions of individual directorates or sections within the Trust.

Colleagues subject to Agenda for Change, 2018/19

With regard to colleagues on agenda for change, the NHS Staff Council formally ratified a three year pay deal and the changes to the NHS Terms and Conditions of Service handbook in June 2018. The new structure increased starting salaries, reduced the number of pay points, and for most staff, shortened the amount of time taken to reach the top of their payment band.

From 1 April 2018, Agenda for Change pay (increment) points began to be removed from pay bands, removing the bottom overlap point, and increasing top pay points in bands 2 – 8c by 3%.

From 1 April 2019, further restructuring of the pay bands took place; two further points removed from the bottom of band 3, one point removed from the bottom of band 4, two points removed from bottom of band 5, three points removed from the bottom of bands 6 and 7, and one point removed from the bottom of bands 8a – 9.

The top pay point in bands 2 – 8c was increased by 1.7%, with the top pay points in bands 8d and 9 being increased by the monetary value of the increase to band 8c.

Those at the top point of their pay bands on 31 March 2019 received a one-off non-consolidated cash lump sum in their April 2019 pay, amounting to 1.1% of the value of the top payment point in their pay band for colleagues on bands 2 – 8c, and the same monetary value as that given to band 8c, for colleagues on bands 8d and 9.

Further restructuring of the pay bands will take place from 1 April 2020.

During 2018/19 the Remuneration Committee and the Council of Governors continued to use annual benchmarked data, including that provided by NHS Providers, as the pay and reward framework upon which to base Executive and Non-Executive salary amounts.

In determining the salaries of Executive Directors for 2018/19, the Remuneration Committee did not approve any pay increases during 2018/19 financial year. However, taking into account national guidance and benchmarking information, salaries were reviewed retrospectively and some adjustments made; these will be reflected in the 2019/20 financial statements.

The remuneration for Non-Executive directors is determined by the Council of Governors, who did not recommend a pay award to the Non-Executive directors for 2018/19.

The Rotherham NHS Foundation Trust has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior managers and we will continue to do this going forward.

Signed:

Barry Mellor
Chair, Remuneration Committee

Senior Managers Remuneration Policy

This section describes the policy relating to the components of the remuneration packages for executive and Non-Executive directors (senior managers).

The aims of the pay and reward framework currently in place, are to:

- Facilitate the recruitment and retention of high quality senior staff;
- Ensure that remuneration reflects the extent of the role and responsibilities of individual posts and their contribution to the Trust;
- Ensure that the remuneration is justifiable and provides good value for money; and
- Provide a transparent framework for determining senior level remuneration.

In setting and reviewing pay, it is vital to recruit and retain talent and to operate the pay system fairly; however, it is also necessary to have a robust process for reviewing remuneration and to be able to demonstrate sensible use of public money.

Element	Policy
Base pay	Base pay is determined by using annual benchmarked data in order to attract and reward the right calibre of leaders to deliver the Trust's short, medium and long term objectives.
Pension	Executive Directors are able to join the standard NHS pension scheme that is available to all staff members.
Bonuses	Bonuses were not given to staff, Executive and Non-Executive Directors.
On call payment	In relation to Executive pay, no Board members receive on call payment
Benefits	The Trust operates a number of salary sacrifice schemes including child care vouchers and a car lease scheme. These are open to all members of staff. The individual foregoes an element of their basic pay in return for a defined benefit.
Travel expenses	Appropriate travel expenses are paid for business miles.
Declaration of gifts	As with all employees Executive and Non-Executive Directors must declare any gifts or hospitality according to Trust policy with a value in excess of £25.

With the exception of the Chief Executive, the Executive Directors and dental colleagues, all other non-medical substantive employees of the Trust, are remunerated in accordance with the national NHS pay structure, Agenda for Change. The majority of the Trust's substantive medical colleagues are remunerated in accordance with national terms and conditions of service for doctors and dentists.

From 1 January 2018, the Treasury increased the threshold for senior pay controls in the NHS to £150,000 and above, against which, approval for payment is required from the Chief Secretary of the Treasury. The Cabinet Office approvals process does not apply to foundation trusts. However, the figure is considered to be a suitable benchmark for trusts to disclose why they consider the remuneration is reasonable in situations where it is paid.

The figure of £150,000 was exceeded in the case of three executive directors during the financial year. These executive directors occupy statutory positions and their remuneration has been benchmarked with others respectively in the same posts. The Trust's remuneration policy is transparent and no performance related elements make up the total amount of remuneration.

Service Contracts Obligations

The contracts of employment of substantive Executive Directors are standardised and contain a notice period of six months. All such contracts are open-ended but are subject to earlier termination for cause or if notice is given under the contract.

Policy on Payments for Loss of Office

There is no entitlement to any additional remuneration in the event of early termination for any of the Executive Directors. During 2018/19 no Executive Director received additional remuneration for loss of office.

Statement of Consideration of Employment Conditions Elsewhere in the Trust

Except for 'senior managers' (as per the definition above) Trust colleagues are subject to national Agenda for Change, or national Medical and Dental Terms and Conditions.

When setting the remuneration policy for senior managers, the pay and conditions of these employee groups was taken into consideration, and the need for a transparent policy decided.

The Trust did not consult with employees when preparing the senior managers' remuneration policy, however annual benchmarked data, including that provided by NHS Providers, was used to determine the appropriate remuneration for the Executive and Non-Executive Directors during the year.

Executive salaries are in line with national executive remuneration benchmarking, and comprise a transparent process. By using benchmarking guidelines, the Trust ensures that salaries are sufficient to attract and retain high calibre candidates, and are appropriate for the benchmarked role.

No performance related bonuses or long term performance related bonuses have been paid.

No additional fees or other items that are considered to be remuneration in nature are paid.

Annual Report on Remuneration

Information not subject to audit

Service Contracts

All Executive Directors who served during the year did so on substantive contracts of employment with no end dates which include a notice period of six months.

With the exceptions listed below, *all of the Executive Directors served for the entirety of the financial year 2018/19 (1 April 2018 to 31 March 2019).*

Chris Morley took up the role of Chief Nurse from 02 October 2017 until 30 September 2018.

Cheryl Clements, employed by the Trust since 18 April 2016, left the Trust on 31 October 2018.

George Briggs took up the role of Chief Operating Officer on 01 April 2018.

Angela Wood took up the substantive role of Chief Nurse on 01 February 2019 (Interim role from 01 October 2018).

Dr Callum Gardner took up the interim role of Medical Director on 03 September 2018.

Paul Ferrie became Acting Director of Workforce on 09 July 2018.

Executive Directors who were in post prior to 01 April 2018:

Louise Barnett, employed substantively by the Trust since 01 April 2014.

Simon Sheppard, employed by the Trust since 03 November 2014.

Chris Holt, employed by the Trust since 06 October 2014.

Conrad Wareham, employed by the Trust since 15 July 2015

None of the Trust's Executive Directors were released by the organisation to serve as a Non-Executive Director elsewhere or in any other capacity.

Non-Executive Directors are generally appointed on terms of three years and for up to two terms, but they can be appointed for up to one year further on an exceptional basis, as follows:

Gabby Atmarow:
01.04.11- 31.03.13
01.04.13 – 31.3.16
01.04.16 – 31.03.17
01.04.17 – 31.03.18
01.04.18 – 31.03.19

Mark Edgell:
01.06.12 - 31.05.15
01.06.15 – 31.05.19

Martin Havenhand (Chairman):
01.02.14 -31.01.17
01.02.17 – 31.01.20

Heather Craven:
17.02.17 – 16.02.20

Dr David Hannah:
11.01.18 - 10.01.20

Barry Mellor:
19.09.13 – 18.09.15
19.09.15 – 18.09.19

Joe Barnes:
26.09.13 – 25.09.16
26.09.16 – 25.09.19

Lynn Hagger (Vice Chair):
01.10.13 – 30.09.16
01.10.16 – 30.09.19

Each of the NEDs and Chairman are able to resign by giving notice.

Remuneration Committee

This committee is chaired by a Non-Executive Director, Barry Mellor, and its responsibilities are set out in its Terms of Reference, which were updated during the year.

Following this Terms of Reference revision, the Remuneration Committee continues to have delegated responsibility for determining the terms of remuneration for the Chief Executive and the Executive directors and also recommends and takes into account the structure and level of remuneration across the organisation as appropriate. Each member of the committee is considered to be independent and none has a personal financial interest in any of the Committee's decisions.

Other Trust employees attend the meeting as requested by the Chair where appropriate, including the Chief Executive, but none were party to decisions made by the Committee.

No services or advice was received by the Committee from third parties that may have materially assisted with their consideration of any matter.

The committee formally met twice during the financial year; membership and attendance details are shown in the table below.

Meeting date	Barry Mellor (Chair)	Heather Craven	Gabrielle Atmarow	Joe Barnes
14 May 2018	√	√	√	X
1 Jan 2019	√	X	√	√
Attendance	2/2	1/2	2/2	1/2

Membership of the Remuneration Committee was updated on 01 April 2018. Barry Mellor continued to Chair the Committee, Joe Barnes replaced Lynn Hagger as Vice-Chair of the Committee, Gabrielle Atmarow and Heather Craven continued as members.

Not subject to audit
Disclosures required by the Health & Social Care Act

Details relating to the expenses of the Executive, Non-Executive Directors and Governors are set out in the table below:

	Number in office		Number receiving expenses	
	2018/19	2017/18	2018/19	2017/18
Governors	26	28	2	4
Directors (including the Chair and Non-Executives)	18	17	9	7

Expenses shown in £00s	2018/19	2017/18
	£00	£00
Aggregate sum of expenses paid to Governors	1	6
Aggregate sum of expenses paid to Directors	106	73
Total	108	79

Information subject to audit

The Single Figure Total Table (1) appearing below, provides details of each of the components of the remuneration package for Executive Directors, who are subject to the senior managers' remuneration policy.

A separate table (2) provides details for Non-Executive Directors, whose remuneration is set by the Council of Governors.

Set out separately are details of the pension entitlements received by the Executive Directors.

Single Total Figure Table (1)

Salaries and Allowances

The following information is required by Paragraph 4 - 16 inclusive of Part 3 of Schedule 8 to the Regulations, or where required by the NHS FT Code of Governnance. These disclosures outline the remuneration figures for Senior Managers made up of a single remuneration figure for each senior manager who served during the year in tabular form as shown below. This Single Total Figure table reports salary and benefits related to the period in office. Pension Benefits are affected by pension inflation in year and salary increases in year. See Table B Pensions, for further details.

Single Total Figure Table	Period 01/04/18 to 31/03/19						Period 01/04/17 to 31/03/18					
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)
Mrs L Barnett, Chief Executive	175 - 180	0	0	0	37.5 - 40.0	215 - 220	175 - 180	0	0	0	45.0 - 47.5	225 - 230
Mr C. Morley, Chief Nurse (in office from 01/04/18 to 30/09/19)	60 - 65	1	0	0	260.0 - 262.5	320 - 325	60 - 65	0**	0	0	160.0 - 162.5	220 - 225
Dr. C Wareham, Medical Director (in office from 01/04/18 to 02/09/18)	70 - 75	0	0	0	227.5 - 230.0	300 - 305	170 - 175	0	0	0	35.0 - 37.5	205 - 210
Mr S. Sheppard, Director of Finance	120 - 125	0	0	0	7.5 - 10.0	125 - 130	120 - 125	0**	0	0	27.5 - 30.0	145 - 150
Mrs C Clements, Director of Workforce (in office from 01/04/18 to 08/07/18)	30 - 35	0	0	0	2.5 - 5.0	35 - 40	120 - 125	0	0	0	25.0 - 27.5	145 - 150
Mr C Holt, Deputy Chief Executive*	135 - 140	0	0	0	27.5 - 30.0	165 - 170	135 - 140	0	0	0	37.5 - 40.0	175 - 180
Mr P Ferrie, Acting Director of Workforce (in office from 09/07/18 to 31/03/19)	75 - 80	0	0	0	72.5 - 75.0	150 - 155						
Dr C. Gardner, Interim Medical Director (in office from 03/09/18 to 31/03/19)	100 - 105	0	0	0	62.5 - 65.0	165 - 170						
Mrs A Wood, Chief Nurse (in office from 01/10/18 to 31/3/19)	60 - 65	0	0	0	97.5 - 100.0	155 - 160						
Mr G. Briggs, Chief Operating Officer (in office from 01/04/18 to 31/03/19)	125 - 130	0	0	0	285.0 - 287.5	410 - 415						

* Mr C Holt's job title was updated from Director of Strategy and Transformation to Deputy Chief Executive in year on 14 September 2018.
** Restated to only include taxable benefits. Non-taxable travel costs were included in last year's report.

Paragraph 4 - 16 inclusive of Part 3 of Schedule 8 to the Regulations requires the disclosure of the remuneration figures detailed above and includes a single remuneration for each senior manager who served during the year in tabular form as shown above.

Mr Chris Holt took up the post of Deputy Chief Executive on 14 September 2018

Mr George Briggs took up the role of Chief Operating Officer on 01 April 2018

Mrs Angela Wood took up the substantive role of Chief Nurse on 01 February 2019 (Interim role from 01 October 2018)

Dr Callum Gardner took up the interim role of Medical Director on 03 September 2018

Mr Paul Ferrie became Acting Director of Workforce on 09 July 2018.

Where the calculation of the increase in pension benefits results in a negative figure, this is entered as Nil in the table above. Only increases to pension benefit are shown. This is as per *NHS Improvement's Foundation Trust Annual Reporting Manual.*

Single Figure Total Table (2)

The remuneration for Non-Executive Directors including the Chairman has been determined by the Council of Governors and is set at a level designed to recognise the significant responsibilities of Non-Executive Directors in foundation trusts, and to attract individuals with the necessary experience, expertise and ability to make an important contribution to the Trust's affairs.

Single Total Figure Table	Period 01/04/18 to 31/03/19						Period 01/04/17 to 31/03/18					
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)
Mr M Havenhand, Chairman	50 - 55	0	0	0	0	50 - 55	50 - 55	0	0	0	0	50 - 55
Mrs G Atmarow, Non-Executive Director (to 31/03/19)	15 - 20	0	0	0	0	15 - 20	15 - 20	0**	0	0	0	15 - 20
Mr M Edgell, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr J Barnes, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mrs L Hagger, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0**	0	0	0	15 - 20
Mr B Mellor, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mrs H Craven, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0**	0	0	0	15 - 20
Dr D Hannah, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	0 - 5	0	0	0	0	0 - 5

** Restated to only include taxable benefits. Non-taxable travel costs were included in last year's report.

Paragraph 4 - 16 inclusive of Part 3 of Schedule 8 to the Regulations requires the disclosure of the remuneration figures detailed above and includes a single remuneration for each senior manager who served during the year in tabular form as shown above.

The Non-Executive Director remuneration framework, agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2018/19 has been consistent with this framework. No additional payments are made for any additional duties carried out.

The Non-Executive Directors took no pay rise during 2018/19.

Non-Executive Directors, including the Trust Chairman, are subject to fixed term appointments.

Pension Entitlements of Executive Directors

Details of pension entitlements of Executive Directors are shown below. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors. This table outlines the real increase during the reporting year of pension benefit, related lump sum and cash equivalent transfer values (CETV) at pension age and the value of accrued pension, lump sum and CETV at the end of the year.

Name and title	Real increase during the reporting year in pension at pension age (bands of £2,500) £000	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at 31 March 2019* (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Real increase in Cash Equivalent Transfer Value (for period in post) £000	Employer's contribution to stakeholder pension £000
Mrs L Barnett, Chief Executive	2.5 - 5.0	0.0 - 2.5	40.0 - 45.0	80.0 - 85.0	565	699	117	NA
Mr C. Morley, Chief Nurse (in office from 01/04/18 to 30/09/19)	5.0 - 7.5	12.5 - 15.0	50.0 - 55.0	150.0 - 155.0	699	1,032	156	NA
Dr. C Wareham, Medical Director (in office from 01/04/18 to 02/09/18)	0.0 - 2.5	7.5 - 10.0	40.0 - 45.0	80.0 - 85.0	688	826	50	NA
Mr S. Sheppard, Director of Finance	0.0 - 2.5	0.0 - 2.5	40.0 - 45.0	90.0 - 95.0	564	678	96	NA
Mrs C Clements, Director of Workforce (in office from 01/04/18 to 08/07/18)	0.0 - 2.5	0.0 - 2.5	35.0 - 40.0	115.0 - 120.0	826	939	24	NA
Mr C Holt, Deputy Chief Executive	0.0 - 2.5	0.0 - 2.5	15.0 - 20.0	0.0 - 5.0	153	214	56	NA
Mr P Ferrie, Acting Director of Workforce (in office from 09/07/18 to 31/03/19)	2.5 - 5.0	0.0 - 2.5	10.0 - 15.0	0.0 - 5.0	119	194	52	NA
Dr C. Gardner, Interim Medical Director (in office from 03/09/18 to 31/03/19)	0.0 - 2.5	0.0 - 2.5	10.0 - 15.0	0.0 - 5.0	66	119	29	NA
Mrs A Wood, Chief Nurse (in office from 01/10/18 to 31/3/19)	0.0 - 2.5	2.5 - 5.0	15.0 - 20.0	30.0 - 35.0	180	294	54	NA
Mr G. Briggs, Chief Operating Officer (in office from 01/04/18 to 31/03/19)	12.5 - 15.0	37.5 - 40.0	40.0 - 45.0	130.0 - 135.0	629	1,014	366	NA

* The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary for State, in England and Wales. As a consequence, it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Further details can be found in the Annual Accounts at note 1.2.

Cash Equivalent Transfer Values (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. It is the amount available to transfer to an alternative plan in exchange for giving up rights under the scheme. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The accrued benefits derived from the member's purchase of added years of service and any 'transferred-in' service must be included in these pension disclosures.

The factors used to calculate a CETV increased on 29th October 2018. This affects the calculation of the real increase in CETV. It does not affect the calculation of the real increase in pension benefits.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Fair Pay Multiple

The Trust is required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce at the reporting period end date (in this case 31 March 2019) on an annualised basis.

Prior to 2018/19 the Trust's reporting mechanisms were such that this calculation included only those staff directly employed on the Trust's primary payroll.

From 2018/19 onwards the Trust is able to include staff employed via the Trust's secondary payroll[7] and also agency staff within the fair pay multiple calculation. 2018/19's fair pay multiple ratio results are therefore shown both with, and without, staff employed via secondary payroll and agency staff to facilitate like for like comparison of the ratio with the previous year.

[7]In this context 'secondary payroll' refers to staff contracted directly by the Trust, but whose recruitment and subsequent payroll service are managed via a secondary payroll provider. The external company with which the Trust has contracted to provide this service supports the Trust to cover mainly medical vacancies and mainly medical rota gaps. The reason the Trust has contracted with another provider to recruit these temporary workers is to reduce the cost of covering these shifts on a temporary basis. In general, this arrangement means that the Trust is able to cover these workforce gaps at a lower cost than if it were to use agency staff.

However, full like-for-like comparison of the entirety of the workforce including secondary payroll and agency staff is not reported due to changes in reporting capability between 2017/18 to 2018/19 which mean that this data for 2017/18 is not available.

The banded mid-point remuneration of the highest paid director in the financial year 2018/19 was £177,500 (2017/18 £177,500). This was 7.4 times (2017/18, 7.2) the median remuneration of the workforce (**excluding** directly engaged and agency staff), which was £23,951 (2017/18, £24,547).

When secondary payroll and agency staff are included, the highest paid director received 7.13 times the median remuneration of the entire workforce which was £24,915 (data not available for 2017/18).

In 2018/19, 30 members of the organisation's total workforce (including agency and secondary payroll staff) received remuneration in excess of the highest-paid director. Remuneration ranged from £7,235 to £307,747 **including** secondary payroll and agency staff (2017/18 £6,844 to £221,608 **without** secondary payroll and agency staff). Of the 30 individuals who received remuneration in excess of the highest-paid director, 23 were secondary payroll staff who are in the main doctors with specialist skills which are in high demand due to limited availability.

In 2017/18 one employee received remuneration in excess of the highest-paid director, however as explained above the 2017/18 figure excluded secondary payroll and agency staff.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The median is the middle number in a sorted list of numbers. The ratio is the number of times the median can be divided into the highest paid director's total remuneration.

	2018/19	2017/18
Mid-Point of Band of Highest Paid Director's Total (Remuneration £000)	**177.5**	177.5
Excluding secondary payroll and agency staff		
Median Total Remuneration (000s)	**24.0**	24.5
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	**7.40**	7.23
Including secondary payroll and agency staff		
Median Total Remuneration (000s)	**24.9**	Data not available
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	**7.13**	

Definition of Senior Managers

For the purposes of this Remuneration Report 'senior managers' are defined as those who influence the decisions of the Trust. This means those who influence the decisions of the Trust as a whole rather than the decisions of individual divisions or sections within the Trust. At The Rotherham NHS Foundation Trust, and for the purposes of this report, the term 'senior manager' applies to the Chair, Non-Executive Directors and Executive Directors only, whether substantive or interim.

This Remuneration Report covers all individuals who hold, or have held, office as Chairman, Non-Executive Director or Executive Director for The Rotherham NHS Foundation Trust during 2018/19, whether or not they were substantively appointed.

Senior Managers with Additional Duties

There were no payments made during 2018/19 to Senior Managers with additional duties.[8]

Payments for Loss of Office

There were no payments made during 2018/19 to Senior Managers for loss of office.

Payments to Past Senior Managers

There were no payments made during 2018/19 to past Senior Managers.

Remuneration Report signed by the Chief Executive in her role as Accounting Officer:

Louise Barnett
Chief Executive
22 May 2019

[8] FReM refers to "medical directors and similar staff", and does not include 'deputy CEO' type roles

Staff Report

Analysis of Staff Costs

Staff Costs	2018/19			2017/18		
	Permanent	Other	Total	Permanent	Other*	Total
	£000	£000	£000	£000	£000	£000
Salaries & wages*	139,880	5,261	145,141	128,570	4,755	133,325
Social security costs	14,045	-	14,045	12,842	-	12,842
Apprenticeship levy	686	-	686	633	-	633
Employer's contributions to NHS pensions	16,739	-	16,739	15,848	-	15,848
Pension cost - other	46	-	46	19	-	19
Termination benefits	58	-	58	83	-	83
Temporary staff - agency/contract staff**	-	9,076	9,076	-	10,453	10,453
TOTAL GROSS STAFF COSTS	**171,454**	**14,337**	**185,791**	**157,996**	**15,208**	**173,204**
Of which: Costs capitalised as part of assets	61	6	67	61	6	67

*'Other' staff includes secondments in and trainee medial staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation.
** The Salaries, Social Security, Apprenticeship levy, Employers contributions and other Pension costs associated with staff employed via a Secondary Contracted Payroll are included in those lines, and not classed as Agency staff as these staff have zero hours' permanent contracts direct with the Trust.

Analysis of Staff: Average Number of Employees (WTE basis)

Average Number of Employed (whole time equivalent basis)	2018/19			2017/18		
	Permanent No.	Other* No.	Total No.	Permanent No.	Other* No.	Total No.
Medical and dental	379	103	481	315	102	417
Administration and estates	1,049	8	1,057	1,043	7	1,049
Healthcare assistants and other support staff	845	-	845	812	1	813
Nursing, midwifery and health visiting staff	1,164	40	1,204	1,162	41	1,203
Scientific, therapeutic and technical staff	419	5	424	417	10	427
Social care staff	92	2	94	89	-	89
	3,947	158	4,105	3,838	161	3,998
Of which: Number of employees engaged on Capital projects	3	3	6	2	0	3

*'Other' staff includes secondments in, and trainee medial staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation. This re-categorisation is also reflected in prior year analysis.

Analysis of Staff: Gender of Staff

As at 31 March 2019 the breakdown of Trust employed staff by gender was as follows:

	Male	Female	Total
Executive Directors	5	2	7
Non-Executive Directors	5	3	8
Employees	898	4152	5050
Total	908	4157	5065

Sickness Absence Data

Figures showing average sick days per Full Time Equivalent (FTE), rather than overall sickness absence as a percentage, are below, with data having been provided by NHS Digital, and based on the 2018 calendar year:

Figures converted by DHSC to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
3,735	35,028	9.38	1,363,235	56,824

Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse
Period covered: January to December 2018
ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.
Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).
There may be inconsistencies between these data and the statutory basis for accounts, in terms of the organisation against which staff are reported for a particular month.

Staff policies and actions applied during the financial year

The Trust has a suite of policies, procedures and initiatives in relation to the workforce in order to support and develop colleagues in their roles. Some of the key policies and actions are detailed below.

During 2018/19 a review of the Trust's approach to equality, across all the protected interest groups, and respecting basic human rights was undertaken. In order to prepare for the Workforce Disability Equality Standard (WDES), work was also undertaken during 2018/19 to encourage colleagues to disclose disabilities. The Trust also engaged with colleagues to support the establishment of a Disability Staff Network commencing in 2019.

Alongside Workforce Race Equality Standard (WRES) and WDES, the Trust continued to use the Equality Delivery System (EDS2) to assist in discussions with local partners including local populations and review and improve performance for people with characteristics protected by the Equality Act 2010.

Modern Slavery is addressed under the umbrella of safeguarding at the Trust, all safeguarding training has been updated to include Modern Slavery and it is included in the Adult Safeguarding Policy. All colleagues are required to undertake safeguarding training to ensure they understand how to raise a concern

The Recruitment, Selection and Promotion Policy contains full information on the processes for recruitment and the various training policies contain information on access to training for colleagues.

The organisation's policy in respect of disabled applicants who clearly indicate that they wish to be considered for a post under the 'Positive about Disability Scheme' is that they will be shortlisted and invited for interview where they meet the requirements for the post.

Trust managers, with the help from the Occupational Health service and Human Resources, regularly make reasonable workplace modifications for colleagues which ensure that disabled colleagues can not only continue in their role with the Trust but also seek promotion opportunities. Work is undertaken on a proactive basis, where applicable, with outside agencies to help support the continued employment and promotion of colleagues.

The Learning and Development department acts as a contact point for all colleagues for special requirements for training provided by the Trust. In this way the organisation ensures that reasonable adjustments are made to support colleagues who disclose a disability which may mean they require extra support with their learning and development.

All colleagues have access to local workforce development programmes and training courses; colleagues discuss their training needs with their line manager during their annual appraisal, at one-to-one meetings or at other times, as arranged locally.

The Trust continues to strive for continuous improvement and to prioritise engagement with colleagues, setting high standards, learning from colleague experience, and strengthening partnership working. Ensuring active colleague involvement in the management and direction of services at all levels is achieved through valuing colleagues,

listening and responding to their views and monitoring quality workforce indicators. Equally, the organisation acknowledges that its colleagues should have confidence that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship.

There are a number of mechanisms through which information, including that relating to the performance of the Trust, is communicated to colleagues. These include weekly all user e-mails and bulletins, monthly Team Brief sessions, departmental meetings, ad hoc briefings, Twitter and Facebook posts, personal letters, and payslip messages and attachments. The 'Dear Louise' facility is also available to enable colleagues to ask questions of the Chief Executive (anonymously if desired). The method(s) used will be the most appropriate for the particular information to be conveyed however, one or more methods will be used for all matters of importance.

There is a colleague intranet which provides information regarding the latest changes and developments as well as routine information. Not all clinical and support colleagues use electronic communication methods and consequently, managers are asked to make all colleagues aware of information communicated by electronic means.
The weekly all user e-mails, the intranet and Team Brief are all used as a means of conveying official information, as appropriate, which is of benefit to colleagues in a social, personal and developmental way. Examples include reporting on the achievements of colleagues, benefits and services available, activities and events taking place, health related information and offers. There are separate pages on the intranet for colleague health, benefits and wellbeing offering an extensive range of discounts and contacts as well as sources for support, development and training.

Colleagues are actively engaged with, and their feedback obtained, on matters being communicated. This occurs through the 'Team Brief' process led by the Executive Directors, Colleague Forums and through the regular meetings of the Joint Partnership Forum and Local Negotiating Committee where Trade Unions and professional association representatives meet with senior managers to discuss issues affecting staff and local conditions of service. A sub group of the Joint Partnership Forum, the Joint Policy Group, agrees and updates HR policies in line with current employment law and ensures they have broad agreement within the organisation. The Local Negotiating Committee is the forum for medical and dental colleagues.

All Trust policies are available on the intranet for colleagues, including the extensive range of HR policies, many of which are about services available directly in support of colleagues. Examples include: Special Leave, Flexible Working, Managing Attendance, Health and Wellbeing policies, Freedom to Speak Up (Raising Concerns) and Shared Parental Leave.

The Trust recognises that valuing and celebrating the achievements of the workforce is essential to enable the future growth and development of the organisation and the individuals who are part of it. This was demonstrated when specific events were arranged to support Innovation Week, Values Week and PROUD Week culminating in an awards ceremony for colleagues held on 08 November 2018.

Health & Safety and Occupational Health

A fifth consecutive gold award was received by the Trust for preventing accidents on its hospital and community sites from the Royal Society for the Prevention of Accidents (RoSPA), as part of their RoSPA Occupational Health and Safety Awards 2018/19. Only organisations able to maintain continued high standards in health and safety are able to achieve the gold award. During the year the Trust become the first Trust in the country to be awarded the Gold Medal in the RoSPA Occupational Health and Safety Awards. The Trust received the medal after having received the gold award for five consecutive years.

The Occupational Health service is located discretely behind the main Woodside building, offering professional specialist nurse, counselling and proactive occupational health services.

During 2018/19 the contract for occupational health provision was awarded to a new service provider, People Asset Management (PAM Group), which commenced in September 2018. As part of this new provision the Trust launched a new Employee Assistance Programme (EAP), which provides confidential support by qualified counsellors 24 hours a day to staff.

The Occupational Health service continued to deliver high quality interventions to all employees, supporting a healthier, fitter workforce and supporting the Trust's objective to reduce sickness absence.

Countering fraud, bribery and corruption

The Trust's Chief Executive and Director of Finance are jointly responsible for ensuring adherence to the NHS Counter Fraud Authority (NHSCFA) Anti-Crime Strategy for countering fraud, bribery and corruption. The NHSCFA is responsible for ensuring the quality of measures to counter fraud, bribery and corruption within NHS Foundation Trusts.

Service condition 24.2 of the NHS Standard Contract 2017 to 2019 sets out the Trust's obligations to safeguard NHS funds and resources through compliance with 23 standards for countering fraud, bribery and corruption:

Strategic Governance (7 standards): covers standards in relation to the Trust's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

Inform and Involve (4 standards): covers requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of fraud, bribery and corruption against the NHS.

Prevent and Deter (6 standards): covers the requirements in relation to discouraging individuals who may be tempted to commit fraud against the NHS and ensuring that opportunities for crime to occur are minimised.

Hold to Account (6 standards): sets out the requirements in relation to detecting and investigating economic crime, obtaining sanctions and seeking redress.

In order to demonstrate compliance with the standards, the Trust is required to complete and submit an annual Self Review Tool (SRT) assessment rating compliance against a red/amber/green scale. An SRT against these standards was completed in March 2018 which demonstrated an overall 'Green' rating.

The Trust has a nominated Counter Fraud Specialist (CFS) in place provided by 360 Assurance. The CFS is responsible for carrying out a range of activities in compliance with the above standards that are overseen by the Director of Finance and the Audit Committee. The CFS undertakes fraud, bribery and corruption risk assessments throughout the year which are used to inform the annual programme of activities that are undertaken within the above areas.

During the reporting year, counter fraud activity has focussed on activities to ensure compliance with NHSCFA standards and to address areas of heightened risk including:

- Cyber-crime
- Staff secondary working
- Bank and Agency Staff
- Mandate Fraud
- Declarations of interest; and
- Overseas Visitors

The Trust has a Fraud, Bribery and Corruption policy which outlines the Trust's zero tolerance approach to fraud, bribery and corruption and sends a clear message that all available sanctions will be pursued in respect of those caught committing offences against the Trust. Clear reporting procedures are included within the policy and the policy is signposted to staff within all training delivered by the CFS.

Where fraud is identified or reported it is formally investigated in accordance with the Trust's Fraud, Bribery and Corruption policy. During 2018/19, 11 referrals of suspected fraud, bribery or corruption were made to the CFS, demonstrating a good awareness and understanding of the Fraud, Bribery and Corruption policy.

Trade Union Facility Time Disclosures

As required by law, the Trust published Trade Union Facility Time data for 2017/18. During this period the Trust had between 1501 and 5000 employees and employed 25 accredited Trade Union representatives, whose total contracted working time equated to 22.05 whole time equivalents (WTE). All of these Trade Union representatives spent between 1% and 50% of their working hours on facility time.

The Trust's total pay bill for the period was £157,854,240.85, and the total cost of facility time was £43,569.88. The total percentage of the Trust's pay bill spent on facility time was 0.03%

During the period, 2,444 hours were spent by accredited trade union representatives on paid facility time, with 14.5 of those hours (0.59%) being spent of paid Trade Union Activities.

Staff Survey

Staff Engagement

The Rotherham NHS Foundation Trust has continued to work to support its ambition to be a high performing Trust. In this special year at the Trust, its 40th anniversary in addition to the 70th anniversary of the NHS, never has it been more important to work with colleagues to improve staff engagement. Our colleagues celebrated this historic milestone via a series of celebration events and came together to celebrate and to share memories reflecting on how far healthcare has progressed since the inception of the NHS.

Through the Trust's engagement model, Together We Can (TWC), and Strategy and Transformation Service, colleagues had the opportunity to participate in and shape, changes across the organisation. 'Innovation week' proved very successful leading to great ideas generated from the workforce. This was reflected as a category in the organisation's annual colleague awards, the Proud Awards.

The core values have continued to be embedded and what these mean to colleagues has been celebrated. Time has been taken to identify what the values mean personally to colleagues and how they promote these in the workplace.

Success continued to be celebrated at the annual 'Proud Awards' and throughout the year via the suite of reward and recognition packages. These achievements were also celebrated through various internal and external Trust newsletters, on social media and via electronic communications channels.

In 2017/18, the Trust developed and implemented the LEAD (Leadership Exploration and Discovery) programme to develop its middle management, which continued to run throughout 2018/19 and this year, a senior clinical leadership programme was introduced, primarily aimed at medical staff. This work sought to develop clinical and non-clinical management reflecting on culture, behaviours, leadership styles and innovation and development. To date in excess of 300 colleagues have participated in the LEAD programme. The rolling programme extends its target audience, will continue throughout 2019/20 and will complement the Trust's soon to be launched talent management programme.

Members of the Board of Directors continued to undertake board to ward visits throughout the year and the Trust participated in and won a number of awards at external events recognising the innovative and progressive ambition of colleagues.

The Trust performed well during the 'flu campaign of winter 2018/19, achieving the national target of 75% with over 80% of frontline workers taking up the offer of vaccination. The Trust continued to support the colleague wellbeing agenda and procured a colleague Employee Assistance Programme (EAP) towards the later part of the year. EAP provides additional help and support for colleagues to stay well and source early assistance should they require it in confidence 24 hours a day, 7 days a week.

NHS Staff Survey

The Trust undertook an all staff full census staff survey. The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among Trust staff was 38% (2017: 41%). Scores for each indicator together with that of the survey benchmarking group Combined Acute Community Trusts are presented below.

Whilst the Trust has not reached its ambition, it has held steady in a climate of uncertainty and national pressure.

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.2	9.2	9.2	9.2	9.3	9.3
Health and wellbeing	5.8	5.9	5.9	6.0	6.0	6.1
Immediate managers	6.7	6.8	6.6	6.8	6.6	6.8
Morale	5.8	6.2	N/A	N/A	N/A	N/A
Quality of appraisals	4.9	5.4	4.9	5.3	5.1	5.4
Quality of care	7.2	7.4	7.1	7.5	7.4	7.5
Safe environment: bullying and harassment	8.2	8.1	8.3	8.1	8.4	8.2
Safe environment: violence	9.5	9.5	9.5	9.5	9.6	9.5
Safety culture	6.5	6.7	6.3	6.7	6.5	6.7
Staff engagement	6.6	7.0	6.5	7.0	6.7	7.0

Reviewing the staff survey results across the NHS as a whole reveals the impact of the overall pressures experienced by colleagues. This is reflected in the results of the number of colleagues nationally recommending the NHS as a place to work. This trend was reflected locally in the Trust's own staff survey findings report. However, effective engagement of colleagues remains a key priority for the Trust in 2019/20, with actions being developed to drive improved outcomes as measured by the 2019 National Staff Survey.

Future Priorities and Targets

Statement of key priority areas

- Build an Organisation Development Strategy which will include the Trust's approach to Talent Management, succession planning and career development pathways
- Revise the Engagement and Wellbeing Strategy in response to colleague feedback and best practice. Implement the key activities over the next three years in line with the operational strategy
- Revise and remodel the Communication Strategy
- Build on wellbeing work with particular focus on mental wellbeing. Adopt the 'Thriving at Work' mental health core standards[9] and fulfil the revised NHS contract

These plans will have underpinning action plans with key milestones and will be reviewed and monitored through the operational workforce group and the Strategy and Business Planning Committee.

Performance against priority areas

Personal Development Reviews (PDR): The organisation acknowledges the need to improve the quality of PDRs. A programme of training has been rolled out to support both reviewers and those being reviewed, and to ensure that everyone has a high quality PDR. Work has commenced to develop wider engagement in response to the National Staff Survey response. Whilst acknowledging the Trust has not reached its target of improvement, it has maintained a steady course with marginal gains in survey performance.

Monitoring Arrangements

Performance will be monitored through the Committee structures in place including the Operational Workforce Group and the Strategy & Business Planning Committee and ultimately the Board of Directors. Locally, each Division will develop a two-year plan to address divisional-specific improvements relevant to the respective Divisions supported by data from the National Staff Survey results and other Trust metrics supported by the HR Business Partners. The wider engagement activities will be monitored through the Operational Workforce Group chaired by the Deputy Director of Human Resources. The action of this group and any associated work plans will provide the appropriate assurance to the Strategy & Business Planning Committee members.

Future priorities and how they will be measured

Wider colleague engagement remains key and the 'Together We Can' (TWC) approach continues to be embedded ensuring colleagues have the opportunity to contribute towards improvements and have a voice to share their great ideas to deliver high quality care in an environment conducive to this. The introduction of a revised 'Pulse check' measuring progress and 10 TWC teams will complement the approach to good colleague engagement. This remains an area of focus.

The Trust is currently developing its new engagement and wellbeing strategy to ensure continued improvement in its approach to staff engagement. The key underpinning principles include ensuring the Board of Directors is sighted on the Trust position in terms of how staff feel and that staff drive this. In response to this the Board has developed its Operational Plan for 2019/20 which includes the following engagement priorities:

- Introduction of PULSE surveys: with a continuous improvement in participation each quarter and improved baseline results
- Implementation of staff inclusion networks: with a minimum of 2 networks established (those for black, Asian and minority ethnic colleagues and colleagues with a disability)
- Establishment of new Together We Can teams: with agreed deliverables and outcomes across a range of priority areas, targeting 10 teams

Expenditure on Consultancy

Consultancy costs during 2018/19 were £0.827M. These included work on the development of a community hub as part of the Rotherham Place programme, development of a business case proposal for a Wholly Owned Subsidiary and continued support from KPMG with regards to the Trust's efficiency programme.

Staff Exit Packages

The table below summarises the total number of exit packages agreed during the year. Included within these are compulsory redundancies and other schemes including MARS (Mutually Agreed Resignation Scheme) applications. The table below shows packages agreed in year, irrespective of the actual date of accrual or payment.

This table has been restated for prior year to remove the inclusion of payment in lieu of notice (PILON) payments made as part of standard contractual terms, and not part of a wider exit package.

Exit costs in this table are the full costs of departures agreed in the year. Where The Rotherham NHS Foundation Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

[9]Thriving at work, The Stevenson / Farmer review of mental health and employers, October 2017, source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf last accessed 21/3/19

Exit package cost band	Number of compulsory redundancies		Number of other non-compulsory departures agreed		Total number of exit packages by cost band	
	2018/19	2017/18	2018/19	Restated 2017/18	2018/19	Restated 2017/18
<£10,000	0	0	0	0	0	0
£10,000 – £25,000	0	1	0	0	0	1
£25,001 – £50,000	0	0	0	0	0	0
£50,001 – £100,000	1	1	0	0	1	1
£100,001 – £150,000	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	1	2	0	0	1	2
Total resource cost £000s	58	83	0	0	58	83

Analysis of non-compulsory departure payments

The table below discloses non-compulsory departures and values of associated payments by individual type. The table shows packages agreed in year, irrespective of the actual date of accrual or payment. As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number below will not necessarily match the total numbers in the Exit Packages table above which will be the number of individuals

	Number of Agreements		Total Value of Agreements £000	
	2018/19	2017/18	2018/19	2017/18
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice*	13	22	112	94
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval**	0	0	0	0
Total	13	22	112	94
of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0		

* Any non-contractual payments in lieu of notice is disclosed under "non-contractual payments requiring HMT approval" above.
* Includes any non-contractual severance payment made following judicial mediation and amounts relating to non-contractual payments in lieu of notice.
The Remuneration Report includes exit payments payable to individuals named in that Report where applicable. Those exit payments will also be included in this table above.

Off Payroll Engagements

The decision to appoint Board members or senior officials with significant financial responsibility through an off-payroll arrangement is made at a very senior level for exceptional operational reasons.

The standard process during 2018/19 was to seek assurance for all off payroll workers that they were compliant with IR35 and that all relevant taxes were being paid.

Table 1: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

Number of existing engagements as of 31 March 2019	**3**
Of which:	
No. that have existed for less than one year at a time of reporting	2
No. that have existed for between one and two years at time of reporting*	1
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration between 01 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	**3**
Of which:	
Number assessed as within the scope of IR35	1
Number assessed as not within the scope of IR35	2
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 01 April 2018 to 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements*	10

*There are 7 Executive Director members of the Board who are on the Trust's payroll. During the year there have been two Chief Nurses, two Medical Directors and two Directors of Workforce.

Governance and Organisational Structure

Board of Directors

The Trust's Board of Directors operates as a unitary board which is collectively responsible for all areas of the Trust's performance (clinical and service quality, operational performance, financial performance and management and governance). As part of its governance framework the Board uses best practice standards.

The Board is legally accountable for the services provided by the Trust, and its key responsibilities include:

- Setting the strategic direction (having taken into account the Council of Governors' views)
- Ensuring that adequate systems and processes are maintained to deliver the Trust's annual Operational Plan
- Ensuring that its services provide safe, clean, high quality and professional care for patients
- Ensuring robust governance arrangements are in place supported by an effective assurance framework which supports sound systems of internal control including the appointment and dismissal of Board Committees
- Ensuring rigorous performance management which enables the Trust to continue to achieve local and national targets
- Seeking continuous improvement and innovation
- Measuring and monitoring the Trust's effectiveness and efficiency
- Approving proposed expenditure above specified financial limits
- Ensuring that the Trust, at all times, remains compliant with its Licence, as issued by NHS Improvement
- Exercising the powers of the Trust established under statute, as described within the Trust's Constitution

The Board's responsibilities also include establishing the values and standards of conduct of the Trust and its colleagues ensuring these are in accordance with NHS values and the 'Nolan Principles'[10] of public life: selflessness, objectivity, integrity, accountability, openness, honesty and leadership. The 'Nolan Principles' set out the ethical standards expected of individuals who hold public office. The Trust has ensured its systems during 2018/19 remained compliant with NHS England's Conflicts of Interest guidance which came into force in June 2017.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Matters Reserved for the Board and Scheme of Delegation. These 'Matters Reserved' were revised during the year and approved by the Board in December 2018.

The Board delegates management, through the Chief Executive to the Executive Directors, for the overall performance of the organisation which is conducted principally through the setting of clear objectives and ensuring that the organisation is managed efficiently and to the highest standards in keeping with its values. The Board receives monthly updates on all aspects of performance from the Executive Directors.

Composition of the Board of Directors

The Board of Directors is composed of both full-time Executive and part-time Non- Executive Directors. The Non-Executive Directors are appointed by the Council of Governors from the pool of Members of the Trust. Non-Executive Directors are chosen for their broad business, clinical or other experience and include individuals specifically appointed due to their financial and/or commercial experience, existing knowledge of the NHS, educational backgrounds, voluntary and charitable sector experience.

All the Non-Executive Directors are independent in character and they are free from material business or other relationship which may interfere with their judgement.

The Board's mixture of skills, knowledge and experience is considered appropriate, balanced and complete for the challenges currently facing its Directors. However, following both the external well-led review and the CQC inspections both undertaken in 2018, during 2019/20 the Board will seek to further increase the diversity of its membership.

Annual performance evaluation and appraisal is undertaken for all Executive and Non-Executive Directors. The performance appraisal and objective setting for the Chairman is undertaken jointly by the Senior Independent Director and the Lead Governor. The performance appraisal for the Non-Executive Directors is undertaken by the Chairman in conjunction with the Lead Governor. Both appraisal processes are informed by a collective view on each individual Non-Executive Director's performance provided by the Executive Directors.

The Chairman undertakes the performance appraisal of the Chief Executive and the Chief Executive carries out the performance appraisals of the Executive Directors.

During the year the performance of the Board has been further evaluated internally through Board Development away days, Board seminar sessions and through the on-going, quarterly review of the Board Assurance Framework.

In addition, two external well-led reviews were undertaken, one commissioned by the Trust and the other undertaken as part of the regular inspection of the Trust by the CQC. A further evaluation of the extent to which the Trust makes good use of its resources was undertaken by NHS Improvement.

The Board Assurance Framework (BAF), which was highly rated by the Trust's Internal Auditors during 2017/18, was further refined during the year. The BAF provides a comprehensive review of the manner in which the Trust is identifying, managing and mitigating the risks to the achievement of its strategic objectives.

Meet the Board of Directors

The descriptions below of each Director's expertise and experience demonstrate the balance and relevance of the skills, knowledge and expertise that each of the Directors bring to the Trust. Details are provided for those in post as at 31 March 2019.

[10] https://www.gov.uk/government/publications/the-7-principles-of-public-life

Martin Havenhand
Chairman

Louise Barnett
Chief Executive

Lynn Hagger
Non-Executive Director / Vice Chair

Mark Edgell
Non-Executive Director

Gabrielle Atmarow
Non-Executive Director

Joe Barnes
Non-Executive Director / Senior Independent Director

David Hannah
Non-Executive Director

Barry Mellor
Non-Executive Director

Heather Craven
Non-Executive Director

Chris Holt
Deputy Chief Executive / Director of Strategy and Transformation

Callum Gardner
Interim Medical Director

Angela Wood
Chief Nurse

Simon Sheppard
Director of Finance

Paul Ferrie
Acting Director of Workforce


THE LARYNX
THE LARYNX
KEY NURSING SKILLS
Sheffield Hallam University
STUDENT
NHS NHS NHS NHS NHS NHS
SOCIAL

Non-Executive Directors

All Non-Executive Directors on the Board of Directors are considered to be independent. The Trust's policy in relation to Non-Executive Director appointments is that appointments are made for up to a three-year term of office as per the Trust's Constitution with one month's notice on either side. The initial three-year term of office may be renewed once to mean a Non-Executive Director may serve up to 6 consecutive years on the Board of Directors. A Non-Executive Director may, in exceptional circumstances, serve longer than six years; however, this arrangement is subject to annual review in accordance with *The NHS Foundation Trust Code of Governance.*

Martin Havenhand
Chairman

Martin is a very experienced Chairman and Non-Executive Director. He has a wealth of Executive and Non-Executive experience from both the public and private sectors and is knowledgeable and experienced in regulated industries.

He also brings to the Trust extensive experience and knowledge of the South Yorkshire and Bassetlaw community which is invaluable as the Trust continues to develop and enhance local health care services for the future.

The Rotherham NHS Foundation Trust is a key partner in the Rotherham Together Partnership and in March 2019 Martin was appointed Chairman of the Ambition Rotherham Board which is made up of private and public sector leaders to promote the Rotherham Story on behalf of the Partnership.

The Council of Governors initially re-appointed Martin as Chairman at their meeting in July 2016 for a further three-year term effective from February 2017. In April 2019 the Council of Governors again re-appointed Martin as Chairman for a further three-year term effective from February 2020, subject to satisfactory annual review.

As Chairman Martin chairs the Board of Directors, the Board Nominations Committee and the Strategy and Transformation Committee. He is also the Chair of the Council of Governors' meetings and the Chair of the Governors' Nominations Committee.

From 01 April 2019 Martin assumed the Chairmanship of the new Strategy and Business Planning Committee which replaced the Strategy & Transformation and Strategic Workforce Committees.

The other significant commitments of the Chairman were disclosed before formal approval of the appointment by the Council of Governors and are documented in the Register of Interest. Details about how to access the Register of Interests are described above.

Gabrielle Atmarow
Non-Executive Director

Gabrielle is an experienced former NHS Nurse Director with extensive clinical and managerial experience. She has held Director posts in primary and community care, acute care, a Strategic Health Authority and has experience working at the Department of Health. She has a strong commitment to the achievement of the highest standards for the patient experience wherever care is delivered.

From 2009 to 2016 she was a member of the Board of Governors of Leeds Beckett University. Gabrielle was appointed as a Justice of the Peace in 2008 and serves as a Magistrate on the Leeds Adult Bench and is also a Family Justice. She views this responsibility as both humbling and a privilege.

Gabrielle has served as a Non-Executive Director at the Trust since April 2011, having originally been appointed for a two-year term. She was re-appointed for a further three-year term of office by the Council of Governors from April 2013. In January 2016 Gabrielle was appointed for a further one-year term of office, concluding in March 2017, by the Council of Governors.

Once a Non-Executive Director has served for six years, the NHS Foundation Trust Code of Governance states that Non-Executive Directors should be subject to annual re-appointment following a rigorous review. Having served six years as a Non-Executive Director of the Trust such a review was undertaken by the Council of Governors' Nomination Committee in June 2016. As a result, the Council of Governors re-appointed Gabrielle at their meeting in July 2016 for a further one-year term of office from April 2017 to provide a clinical perspective through to the completion of the Emergency Centre in 2017. At the Council of Governors meeting in April 2018 it was agreed that due to exceptional circumstances in the increase of the Board composition, Gabrielle should be appointed for a further one-year term of office from April 2018.

During 2018/19 Gabrielle became Chair of the Strategic Workforce Committee, remained as Vice-Chair of the Finance & Performance Committee and continued as a member of both the Remuneration Committee and the Charitable Funds Committee.

Joe Barnes
Non-Executive Director and Senior Independent Director

Joe spent almost nine years as a Non-Executive Director at Doncaster and Bassetlaw NHS Foundation Trust where, at various times, he was Chair of the Audit and Clinical Governance Committees, Senior Independent Director and Deputy Chair. He spent most of his career with British Coal and the Coal Pension Funds and he is a qualified accountant.

Joe joined the Trust as a Non-Executive Director in September 2013. In July 2016 the Council of Governors re-appointed Joe for a further three-year term of office from September 2016.

From 01 April 2018 Joe became the Trust's Senior Independent Director. During 2018/19 he was Chair of the Audit Committee, Vice-Chair of the Remuneration Committee and a member of the Finance & Performance Committee.

From the beginning of April 2019 Joe continued as Chair of the Audit Committee, Vice-Chair of the Remuneration Committee and a member of the Finance & Performance Committee

Heather Craven
Non-Executive Director

Heather is a Chartered Accountant who trained with KPMG and has spent most of her career working across a wide spectrum of industries at director levels including FTSE and AIM listed companies. Since 2006

she has helped a number of organisations to identify operational and financial issues and weaknesses and has delivered solutions to resolve those problems.

Heather has been a Non-Executive Director at the Trust since February 2017 and remains committed to using her skills and experience to assist the Trust in meeting the challenges it faces in delivering a quality healthcare service.

During 2018/19 Heather continued as Chair of the Finance & Performance Committee and a member of the Strategic Workforce Committee and the Remuneration Committee.

From 01 April 2019 Heather continued as Chair of the Finance & Performance Committee and a member of the Remuneration Committee. She also became a member of the Strategy and Business Planning Committee which replaced the Strategy & Transformation and Strategic Workforce Committees.

Mark Edgell
Non-Executive Director

Mark joined The Rotherham NHS Foundation Trust as a Non-Executive Director on 01 June 2012. Mark has lived in central Rotherham since the mid-1980s and has a deep commitment to the town, the Borough and South Yorkshire. He spent 13 years as a Councillor and was Leader of Rotherham Metropolitan Borough Council for several years in the early 2000s.

Through his role at the Trust and his passion for ensuring local people enjoy high quality public services that effectively meet their needs, Mark seeks to help The Rotherham NHS Foundation Trust meet its challenges, both now and in the future.

Once a Non-Executive Director has served for six years at the Trust, the NHS Foundation Trust Code of Governance states that Non-Executive Directors should be subject to annual re-appointment following a rigorous review.

Having served six years as a Non-Executive Director of the Trust such a review was undertaken for Mark by the Council of Governors' Nomination Committee in September 2017. As a result, the Council of Governors re-appointed Mark at their meeting in October 2017 for a further two-year term of office from 01 June 2018, subject to annual review, to maintain continuity on the Quality Assurance Committee which is chaired by Mark.

During 2018/19 Mark continued to serve as Chair of the Quality Assurance Committee and as a member of both the Strategy & Transformation Committee and the Board's Nomination Committee.

From the beginning of the 2019/20 financial year, Mark continued as Chair of the Quality Assurance Committee and as a member of the Board's Nomination Committee. He became a member of the Strategy and Business Planning Committee which replaced the Strategy & Transformation and Strategic Workforce Committees.

Lynn Hagger
Non-Executive Director and Vice Chair

After careers in social work and legal practice, Lynn became a legal academic with lectureships at the Universities of Manchester, Liverpool and then Sheffield. She has taught administrative / public law, contract, environmental and European law but then specialising in healthcare law and ethics at undergraduate and postgraduate level.

Lynn has published extensively in this area including two books: *The Child as Vulnerable Patient: Protection and Empowerment* and *A Good Death: Law and Ethics in Practice*. In parallel with these activities, Lynn has been involved in the NHS for over 25 years, mostly as a Non-Executive Director of acute hospital boards, and including as Chair of Sheffield Children's NHS Foundation Trust and Non-Executive Director at Leeds Teaching NHS Trust.

The Council of Governors re-appointed Lynn for a further three-year term of office with effect from October 2016 at their meeting in July 2016.

During 2018/19 Lynn was Vice-Chair of the Strategy & Transformation Committee, the Board's Nomination Committee and the Charitable Funds Committee. She was also a member of the Quality Assurance Committee.

From 01 April 2019 Lynn continued as Vice-Chair of the Board's Nomination Committee and the Charitable Funds Committee. She also remained a member of the Quality Assurance Committee. Lynn became a member of both the Audit Committee and the Strategy and Business Planning Committee which replaced the Strategy & Transformation and Strategic Workforce Committees.

Barry Mellor
Non-Executive Director

Barry has had a rewarding career in both the private and public sector helping large complex organisations through transformational changes and developments which deliver tangible benefits to staff, customers and patients. He is professionally qualified in marketing, IT, change management and procurement and logistics.

He is no stranger to the NHS nor to The Rotherham NHS Foundation Trust, in his previous role as Chief Executive of NHS Logistics (later NHS Supply Chain). After NHS Logistics, Barry was Commercial Director for Sheffield City Council and as Chair of the Yorkshire & Humber Strategic Procurement Group has worked closely with Rotherham Council. Barry has also been a Non-Executive Director at Derbyshire Healthcare NHS Foundation Trust, a mental health and community Trust.

Barry was originally appointed for a two-year term of office from September 2013. The Council of Governors re-appointed Barry for a further three-year term of office with effect from September 2015 at their meeting in April 2015. In April 2018 the Council of Governors re-appointed Barry for a further one-year term of office from September 2018.

During 2018/19 Barry was Chair of the Remuneration Committee and the Charitable Funds Committee. He was also Vice-Chair of both the Audit Committee and the Strategic Workforce Committee. Barry is also Chair of the Organ Donation Committee.

From the beginning of April 2019 Barry continued as Chair of both the Remuneration Committee and the Charitable Funds Committee and Vice-Chair of the Audit Committee. He joined the Finance & Performance Committee as a member.

David Hannah
Non-Executive Director

David is a recently retired GP, having completed 30 years as a GP principal in a large practice north of Nottingham, with a similar socio-economic demographic to Rotherham. As a GP he was actively involved in commissioning health services and was a founder member of the Nottingham Total Commissioning Project. He was particularly involved in commissioning children's and young people's services in Nottinghamshire, an interest which resulted in him becoming the GP representative on the Nottinghamshire County Council Children's Trust Board.

David has always been motivated by the vision to provide the best possible health care for his patients and those in the wider locality. He brings his skills and experience from a background in Primary Care and CCG work to The Rotherham NHS Foundation Trust and adds a new diversity to the Board of Directors' composition.

David became a Non-Executive Director at the Trust in January 2018. During 2018/19 David was Vice-Chair of the Quality Assurance Committee as well as a member of the Audit Committee, Strategy & Transformation Committee and the Board's Nominations Committee.

From 01 April 2019 David continued as Vice-Chair of the Quality Assurance Committee and a member of both the Audit Committee and the Board's Nominations Committee. He also became a member of the Charitable Funds Committee.

Executive Directors

Louise Barnett
Chief Executive

Louise Barnett is Chief Executive of The Rotherham NHS Foundation Trust. She joined the Trust as Interim Chief Executive in October 2013, prior to being appointed to the substantive position in April 2014.

Louise has a wealth of experience, having worked at a senior level in both the public and private sectors. Louise has held a number of NHS board positions, including Non-Executive Director at Sherwood Forrest Hospitals NHS Foundation Trust, and Interim Chief Executive at Peterborough and Stamford Hospitals NHS Foundation Trust.

Louise is a Chartered Fellow of the Chartered Institute of Personnel and Development, a Fellow of the Chartered Management Institute and Chair of the Yorkshire and Humber Regional Leadership Council.

Chris Holt
Deputy Chief Executive (from 14 September 2018)
Director of Strategy & Transformation and Deputy Chief Executive (to 13 September 2018)

Chris Holt joined the Trust in October 2014 as Chief Operating Officer with responsibility for ensuring the safe and effective day-to-day operational performance of the organisation. Prior to joining The Rotherham NHS Foundation Trust, Chris spent 3 years at Mid Staffordshire NHS Foundation Trust as Deputy / Chief Operating Officer following the Francis inquiry and supported the organisation through the administration process.

Before taking the decision to join the NHS, Chris spent a number of years working with healthcare organisations across both primary and secondary care in England and Scotland as well as roles across the private and public sectors (working for KPMG / Atos) and 10 years working for Alstom Transport in the UK and across Europe.

Chris is passionate about improving the health and wellbeing of the local population. He is a strong believer in the closer integration of the health and social care agenda and in providing strong community based care services to ensure that the Trust continues to deliver excellent services and a safe and first class experience for all.

In February 2017 Chris became the Director of Strategy and Transformation and Deputy Chief Executive and in September 2018 Chis became Deputy Chief Executive.

George Briggs
Chief Operating Officer (from 01 April 2018)

George and his family live in Lincolnshire. George has worked in the NHS for 30 years working in a variety of organisations including Trusts and CCGs. He has extensive experience as a general manager in a number of specialties including cardiology, intensive care and medicine. George has also held a number of director positions in acute Trusts. Over recent years, George has enjoyed working in a number of interim roles across the UK which gave him the opportunity to support and learn from a number of NHS organisations.

Cheryl Clements
Director of Workforce (to 08 July 2018)

Cheryl Clements was the Trust's Director of Workforce and joined the organisation in April 2016. She began her NHS career as an adult and children's nurse, training in Sheffield. She worked in Rotherham at the hospital, as a Staff Nurse in the 1980s, a Ward Sister in Doncaster, Head of Education in Chesterfield and has general management and teaching experience. She is committed to supporting and developing staff to provide excellent health care.

Cheryl has held Director posts in a variety of provider and commissioning organisations, acute care, PCTs, Community care, Mental Health and Learning Disability Services. She joined the Trust from Coventry and Warwickshire Partnership Trust.

Paul Ferrie
Acting Director of Workforce (from 09 July 2018)
Paul Ferrie was the Acting Director of Workforce from 09 July 2018 until 31 March 2019, supporting the Trust in the lead up to the new joint Director of Workforce beginning in post in April 2019.

Paul joined the NHS in February 2010, working in the HR team at the Rotherham Community Health Centre. From April 2011, Paul led the workforce aspect in the integration of Rotherham's hospital and community services and following this, has undertaken a number of senior HR roles at the Trust including Deputy Director of HR.

Prior to his time in the NHS, Paul had a very successful career with Royal Mail where he gained experience in a number of senior managerial roles over a 17-year period.

Callum Gardner
Interim Medical Director (from 03 September 2018)
Dr Callum Gardner joined the Trust as Interim Medical Director in September 2018 bringing a wealth of experience to the organisation. He is a consultant acute and general physician at North West Anglia NHS Foundation Trust (NWAFT) with a sub-specialty interest in respiratory medicine. He also held the position of Divisional Director for the Emergency & Medicine division at NWAFT, leading the division from 'requires improvement' to 'good' in the 2018 CQC inspection.

He has previously held a number of key roles including Deputy Medical Director and Associate Medical Director, and was a doctor in the Royal Navy for almost 18 years.

Chris Morley (to 30 September 2018)
Chief Nurse
Chris joined the Trust in October 2017 from Sheffield Teaching Hospitals NHS Foundation Trust where he held the role of Deputy Chief Nurse.

He had previously held a number of leadership roles in healthcare governance, patient safety and nursing management. Chris possesses a BMedSci in Professional Nursing Studies from the University of Sheffield and an MSc in Health and Social Care Leadership from Sheffield Hallam University.

He was the Chair of the Association of United Kingdom University Hospitals Deputy Nurse Director Group between September 2016 and October 2017.

Simon Sheppard
Director of Finance
Simon Sheppard joined the Trust in November 2014 from the University Hospitals of Leicester NHS Trust where he was Acting Director of Finance and, before that, Deputy Director of Finance and Procurement.

Simon started in the NHS on the Graduate Management Training Scheme and has over 20 years' experience at a senior level in large acute teaching hospitals including the Nottingham University Hospitals NHS Trust.

Conrad Wareham (to 02 September 2018)
Medical Director
Conrad joined the Trust in July 2015, when he returned to the UK from Australia where he had held a number of senior roles including Executive Director for Medical Services.

He has a wealth of experience including: the strategic development of clinical streams; shaping and designing services across North Adelaide Local Health Network; and working closely with clinical and consultant colleagues to deliver changes for patients. He trained in the UK and specialises in anaesthesia and critical care.

Angela Wood
Chief Nurse (from 01 February 2019)
Interim Chief Nurse (from 01 October to 31 January 2019)
Angela Wood joined the Trust in October 2018 as Interim Chief Nurse before being appointed to the substantive Chief Nurse position. Angela, who has been nursing for 31 years, joined the Trust from North Lincolnshire and Goole NHS Foundation Trust where she was the Interim Deputy Chief Nurse, on secondment from her substantive role as Deputy Director of Nursing at NHS England. She has held a number of senior nursing roles throughout her career, both strategic and operational, including significant experience in acute settings. She has a track record of achievement in quality, patient safety and patient experience agendas, and is passionate about patients receiving safe, good quality care.

Attendance at Board of Directors' Meetings 2018/19

Board of Directors	Martin Havenhand (Chair)	Gabby Atmarow	Joe Barnes	Heather Craven	Mark Edgell	Lynn Hagger	David Hannah	Barry Mellor		Louise Barnett	George Briggs	Cheryl Clements	Paul Ferrie	Callum Gardner	Chris Holt	Chris Morley	Simon Sheppard	Conrad Wareham	Carrie Kelly	Angela Wood
2018																				
24 April	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y		
23 May (extra)	Y	N	Y	Y	Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y		
29 May	Y	Y	Y	Y	Y	N	Y	Y		Y	Y	N			N	Y	Y	Y		
26 June	Y	Y	N	Y	Y	Y	Y	N		Y	Y	N			N	Y	Y	N		
31 July	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	N			N	N	Y	N		
28 August	Y	Y	Y	N	N	Y	Y	Y		N	Y	N	Y		Y	Y	Y	N	Y	
25 September	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	N	Y	N	Y	Y	Y	N		
30 October	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	N	N	Y	Y		Y	N		Y
27 November	Y	Y	N	Y	Y	Y	N	Y		Y	Y		Y	Y	Y		Y	N		Y
18 December	Y	N	Y	Y	Y	Y	Y	N		Y	Y		Y	Y	Y		Y	N		Y
2019																				
29 January	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y	Y		Y	N		Y
26 February	Y	Y	Y	Y	Y	N	Y	Y		Y	Y		Y	Y	Y		Y	N		Y
26 March	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y	Y		Y	N		Y
Attendance	13/13	11/13	11/13	12/13	12/13	11/13	12/13	11/13		12/13	13/13	2/8	7/8	6/7	10/13	6/7	13/13	3/13	1/1	6/6

Directors' Register of Interests

The Directors' Register of Interests is available to view on the Trust's website (http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Our_Board_of_Directors/) or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec,
Company Secretary,
General Management Department Level D,
The Rotherham NHS Foundation Trust
Moorgate Road,
Rotherham, S60 2UD

The contact details above may also be used by Members who wish to communicate with Directors.

Register of Staff Interests including those of members of the Board of Directors

In accordance with NHS England's Conflicts of Interest guidance the Trust also maintains a register of the interests declared by colleagues who are not members of the Board of Directors. This register is updated on a six monthly basis and is located on the Trust's website: (http://www.therotherhamft.nhs.uk/key_documents/)

Committees of the Board

The Board of Directors has the following statutory Committees of the Board:

- Audit Committee
- Nominations Committee
- Remuneration Committee

The Terms of Reference of each of these committees can be found on the Trust's website: (http://www.therotherhamft.nhs.uk/key_documents/)

For details regarding the work of the Remuneration Committee during 2018/19 please see the Remuneration Report section of this Annual Report.

Audit Committee

The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA) and the Department of Health.

The Committee was chaired throughout the year by Joe Barnes, a Non-Executive Director with relevant financial experience. David Hannah and Barry Mellor also served as members of the Committee. All three

of the Non-Executive Director members of the Audit Committee are considered to be independent. The Trust's Chairman is neither the Chair nor a member of the Audit Committee. The Director of Finance and Company Secretary attend every meeting, and in addition, other Executive or Operational Directors attend meetings as required. Since January 2014 two members of the Council of Governors have been invited as observers to the Audit Committee.

Attendance at Audit Committee Meetings 2018/19

Audit Committee	Joe Barnes (Chair)	David Hannah	Barry Mellor
2018			
20 April	Y	Y	Y
23 May	Y	Y	Y
17 August	Y	Y	Y
16 November	Y	Y	Y
12 December	Y	Y	N
2019			
13 February	Y	Y	Y
Attendance	6/6	6/6	5/6

The following areas were the significant issues considered by the Audit Committee during 2018/19:
- Annual Governance Statement 2017/18
- Annual Report and Accounts 2017/18
- Quality Account and Report 2017/18
- Head of Internal Audit Opinion 2017/18
- External Audit ISA 260 review 2017/18
- Draft Internal Audit annual work plan 2019/20
- Counter Fraud annual work plan 2018/19 and risk assessment for 2018/19
- External Audit annual work plan 2018/19
- Board Assurance Framework 2018/19
- Trust's Risk Register (scores of 16 and above to April 2018 and 15 and above from August 2018)
- Annual Review of Standards of Business Conduct
- Annual Report of the Audit Committee
- Annual review of governance arrangements for any additional audit work undertaken by the External Auditors
- Freedom to Speak up Guardian Annual Update
- Changes to Accounting Policies 2018/19

Exceptional items considered were:
- Use of Resources Trust self-assessment
- General Data Protection Regulations
- Complaints, serious incidents and disseminating learning
- Procurement process for Internal Audit Services
- Publication scheme over £25,000 reporting requirement
- External Auditor's contract

Review of:
- Internal Auditor effectiveness
- External Auditor effectiveness
- SFIs and Scheme of Delegation
- Standing Orders
- Matters Reserved to the Board of Directors
- Counter Fraud Policy

The significant risks identified in the External Auditor's (PwC) audit plan for 2018/19 were:
- Risk of fraud in revenue recognition
- Risk of fraud in expenditure recognition
- Risk of management override of controls
- Financial sustainability

During 2018/19 through its regular agenda items the Audit Committee has critically assessed and reviewed the judgments that have been applied in relation to the significant risks identified by the External Auditor as well as the Trust's compliance with the relevant accounting standards.

Internal Auditors
The Trust's risk management and internal control processes have continued to be evaluated during 2018/19 by TIAA, the Trust's Internal Auditors. The recommendations from internal audits are used to continually improve the effectiveness of these processes.

External Auditors
During 2018/19 PricewaterhouseCoopers LLP (PwC) continued as the Trust's External Auditor. This contract began on 1 October 2016 and will end on 30 September 2019 (it is a three-year contract with the option to extend for one year plus one year). The total value of the contract for three years is £187,320 (£62,440 p.a.).

The annual review of the effectiveness of the External Audit function was undertaken in August 2018 and concluded that the provision of the External Audit service was sufficient in supporting the Committee in fulfilling its role

At the February 2019 Audit Committee meeting the Committee supported a recommendation to the Council of Governors at their April 2019 meeting, via the Trust Chairman, that a further contract term be offered to PWC. The Council of Governors approved the extension of PwC's contract for a period of one year from October 2019.

The Terms of Reference of the Audit Committee were approved by the Board in November 2018.

Nominations Committee
The Trust has two Nominations Committees. Responsibility for the appointment of Executive Directors lies with the Board of Directors' Nominations Committee. Responsibility for the appointment of Non-Executive Directors lies with the Council of Governors' Nominations Committee. The Trust's Chairman chairs both of the Nomination Committees.

Executive Director Appointments

The Nominations Committee identifies suitable candidates to fill Executive Director vacancies as they arise. The Committee makes recommendations to the Chairman, the other Non-Executive Directors and the Chief Executive (except in the case of the appointment of a Chief Executive).

Before recommending a candidate for appointment, the Committee considers the balance of qualifications, skills, diversity, knowledge and experience required on the Board of Directors as a whole. The Nominations Committee annually reviews the size, composition and structure of the Board of Directors to ensure it remains appropriate to deliver its statutory responsibilities.

Attendance at Nominations Committee (Executive Director appointments) 2018/19

Nominations Committee	Martin Havenhand (Chair)	Mark Edgell	Lynn Hagger (Vice Chair)	David Hannah	Louise Barnett
2018					
13 April	Y	Y	Y	Y	N
19 July	Y	Y	Y	N	Y
30 July	Y	Y	Y	Y	Y
14 September	Y	Y	Y	Y	Y
27 November	Y	Y	Y	Y	Y
14 December	Y	Y	Y	Y	Y
2019					
08 March	Y	Y	Y	Y	Y
Attendance	7/7	7/7	7/7	6/7	6/7

During 2018/19 Martin Havenhand continued as Chair of the Nominations Committee, Lynn Hagger was Vice-Chair, David Hannah and Mark Edgell continued as members.

Performance Appraisal Processes

The performance appraisal of the Chief Executive is undertaken by the Chairman and the performance appraisals of the Executive Directors are undertaken by the Chief Executive.

The recruitment process undertaken to appoint a new Chief Nurse during 2018/19 was as follows:

- Meeting of the Nominations Committee to discuss the requirements for the post and timelines;
- Applications invited by external search agency;
- Shortlisting took place, with approval for shortlisted applicants by Nominations Committee members;
- A comprehensive selection process took place on 23 November 2018 which resulted in the appointment of Angela Wood as the new Chief Nurse with effect from 01 February 2019.

Following the absence of the Director of Workforce, the Deputy Director of Human Resources, Paul Ferrie, was offered and agreed to fulfil the Executive Director role from 09 July 2018.

The recruitment process to appoint a substantive Joint Director of Workforce between the Trust and Barnsley Hospital NHS Foundation Trust was as follows:

- Meeting of the Nominations Committee to discuss the requirements for the post and timelines;
- Applications invited by external search agency;
- Shortlisting took place, with approval for shortlisted applicants by Nominations Committee members;
- A comprehensive selection process took place on 10 December 2018 which resulted in the appointment of Steve Ned as the new Joint Director of Workforce with effect from 01 April 2019.

Following the absence of the substantive Medical Director, a secondment arrangement was agreed between the Trust and North West Anglia NHS Foundation Trust for Dr Callum Gardner to undertake the interim Medical Director position from 03 September 2018.

Non-Executive Directors Appointments

The Governor Nomination Committee has responsibility for giving assurance that the independence, skill, diversity and experience of

each of the Non-Executive Directors, which includes the Chairman, reflects the needs of the Trust through the composition of the Board of Directors to achieve the Trust's objectives and safeguard the quality of care provided.

The Committee makes recommendations as appropriate to the Council of Governors with regard to the outcome of the meetings, with the minutes also routinely being provided to all Council members.

The Committee met on three occasions during 2018/19.

In April 2018 the Committee made recommendations to the Council of Governors following the annual review of the remuneration, allowances and other terms and conditions of office of the Chairman and other Non-Executive Directors. This resulted in the Council of Governors approving the Committee's recommendation that there would be no increase in Non-Executive Director remuneration in 2018/19.

The Chair and Non-Executive Directors' annual appraisal and objective setting process was undertaken in quarter one 2018/19.

The performance appraisal for the Non-Executive Directors was undertaken by the Chairman in conjunction with the Lead Governor. The performance appraisal and objective setting for the Chairman was jointly undertaken by the Senior Independent Director and the Lead Governor.

All appraisal processes were informed by a collective view on each individual Non-Executive Director's performance provided by fellow Non-Executive Directors, the Executive Directors and members of the Council of Governors.

The Committee considered the outcome of the appraisal reviews for each Non-Executive Director, including the Chairman, with the Senior Independent Director being party to the feedback discussions in relation to the Chairman.

In February 2019 the Committee was informed that a recent externally commissioned well-led governance review had found that the Board was well-led, although equality and diversity issues should be considered when undertaking future Non-Executive Director appointments.

Additionally, the CQC report published in January 2019 highlighted issues in relation to mental health, which it considered could be improved through the appointment of a Non-Executive Director with experience in this field. Such an appointment should provide the necessary Board challenge in this specific area.

Consequently, the Committee decided that recruitment would be undertaken during March 2019 for a Non-Executive Director with mental health experience. The individual would replace an existing Non-Executive Director whose term of office concluded at the end of March 2019.

Recruitment was undertaken via NHS Jobs and NHS Improvement, with the recommendation from the appointments panel and the Governors' Nomination Committee, considered at the April 2019 Council of Governors meeting. The Council of Governors approved the appointment of the candidate proposed by the Governors' Nomination Committee, for an initial one-year term of office commencing on 01 April 2019.

The Committee's terms of reference received their annual review in February 2019 and were approved by Council of Governors at their April 2019 meeting.

Non-statutory Committees of the Board 2018/19

Quality Assurance Committee
Finance & Performance Committee
Strategic Workforce Committee
Strategy & Transformation Committee

The annual revision of the Terms of Reference of the Non-Statutory Board Committees were approved by the Board of Directors in May 2018.

In the autumn of 2018 feedback from Board committee members on the effectiveness of all of the Board Committees was sought ahead of a formal review of each committee's effectiveness. In addition, the effectiveness of all Committees of the Board was assessed by an external well-led review commissioned by the Trust and by the CQC as part of its 2018 inspection of the organisation.

One of the outcomes of the externally facilitated well-led review was a recommendation that the Trust's Board Committee structure should be reviewed. The review drew attention to lengthy agendas and some repetition between meetings. It was recommended that the purpose and remit of these meetings should be revisited, and consideration of the time taken to service the Committees should be taken into account.

As a result, it was agreed that the non-statutory board assurance committees for the new financial year should be: Finance and Performance Committee; Quality Assurance Committee and Strategy and Business Planning Committee.

Council of Governors

The Council of Governors is responsible for making decisions regarding the appointment or removal of the Chairman, the Non-Executive Directors and the Trust's auditors; and the terms and conditions of office of the Non-Executive Directors in addition to approving the appointment of the Chief Executive. The Council of Governors is also consulted by the Board of Directors and its views taken into consideration when formulating the Trust's forward plans.

The Council also considers the Trust's annual accounts and the External Auditor's report on them as well as representing the interests of members and partnership organisations in the governance of the Trust, regularly feeding back information about the Trust to the constituency it represents.

Other statutory duties of the Council of Governors include providing their views to the Board of Directors on the Trust's strategy, to respond to the Board of Directors when consulted and to undertake functions as requested by the Board of Directors, and to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

Should any disagreements between the Board of Directors and the Council of Governors arise the manner in which these will be resolved is described in Annex 6 of the Trust's Constitution which is available on the Trust's internet site.

The Council of Governors comprises 16 elected Public Governors, 5 elected Staff Governors and 7 appointed Partner Governors.

During 2018/19 the members of the Council of Governors were:

Constituency	Name	Term of Office
Public Governors (elected):		
Wentworth North (Covering the electoral wards of Hoober, Swinton, Wath)	Mr Matthew Ukpe	01.06.2018 to 31.05.2021 Resigned 03.06.2018
	Vacancy (x2)	01.06.2017 to 31.05.2018
	Vacancy (x1)	01.06.2018 to 31.05.2019
	Vacancy (x1)	03.06.2018 to 31.05.2019
Wentworth South (Covering the electoral wards of Rawmarsh, Silverwood, Valley)	Lt Col Robert McPherson	01.06.2017 to 31.05.2020
	Mr Leslie Hayhurst	Re-elected 01.06.2017 to 31.05.2020 Stood down 22.03.2019 due to moving outside constituency
Wentworth Valley (Covering the electoral wards of Hellaby, Maltby, Wickersley)	Vacancy (x1)	01.06.2017 to 31.05.2018
	Mr (Richard Arthur) John Turner	01.06.2018 to 31.05.2021 Resigned 17.07.2018
	Vacancy (x1)	17.07.2018 to 31.05.2019
	Mr Graham Barry Jenkinson	Re-elected 01.06.2017 to 31.05.2020
Rotherham South (Covering the electoral wards of Boston Castle, Rotherham East, Sitwell)	Dr Beverly Bennett	01.06.2016 to 31.05.2019
	Mrs Jo Brookes	01.06.2016 to 31.05.2019
Rotherham North (Covering the electoral wards of Keppel, Rotherham West, Wingfield)	Mrs Valerie Lindsay	01.06.2016 to 31.05.2019
	Vacancy (x1)	01.06.2017 to 31.05.2018 01.06.2018 to 31.05.2019
Rother Valley South (Covering the electoral wards of Anston & Woodsetts, Dinnington, Wales)	Mrs Judy Dalton	01.06.2017 to 31.05.2020
	Mr Gavin Rimmer **(Interim Lead Governor from 01.06.2018. Lead Governor** from 18.07.2018)	Re-elected 01.06.2017 to 31.05.2020
Rother Valley West (Covering the electoral wards of Brinsworth & Catcliffe, Holderness, Rother Vale)	Mr Dennis Wray (**Lead Governor** until 31.05.2018)	Re-elected 01.06.2017 to 31.05.2018 (one year)
	Mrs Hilda Littlewood	01.06.2017 to 31.05.2020
	Mr Dennis Moore	01.06.2018 to 31.05.2018
Rest of England (Covering those who live outside the borough)	Ms Jan Frith	01.06.2015 to 31.05.2018
	Vacancy (x1)	09.10.2017 to 31.05.2018
	Dr Stephen Hudson	01.06.2018 to 31.05.2021
	Vacancy (x1)	01.06.2018 to 31.05.2019

Constituency	Name	Term of Office
Staff Governors (elected):		
Staff Governors from March 2018 until September 2018:		
Professional Nurses and Midwives	Vacancy (x1)	01.04.2017 to 11.01.2018
	Mrs June Lovett	Co-opted 11.01.2018 to 31.05.2018 Elected 01.06.2018 to 31.05.2021
Other Health Professionals	Mrs Catherine Ripley	01.06.2016 to 31.05.2019
Medical and Dental	Vacancy (x1)	01.06.2018 to 31.06.2019
Other Directly Employed Staff	Mrs Sandra Lewis	01.06.2016 to 31.05.2019 Left organisation 27.07.2018
Support Staff to Health Professionals	Vacancy (x1)	01.06.2017 to 31.05.2018 01.06.2018 to 31.05.2019
Staff Governors from October 2018 to March 2019: [11]		
Staff Governors	Mrs June Lovett	01.06.2018 to 31.05.2021
Staff Governors	Mrs Catherine Ripley	01.06.2016 to 31.05.2019
Staff Governors	Mrs Tina Senior	Co-opted 15.01.2019 to 31.05.2019 Left organisation 22.03.2019
Staff Governors	Mrs Anne Rolfe	Co-opted 15.01.2019 to 31.05.2019
Staff Governors	Vacancy (x1)	01.06.2017 to 31.05.2018 01.06.2018 to 31.05.2019
Partner Governor Organisations (nominated/appointed):		
Sheffield Hallam University	Dr Christopher Low	01.08.2015 to 31.07.2018 Reappointed 01.08.2018 to 31.07.2021
Sheffield University	Prof Arshad Majid	14.11.2016 to 13.11.2019 Resigned 04.01.2019
	Vacancy (x1)	05.01.2019 to 31.03.2019
Rotherham Partnership	Mrs Carole Haywood	01.09.2016 to 31.08.2019 Left partner organisation 27.09.2018
	Vacancy (x1)	27.09.2018 to 31.03.2019
Voluntary Action Rotherham	Mrs Jean Flanagan	01.09.2017 to 31.08.2020
Rotherham Metropolitan Borough Council	Cllr Patricia Jarvis	06.02.2017 to 05.02.2020
Barnsley and Rotherham Chamber of Commerce	Vacancy (x1)	21.08.2017 to 31.05.2018 01.06.2018 to 31.05.2018
Rotherham Ethnic Minority Alliance	Vacancy (x1)	01.04.2017 to 31.05.2018 01.04.2018 to 11.02.2019
	Shakoor Adalat	12.02.2019 to 11.02.2022

[11]The Trust's Constitution was revised in October 2018 (approved by Board of Directors and Council of Governors) and changed the categories of Staff Governors from 5 classes to 1 class

All Governors, both elected and appointed, hold office for a term of three years. They are eligible for re-election or re-appointment at the end of that period and serve a maximum of three terms (nine years in total). The Trust Constitution outlines that a Governor is eligible to continue in the role subject to annual re-election up to a maximum of 12 years.

All elections for Public and Staff Governor positions are conducted through an independent electoral services provider, in accordance with the requirements of the Trust's Constitution.

In October 2018 the Trust's Constitution was revised and approved by the Council of Governors. The main change related to the composition of the Staff Governor and Staff Member classes.

Whilst the same number of Staff Governors was retained (5 in total), the revised Constitution meant that they were drawn from only one overall staff constituency, rather than the previous five staff constituencies[12]. Consequently, staff Members also became Members of one overall staff constituency rather than the previous five staff constituencies meaning that going forwards all staff Members would be eligible to vote for all of the five Staff Governors.

There were four scheduled meetings of the Council of Governors during 2018/19 with attendance as detailed left.

Attendance 2018/19

Council of Governors meeting	Number of meetings held during tenure	Number of meetings attended
Mr Shakoor Adalat	0	0
Dr Beverly Bennett	4	2
Mrs Jo Brookes	4	4
Mrs Judy Dalton	4	4
Mrs Jean Flanagan	4	3
Miss Jan Frith	1	1
Mr Leslie Hayhurst	4	1
Mrs Carole Haywood	2	0
Dr Stephen Hudson	3	2
Cllr Patricia Jarvis	4	2
Mr Graham Barry Jenkinson	4	3
Mrs Sandra Lewis	2	2
Mrs Valerie Lindsay	4	2
Mrs Hilda Littlewood	4	3
Mrs June Lovett	4	3
Dr Christopher Low	4	1
Lt Col Robert McPherson	4	3
Prof Arshad Majid	3	0
Mr Dennis Moore	3	2
Mr Gavin Rimmer	4	3
Mrs Catherine Ripley	4	4
Mrs Anne Rolfe	1	1
Mrs Tina Senior	1	0
Mr Dennis Wray	1	1

[12] The previous staff constituencies were: Professional Nurses & Midwives; Other Health Professionals; Medical & Dental; Other Directly Employed Staff and Support Staff to Health Professionals.

It is important that members of the Board of Directors (particularly the Non-Executive Directors) develop an understanding of the views of Governors and Members about the Trust. In order to achieve this, both Executive and Non-Executive Directors have attended Council of Governors' meetings, Governors' Forum sessions and Governor development sessions throughout the year. In addition, the Governors have invited both Executive and Non-Executive Directors to attend their quarterly Council of Governors meetings where their input is required in relation to the agenda.

Executive and Non-Executive Director attendance during 2018/19 was as follows:

Current Non-Executive Director	No. of meetings attended
Martin Havenhand	4
Gabrielle Atmarow	3
Joe Barnes	3
Heather Craven	4
Mark Edgell	4
Lynn Hagger	3
David Hannah	3
Barry Mellor	3
Current Executive Director	**No. of meetings attended**
Louise Barnett	2
George Briggs	1
Callum Gardner	2
Chris Holt	1
Simon Sheppard	3
Conrad Wareham	1
Angela Wood	2
Previous Executive Director	**No. of meetings attended**
Cheryl Clements	0
Chris Morley	1

All Governors are required to comply with the Trust's Code of Conduct and Constitution and declare any interests that may result in a conflict of interest in their role as Governors. At each meeting of the Council of Governors a standing agenda item also requires all Governors to make known any interest in relation to the agenda and any changes to their declared interests. An annual review is also undertaken of the Governors' register of interests.

The register of Governor's interests is available to view on the Trust's website (www.therotherhamft.nhs.uk) or by requesting a copy from the Company Secretary.

Ms Anna Milanec, Director of Corporate Affairs/Company Secretary
General Management Department
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

Members who wish to communicate with the Governors can do so by sending an email to rgh-tr.public.governors@nhs.net. Alternatively, they may write to the Governor at the following address:

Name of Governor
C/O Ms Anna Milanec, Director of Corporate Affairs/Company Secretary
General Management Department
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

The Foundation Trust Membership

At the end of 2018/19 there were over 16,038 Members of The Rotherham NHS Foundation Trust (TRFT), which includes public and staff members.

The Trust has two membership constituencies:

A 'public constituency'
A 'staff constituency[13]'

To become a public Member, the individual must be at least 16 years of age and live within the Trust's constituency area (consisting of seven local electoral wards and Rest of England constituency), not be a Member of the staff constituency and have made an application for membership to the Trust.

To become a staff Member, the person must be at least 16 years of age, be employed by the Trust with a permanent contract or have worked at the hospital for at least 12 months and have opted in to Trust Membership[14].

Boundaries for public membership

Rotherham South (Boston castle, Rotherham East & Sitwell)
Rotherham North (Kepple, Rotherham West, Wingfield)
Wentworth South (Rawmarsh, Silverwood, Valley)
Wentworth North (Hoober, Swinton, Wath)
Wentworth Valley (Hellaby, Maltby, Wickersley)
Rother Valley West (Brinsworth, Catcliffe, Holderness, Rother Vale)
Rother Valley South (Anston and Woodsetts, Dinnington, Wales)
Rest of England (covers all areas not within RMBC boundaries)

The Rotherham NHS Foundation Trust constituency boundaries reflect the Rotherham Metropolitan Borough Council (RMBC) area assembly boundaries.

Membership composition as at 12 February 2019

Public	
Rotherham South	1,971
Rotherham North	1,482
Wentworth South	1,634
Wentworth North	1,168
Wentworth Valley	1,661
Rother Valley West	1,280
Rother Valley South	1,015
Rest of England	1,522
Out of trust area	0
Total	11,733
Staff	
Staff Class	4,305
Total	4,305
Total membership	16,038

[13]In October 2018 the Trust's Constitution was revised, with a decision taken to change the Staff Constituency to be one staff class.
[14]From April 2018 colleagues had to opt-in to become a member of the Foundation Trust.

Public Members are able to contact their local Governor by sending an e-mail to: rgh-tr.public.governors@nhs.net indicating the name of the Governor they wish to contact in the subject line of the e-mail.

In a similar manner, staff Members are able to contact their Governor by sending an e-mail to: rgh-tr.staffgovernors@nhs.net also including the name of the Governor in the subject line of the e-mail.

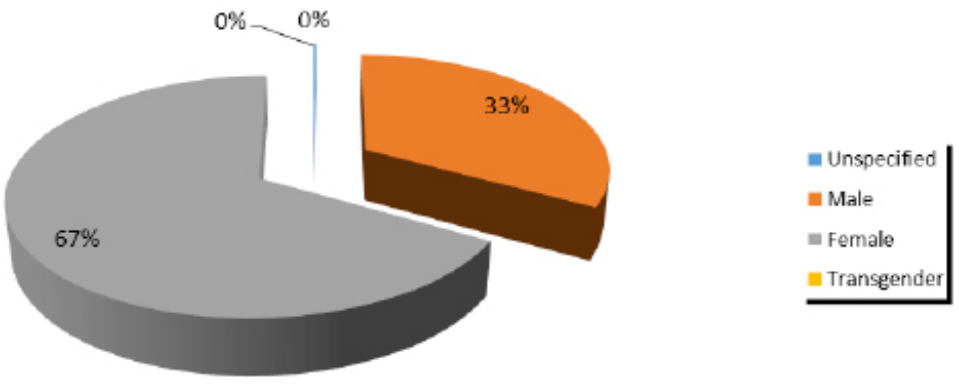
Public Members are able to contact the Trust's Directors through a variety of mechanisms: via the public Board of Directors meetings or the public Council of Governors meetings; via their Governor; via the Trust's your.experience@nhs.net e-mail address or the Trust's switchboard.

The Trust values the continued support and engagement of its Membership and recognises the importance of a Membership that is representative of all the communities it serves. The Trust strives to ensure that its Membership is as representative of the population it serves as possible.

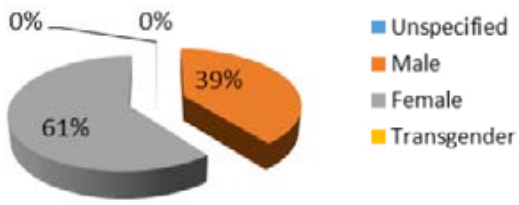
As at 12 February 2019 the Trust's membership was composed as follows:

Membership Breakdown	Public	Staff	Total
Ethnicity Breakdown below	11,733	4,305	16,038
White - English, Welsh, Scottish, Northern Irish, British	4,054	3,029	7,074
White - Irish	16	10	26
White - Gypsy or Irish Traveller	0	0	0
White - Other	14	31	45
Mixed - White and Black Caribbean	2	5	7
Mixed - White and Black African	1	3	4
Mixed - White and Asian	1	10	11
Mixed - Other Mixed	8	5	13
Asian or Asian British - Indian	34	56	90
Asian or Asian British - Pakistani	169	29	198
Asian or Asian British - Bangladeshi	3	2	5
Asian or Asian British - Chinese	6	8	14
Asian or Asian British - Other Asian	20	19	39
Black or Black British – African	23	23	46
Black or Black British - Caribbean	5	8	13
Black or Black British - Other Black	13	5	18
Other Ethnic Group – Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	68	29	97
Not stated	7,296	1,042	8,338

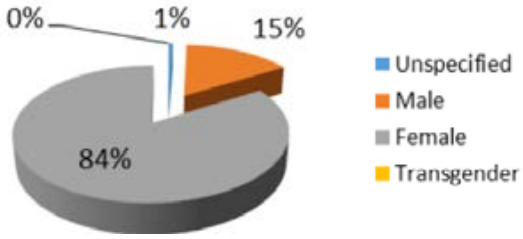
Total Membership Gender chart



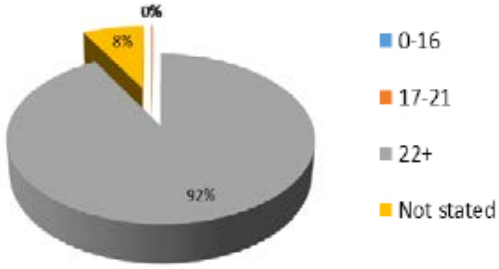
Public Membership Gender chart



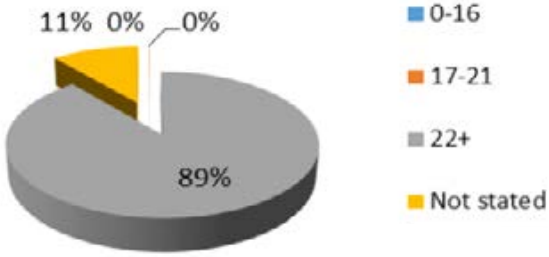
Staff Membership Gender chart



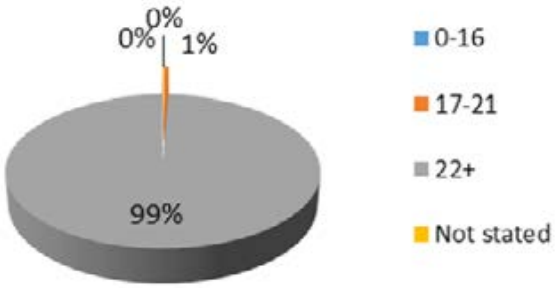
Total Membership Age Chart



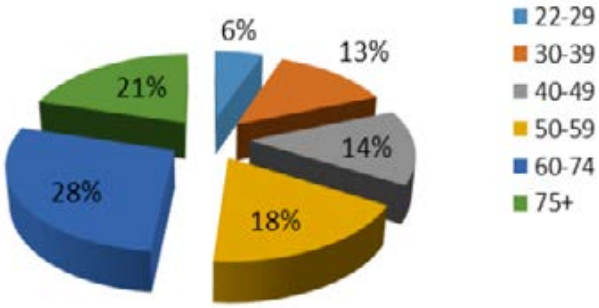
Public Membership Age Chart



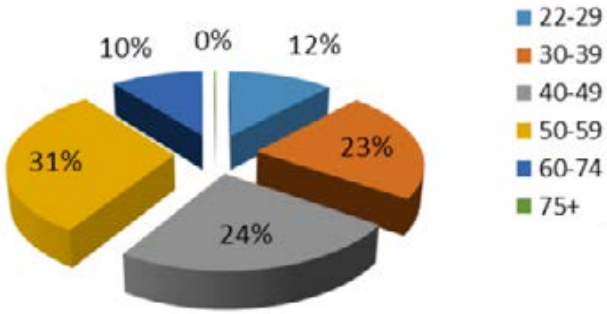
Staff Membership Age Chart



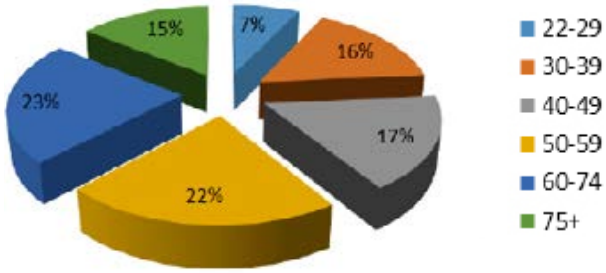
Public Membership Age 22+chart



Staff Membership Age 22+ chart



Total Membership Age 22+ chart



Continuing from last year, the Membership strategy has been to shift the focus from improving the visibility of Membership to building on the service offered to Members through more accessible engagement; and to continuing to raise the profile of the Trust and its Membership base within the local community.

The Communications Team continue to provide a quarterly e-newsletter for Members, which provides an opportunity to share more timely information and keep Members up to date with Trust news and events throughout the year.

The annual edition of 'Your Choice' continues to be the traditional method of communication with the entire Membership base. Produced in February or March each year it provides information on a variety of topics such as service developments, Proud Awards for staff, and the Rotherham Hospital and Community Charity. Its publication is timed to showcase the role of the Governor and announce the forthcoming annual Council of Governors' Elections. Members are encouraged to stand as prospective Governors and to vote in the Governor elections.

Quarterly 'Governors' Surgeries' continued to be held during the year at the hospital as well as in community locations. They provide an opportunity for Members and the general public to speak with the Governors, giving their views on services and asking questions of the Governors. The feedback from these sessions is seen by the senior management within the Trust to ensure opportunities for quality improvements in patient care and experience are acted upon.

Disclosures as set out in the NHS Foundation Trust Code of Governance

The Rotherham NHS Foundation Trust has applied the principles of the *NHS Foundation Trust Code of Governance* on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Disclosures:

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Partly compliant: A statement describing how any disagreements between the Council of Governors and Board of Directors would be resolved, appears in annex 3 of the Trust's Constitution. Summary statements included in the Accountability Report.
2: Disclose	Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Compliant. Summary of Schedule included in Accountability Report
2: Disclose	Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration[15] committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 7.25 as part of the directors' report.	Compliant. Included in the Annual Report as follows: Director's Report, Remuneration Report and Governance & Organisational Structure section (Board of Directors, Audit Committee, Nominations Committee)
2: Disclose	Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Compliant. Included in Governance & Organisational Structure section (Council of Governors Section)
Additional requirement of FT ARM	Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Compliant. Included in Governance & Organisational Structure section (Council of Governors Section)
2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Compliant. Included in the Governance & Organisational Structure section (Composition of the Board of Directors section)

[15] This requirement is also contained in paragraph 7.45 as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Compliant. Included in the Governance & Organisational Structure section (Composition of the Board of Directors and Meet the Board of Directors sections)
Additional requirement of FT ARM	Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Compliant. Included in the Director's report (Meet the Board of Directors section)
2: Disclose	Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Compliant. Included in Governance & Organisational Structure section (Nominations Committee section)
Additional requirement of FT ARM	Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Compliant. Included in Governance & Organisational Structure section (Nominations Committee section)
2: Disclose	Chair / Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Compliant. Included in the Governance & Organisational Structure section (Board of Directors section in the Chairman's biography)
2: Disclose	Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Compliant. The Governors canvassed the opinion of members and the public on the Trust's Operational Plan for 2019/20 including its objectives, priorities and strategy via the Council of Governors meeting in January 2019 and their Forum meeting in February 2019. Their views have been communicated to the Board of Directors.
Additional requirement of FT ARM	Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Compliant. During 2018/19 the Governors have not have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance. This is because the Directors regularly attend the quarterly Council of Governors meetings.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Compliant. Included in Governance & Organisational Structure section (Nominations Committee) for Board members' evaluation. Also in 'Non-statutory Committees of the Board of Directors' section for committee evaluation. At the end of each Board meeting one of the Executive or Non-Executive Directors feeds back their evaluation of the meeting.
2: Disclose	Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Compliant. In 'Non-statutory Committees of the Board of Directors' section. During 2018/19 an external well-led review was commissioned by the Trust and undertaken by The Governance Forum / RSM. The Governance Forum also facilitated the Board Development programme during 2018/19. NHS Improvement undertook a 'Use of Resources' review and the Care Quality Commission undertook a well-led review during 2018/19. CQC and NHSI are both regulators of the Trust.
2: Disclose	Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 7.92.	Compliant. Included in the Directors' report and Annual Governance Statement section
2: Disclose	Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Compliant. Included in the Annual Governance Statement section
2: Disclose	Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Compliant. Included in Governance & Organisational Structure section (Audit Committee section)
2: Disclose	Audit Committee / Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Compliant. • Included in Governance & Organisational Structure section (Audit Committee section) • Included in Governance & Organisational Structure section (Audit Committee section) • Not applicable: no non-audit services were provided by PwC during 2018/19.
2: Disclose	Board / Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Compliant. None of the Trust's Executive Directors were released, for example to serve as a Non-Executive Director elsewhere, during 2018/19
2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Website: Compliant. Annual Report: Compliant, included in Governance & Organisational Structure section (Council of Governors section, FT membership section and Board of Directors section)
2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Compliant. Included in Governance & Organisational Structure section (Council of Governors section)
2: Disclose	Board / Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Compliant. Included in FT Membership section of Governance & Organisational Structure section.
Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Compliant. Included in FT Membership section of Governance & Organisational Structure section

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
Additional requirement of FT ARM (based on FReM requirement)	Board / Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph as directors' report requirement.	Compliant. Included in Governance & Organisational Structure section: • Board of Directors section • At end of Council of Governors section.
6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery	Compliant.
6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	Compliant.
6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.	Compliant.
6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions.	Compliant.
6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life	Compliant.
6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	Compliant.
6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Compliant
6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	Compliant.
6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.	Compliant.
6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.	Compliant
6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Compliant.
6: Comply or explain	Council of Governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.	Compliant.
6: Comply or explain	Council of Governors	A.5.2	The council of governors should not be so large as to be unwieldy.	Compliant.
6: Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.	Compliant.
6: Comply or explain	Council of Governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	Compliant.
6: Comply or explain	Council of Governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Compliant.
6: Comply or explain	Council of Governors	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.	Compliant.
6: Comply or explain	Council of Governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Compliant.
6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	Compliant.
6: Comply or explain	Board / Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	Compliant.
6: Comply or explain	Board / Council of Governors	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).	Compliant.
6: Comply or explain	Nomination Committee(s)/ CoG	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	Compliant.
6: Comply or explain	Council of Governors	B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	Compliant.
6: Comply or explain	Council of Governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	Compliant.
6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Board / Council of Governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	Compliant.
6: Comply or explain	Board	B.5.2	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis	Compliant.
6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Compliant.
6: Comply or explain	Board / Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Compliant.
6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.	Compliant
6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	Compliant.
6: Comply or explain	Chair / Council of Governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	Compliant. Survey undertaken in October 2018. Results presented to April 2019 Council of Governors meeting.
6: Comply or explain	Council of Governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Compliant.
6: Comply or explain	Board / Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Compliant.
6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 7.15.	Compliant.
6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Board	C.1.4	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	Compliant
6: Comply or explain	Board / Audit Committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Compliant.
6: Comply or explain	Council of Governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Compliant.
6: Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Compliant.
6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Compliant.
6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Compliant.
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Compliant.
6: Comply or explain	Council of Governors / Remuneration Committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Compliant. The Council of Governors did not consult external professional advisors to market test the remuneration levels of the Chairman and/or other Non-Executive Directors in year. However a review of other NHS Trusts' Non-Executive Director pay was undertaken and informed the Governors' decision on Non-Executive Director pay for 2018/19.
6: Comply or explain	Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Compliant.
6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	Compliant.
6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	Compliant.
6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	Compliant.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Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence..

Segmentation

The Rotherham NHS Foundation Trust is in segment 3. This means that the Trust has been in receipt of mandated support from NHS Improvement.

This segmentation information is the Trust's position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

During 2018/19, the breaches against the Trust's Provider Licence remained in place. These breaches resulted from Enforcement Action taken against the Trust by Monitor in April 2013. The Trust was required to take specific actions, pursuant to section 106 of the Health and Social Care Act 2012, relating to financial planning, governance breaches, and breaches relating to the Electronic Patient Record (EPR) system.

In 2014/15 two of the breaches (those relating to governance and the EPR system) were lifted because NHS Improvement (then Monitor) considered that the Trust had taken all of the actions required of it.

The Trust also made progress in relation to the outstanding financial and strategic planning breaches in terms of the Trust evidencing its compliance with the required actions. The Trust has not yet formally submitted this evidence to the regulator because of the extensive changes that have taken place across the NHS since the requirements were enforced and due to its financial position.

Consequently, the following breaches against the Trust's Licence remained in place throughout 2018/19: Licence conditions FT4(5)(a), FT4(5)(b), FT4(5)(d), FT4(5)(e), FT4(5)(f), FT4(5)(g) and CoS3(1).

The Trust's allocation of a segment 3 rating by NHS Improvement in October 2016, reflected the Trust's regulatory position at that time. Further details are provided in the Annual Governance Statement section of this Annual Report in the 'Future Risks' section.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score.

Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust might not be the same as the overall finance score here.

Area	Metric	2018/19 Scores				2017/18 Scores	
		Q1	Q2	Q3	Q4	Q4	Q3
Financial Sustainability	Capital service capacity	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4
Financial Efficiency	I&E margin	4	4	4	4	4	4
Financial Controls	Distance from financial plan	1	1	1	1	4	4
	Agency spend	3	3	3	3	2	2
Overall Scoring		3	3	3	3	4	4

Accountability Report signed by the Chief Executive in her role as Accounting Officer:

Louise Barnett
Chief Executive
22 May 2019

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of The Rotherham NHS Foundation Trust.

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Rotherham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Rotherham NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Signed:

Louise Barnett
Chief Executive
22 May 2019

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The Trust's Standing Orders and Scheme of Delegation outline the accountability arrangements and scope of the responsibility of the Board of Directors, executive directors and the organisation's officers.

The unitary Board has been fully involved in developing and agreeing the strategic priorities of the Trust, with the key priorities set out in the Trust's Annual Plan and Objectives. The Council of Governors receives regular performance reports

The Board receives regular minutes and reports from each of the board committees. The terms of reference of the committees of the Board have been reviewed to ensure that governance arrangements continue to be fit for purpose

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Rotherham NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Rotherham NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risks which may lead to failure of objectives and the organisational strategy. It is based on an on-going process of identifying and prioritising the risks to the achievement of the Trust's strategy and operational plan, and evaluating the potential for those risks to be realised and the impact that they might have, whilst ensuring that they are managed effectively, economically and efficiently.

The Board of Directors is responsible for ensuring sound risk management systems are in place throughout the organisation, and is supported by a number of committees which oversee the effectiveness of risk management, internal control and assurance arrangements.

Overall, I have the responsibility, as Chief Executive and Accounting Officer, for the management of risk in the organisation.

Each member of the executive team has an area of responsibility for risk management, in accordance with their portfolios, which supports me in my role as Accounting Officer.

The Director of Finance oversees the adoption and operation of the Trust's standing financial instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud. The Director of Finance attends the Trust's Audit Committee but is not a member, and liaises with internal and external audit, who undertake programmes of audit with a risk based approach.

The Chief Nurse is the executive lead with responsibility for the development, management and implementation of the Trust's Quality Improvement Strategy, Risk Management Strategy and risk management framework, and with the Medical Director, is responsible for overseeing clinical risk and the management of risk in relation to the quality of care. The Chief Nurse is also accountable for ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) Registration legal requirements. The Chief Nurse is the professional lead for nursing, midwifery and Allied Health Professionals, and the executive lead, and member, of the Board's Quality Assurance Committee. She is also the Director of Infection Prevention and Control (DIPC).

The Medical Director supports the Chief Nurse with the implementation and management of the Trust's Quality Improvement Strategy, and is the professional lead for medical staff. He is responsible for overseeing clinical risk and, in conjunction with the Chief Nurse, for the management of risk relating to the quality of care. He is also the Trust's Caldicott Guardian, and works closely with the Trust's Responsible Officer and Guardian of Safe Working. The Medical Director is a member of the Board's Quality Assurance Committee.

The Director of Workforce is responsible for issues relating to workforce, including recruitment and retention, workforce productivity, pay efficiencies, engagement frameworks, and health and wellbeing.

The Chief Operating Officer oversees operational performance, and is responsible for the day-to-day management of both hospital and community services. He also has responsibility for ensuring that the Trust meets national and local performance standards and objectives, and he also has the role of Accountable Emergency Officer. The Chief Operating Officer is also responsible for the running and maintenance of the estate and facilities, working with the Deputy Chief Executive to ensure that the estate is developed to support the Trust's strategy and plan.

The Board has appointed a Deputy Chief Executive, who is responsible for strategy, business planning and the Trust's performance management framework which supports delivery of the Trust's annual operational plan. The Deputy Chief Executive also ensures that the estate is developed to support the Trust strategy, and leads on the digital agenda.

Building on progress made the previous year, the Trust sought to take a more strategic approach to internal audit for 2018/19, using audit as a tool to further strengthen the system of internal controls in order to inform future priorities. The decision to move to a more strategic approach was taken in the knowledge that the Trust would be testing systems of controls that could result in 'limited assurance' ratings. However, this has been instrumental in identifying a number of actions, which seek to improve the breadth and depth of internal controls, in order to provide assurance on a wider scale of internal control, whilst being assured that fundamental controls remain robust.

The Board of Directors regularly reviews the approach to risk management, led by the Chief Nurse and ensures that all board directors are aware of their responsibilities and role in relation to risk management. Furthermore, a number of changes have been implemented during 2018/19, including the introduction and refinement of the Risk Analysis Group to better support staff within the Trust to effectively identify and mitigate risk, in addition to training which has been provided to 39 staff across the Trust.

The risk and control framework

The Trust's Board-approved risk management strategy, sets out the organisation's approach to risk, the executive and non-executive directors' responsibilities, and the framework which is in place for the management of risk throughout the organisation. Risk appetite is determined by the Board and is reviewed on a regular basis. The risk management strategy also includes details of the role of Board Committees in providing assurance that risks are being managed effectively.

The former Chief Nurse began a review of the Trust's risk management framework during Q4 2017/18, and some improvements were made during the first half of the 2018/19. Together with feedback from an external well-led review and CQC inspections since that time, the action plan for implementation of the improved risk management framework was presented to the Board of Directors in March 2019. These actions serve to further strengthen and embed effective risk management across the organisation.

Operationally, risk management is delegated through the Risk Management Committee, chaired by the Chief Nurse. This Committee provides assurance to the Board on the function of the Trust's systems of risk management, and is supported by the Risk Analysis Group and the Trust Management Committee, the latter of which I chair and which is made up of executive directors and the senior leadership team.

In addition, clinical directors, operational managers, senior nursing colleagues all have delegated responsibility for ensuring effective risk management within their own areas.

The Quality Governance, Compliance and Risk Manager reports directly to the Chief Nurse and provides additional support and expert risk management guidance to colleagues across the Trust.

The Board Assurance Framework (BAF) evidences the system of control relating to the delivery of the Trust's strategic objectives. Each strategic risk on the BAF has been allocated to one of the Executive Directors for oversight, and is formally reviewed quarterly by the relevant board assurance committee and Board of Directors. The Board assurance committees review related mitigation controls, and seek assurance that the controls are appropriate to manage any gaps.

Operational and other corporate risks with scores of 15 and above,

are also reviewed by the Board as part of its regular monitoring of risk management.

In partnership with key external stakeholders, the Trust is committed to delivering excellent care at home, in our community and in hospital. To support this aim, the Trust sets out annual quality priorities. The annual quality priorities for 2018/19 are set out in the Quality Report (page 68), together with the quality priorities for 2019/20 (page 38).

Performance against national targets and standards, compliance with CQC registration required and internal safety measures and process measures, is monitored at various levels throughout the organisation, from ward to Board. Information is presented through divisional reporting structures, with issues escalated to the Clinical Governance Committee. The Board's Quality Assurance Committee seeks assurance that safe, effective and high quality care is provided by our services, and regularly receives reports on matters such as the incidence of complaints, serious incidents, infection control, the outcome of quality impact assessments, nurse staffing figures, and other matters.

The Trust's year-end key performance indicators are confirmed in the Quality Report (page 68).

The Board approved its new Quality Improvement Strategy 2019 – 2024, in March 2019. The basis of the strategy is derived from the NHS' High Quality Care for All NHS Next Stage Review Final Report, and also reflects feedback provided from the recent CQC inspections at the Trust. Further details about the Strategy, including the Safe and Sound framework, can be found in the Quality Report (page 90).

Data security risks are managed in line with the Trust's risk management framework, and where appropriate, are recorded on the Trust's risk register.

All Trust colleagues are subject to a code of confidentiality, and access to data held on IT systems is restricted to authorised users. The Trust's IT department maintain up-to-date technical security measures to minimise the threat to Trust network resources from outside threats and inappropriate access.

Network and information system risks which may have a 'significant' impact on the continuity of essential services, are reported to the DHSC, in accordance with the Security of Network and Information Systems Regulations 2018.

Risks and issues involving information security are monitored by the Information Governance Committee (IGC) which reports to the Trust Management Committee. The Combined Clinical Health Informatics Development Group and IT Security Group report to the IGC.

The major risks faced by the Trust during 2018/19, were as follows:

Quality of care:

This relates to the failure to deliver high quality patient care, leading to poor patient experience, avoidable harm and poor clinical outcomes.

Details of the findings from the recent CQC inspections, can be found in the Quality Report (pages 54-56.) Overall the Trust continued to be rated as 'requires improvement', and was rated 'good' for responsive and caring. However, Urgent and Emergency Services were rated as 'inadequate' for the safe and well led domains, which resulted in an overall 'inadequate' rating for that service. Significant actions have been taken to drive improvements in the quality of care for our patients since the inspections and the CQC stated in their inspection report that:

"In response to our inspection and subsequent enforcement action, the executive leadership of the trust, senior leadership team and management within the department had worked together to formulate and deliver an immediate short-term solution to our concerns. They had also formulated short, medium and long-term plans to meet the requirements of our enforcement notice." [16]

Much work has been undertaken to improve the situation including recruitment of additional clinicians, consideration of new methods of working, and engaging with external agencies such as ECIST and NHS Improvement academy.

Improvements continue to be made across the organisation where required, including increased nursing and clinical capacity in a number of areas, however, significant workforce challenges remain in a number of areas.

Operational delivery:

The Trust continued to face challenges in consistently meeting the A&E four-hour access target, but also experienced days of strong performance, mainly in the first part of the year. Against the 95% target, performance at year end was 85.7% (2017/18: 84.95%) which was a slight improvement on the previous year. However, performance fell short of the national standard, with significant pressure particularly during winter.

Despite building on feedback from 2017/18 and making enhancements to the approach to winter planning, the plan failed to sufficiently forecast the level of patient acuity that we experienced, resulting in a lack of acute surge capacity, which resulted in significant pressure on the urgent and emergency care pathway within the hospital. A review of bed capacity and ward staffing levels has begun and will conclude in quarter 1 2019/20 to determine how best to optimise the bed and workforce capacity to meet demand, balancing quality, workforce, operational and financial challenges and seeking to mitigate key risks across these areas.

The Trust, during 2019/20, will be field testing the revised urgent and emergency care access standards, arising from the findings of the Powis report.[17] This approach should complement and reinforce the progress made so far, ensuring a strong focus on patient safety, clinical effectiveness and patient experience, whilst aiming to achieve efficient and effective use of resources across the urgent and emergency care pathway.

[16] Page 26 of the CQC Inspection Report, published 18 March 2019: https://www.cqc.org.uk/sites/default/files/new_reports/AAAH7460.pdf

[17] Clinically-led Review of NHS Access Standards, interim report from the NHS National Medical Director, published March 2019, NHSE publications gateway reference: 000305

Whilst the Trust achieved the 31-day treatment standard and the 62-day standard for patients referred from one of the cancer screening programmes the cancer 62-day wait for first treatment standards have been disappointing, ending the year at 81.2% (UNVALIDATED) (2017/18: 84%) against a national target of 85%. Recovery actions were taken during the year, including provision of increased support for cancer trackers, additional MRI facility, and daily scrutiny of data, resulting in the Trust achieving the standard in Q2. However, this was not sustained and further actions have been put in place to improve and sustain this position during 2019/20.

The Trust has continued to deliver the 18-week referral to treatment standard (92% and over) throughout the year. However, the Trust failed to deliver the total waiting list position.

Workforce:

Ongoing recruitment initiatives are in place for clinical, nursing and technical staff, but national and local shortages of qualified colleagues continue, and the risk of the inability to recruit and retain colleagues, is arguably the most significant risk for the Trust due to the potential impact on quality. The risk of continuity of care and performance against standards and targets, will remain high, with further actions being taken during 2019/20 to attempt to mitigate the current and future risk. In addition, the Trust continues to explore collaborative arrangements with partner organisations where this could improve the resilience and sustainability of services for the population we serve. In particular, the Trust is working actively with Barnsley NHS Foundation Trust in a number of areas and continues to participate in the development of initiatives across the ICS to improve workforce recruitment and retention in South Yorkshire and Bassetlaw.

Finances:

The Trust delivered a £19.9M income and expenditure deficit plan for 2018/19, which was £0.4M favourable to the financial plan. We also delivered the 2018/19 Cost Improvement Programme (CIP) with a year-end value of £9.8M saving (3.6% of costs), £56K ahead of the annual target, with a full year effect of just over £10.5M (figures). However, the Trust recognises the continued risk of failing to achieve financial targets in 2019/20 for both the Trust and the SYB ICS.

External Environment:

The Trust continues to support the South Yorkshire and Bassetlaw Integrated Care System and the Rotherham Integrated Care Partnership. Whilst recognising that the national legal framework has not yet been established to fully support the systems' governance structures, a revision of legislation is currently being considered by the government.

Future Risks

Potential risks that could affect the Trust achieving its objectives in 2019/20 can be summarised as:

- Standards and quality of care are not achieved, despite launching the Quality Improvement Strategy in March 2019, and Safe and Sound framework in April 2019;
- Performance against existing and / or new urgent and emergency care and other standards/targets is fragile;
- Workforce shortages and lack of colleague engagement;
- Interdependency on external partners and the uncertainty of potential changes in models of care in the ICS, aimed at improving the resilience and sustainability of services.

Well-led Framework

In Q3 of 2018/19, the Trust undertook an externally commissioned developmental review of leadership and governance using NHSI's 'well-led' framework, with the final report and the recommendations being published in March 2019. The report concluded that the Trust was a 'corporately well-led organisation that is open and transparent in its system working' where 'many areas of good practice' were identified. Some recommendations were made from the report, which have been considered by a Board task and finish group, alongside the feedback from the recent CQC Well led Review carried out in October 2018, and an action plan developed to implement these, including:

- Development of an Organisational Development Strategy aligned to the Trust's values and which is communicated throughout all levels of the organisation; and
- Develop and launch a Quality Improvement Strategy.

During the year, the Trust retained breaches against its Licence, resulting from Enforcement Action taken by Monitor against the Trust in April 2013. Outstanding financial planning breaches, i.e. those relating to Licence conditions FT4(5)(a), FT4(5)(b), FT4(5)(d), FT4(5)(e), FT4(5)(f), FT4(5)(g) and CoS3(1), remain in place. The allocation of a segment 3 sector rating by NHSI in October 2016, reflect the regulatory position.

In order to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b), the Trust has assessed the extent with which it complies with the Code of Governance, and has considered feedback from both an externally facilitated well led review, and the CQC well led review, carried out in Q3 2018/19.

The Trust's strategic and operational objectives are reviewed during the Board of Directors' annual cycle of business, and the annual operational and financial plans provide the framework through which to achieve those objectives.

In addition, the Board recognises the need to horizon scan for emerging risks and to review low probability / high impact risks to ensure that contingency plans are in place.

The Trust learns from the outcomes of external reviews and has paid attention to reviewing current practice in light of the findings of national reports and implementing recommendations where appropriate. It is supported in this work by the Clinical Governance Committee and Quality Assurance Committee.

As part of the development of the annual review of strategic objectives, the Board determines how each will be managed within the Board Assurance Framework.

Each executive director is responsible for reporting progress to the Board, on a monthly basis, against specific priorities that have been identified as areas for improvement or potential risk to achievement of the strategic objectives. Key priorities have an implementation plan that indicates required milestones, KPIs and outcomes.

The Board committees also seek more detailed assurance that milestones are being achieved, KPIs are being met and that outcomes are as anticipated. The Board also receives, on a monthly basis, an Integrated Performance Report ("IPR"), containing information on an

extensive range of performance related KPIs, national priority indicators, statutory and regulatory requirements and local priorities.

Operational committees report through the monthly Trust Management Committee (TMC) which is attended by all the Trust's senior leadership team which includes all executive directors.

The Trust aims to facilitate a pro-active approach to risk management and learning from good practice through staff training and other awareness-raising initiatives. Colleagues are required and encouraged to report incidents in the Trust, via Datix, and this is supported by clear and structured processes. The majority of incidents reported are no harm or low harm incidents. However, the Trust declared four never events during the year, which have been subject to a thorough process of investigation, and subsequent learning where appropriate (the Quality Report at page 85 provides more details.)

Risk management training is provided throughout the year as essential training for colleagues of band 8a and above, including members of the Board of Directors.

A corporate induction programme is undertaken by all colleagues and volunteers, and ensures that everyone is provided with details of the Trust's risk management systems and processes; and this is augmented by local induction organised by line managers. We recognise the importance of training colleagues to be able to recognise and manage key risks in the organisation such as quality, workforce, operational, financial, fire safety, health and safety, manual handling, resuscitation, infection control and safeguarding.

Internal and clinical audit programmes are also used to provide assurance against internal controls, and recommendations are made where improvements may be appropriate.

The Trust currently has 11 Freedom to Speak Up Guardians who work in different areas of the organisation, and are readily available to listen to concerns and issues raised by colleagues, in addition to other routes by which colleagues can raise concerns and share ideas and suggestions for improvement.

Stakeholder involvement in managing risks which impact upon them:

Established and effective arrangements are in place for working with key public stakeholders across the local health economy, including:

- Rotherham Clinical Commissioning Group
- Rotherham Metropolitan Borough Council
- Health Select Commission (RMBC)
- HealthWatch Rotherham
- Rotherham and Barnsley Chamber of Commerce
- Rotherham College / University College Rotherham
- Rotherham Place Board
- Voluntary Action Rotherham
- Yorkshire Ambulance Service
- South Yorkshire Police
- South Yorkshire Fire and Rescue Services
- South Yorkshire and Bassetlaw Integrated Care System
- NHS England
- NHS Improvement
- The Trust's Council of Governors, Trust members, and members of the public

The Board of Directors and committees of the Board receive regular reports detailing the staffing arrangements in place, which provide assurance in respect of safety, sustainability and effectiveness. The reports detail areas of risk and mitigation strategies in relation to workforce. Workforce assurance is also provided through the Board committees in respect of key workforce metrics e.g. establishment data, sickness absence and turnover. The Trust will use a triangulated approach to maintaining assurance around workforce strategies and safe staffing systems. This approach will include utilising evidence based tools and include establishment reviews, roster information, together with professional judgement and patient outcome measures. The Nursing and Medical Director will provide information to the Board detailing the outcome of staffing reviews.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission, with conditions.

The CQC carried out focussed unannounced inspections at the Trust during 2018/19, and as a result, placed the following conditions on the Trust's registration:

- Until such time as the appropriate number of substantive posts have been recruited to, there must, in the meantime and with immediate effect, be a minimum of two registered sick children's nurses (RSCN) in the pediatric emergency department, twenty-four hours a day, seven days a week.

- With immediate effect, there must be full-time medical oversight of, and presence within, the pediatric emergency department, twenty-four hours a day, seven days a week.

Four requirement notices have been given to the Trust, as follows;

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

Details relating to the inspections carried out by the CQC during the year, can be found in the Quality Report at page 54-56 with copies of the reports available from the CQC's website.

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer with staff entitled to membership of the NHS' Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust seeks economy, efficiency and effectiveness through a variety of means, including:

- A suite of effective and consistently applied financial controls
- A robust pay and non-pay budgetary control system
- Effective tendering procedures
- Robust establishment controls
- Continuous service and cost improvement and transformation

The Trust benchmarks efficiency in a variety of ways, including through the national reference costs index, use of 'model hospital' and by comparison with key indices such as length of stay and day case percentages. The Board of Directors performs an integral role in maintaining the system of internal control supported by the Audit Committee, internal and external audit, and other key bodies.

In addition to the financial review of resources and the quarterly monitoring returns to NHS Improvement (NHSI), all budget holders are provided with monthly financial information to help them ensure resources are used economically, efficiently and effectively. Monthly finance and performance reports are provided for the Board.

The Trust has an internal performance management review process which provides evidence of performance at divisional level and the actions being taken to ensure resources are being used effectively and efficiently. In addition, the annual business planning process, including the requirement to identify productivity and efficiency opportunities, provides another mechanism to achieve this aim. The Trust had an annual allocation for Commissioning for Quality & Innovation, (CQUIN) schemes, of £3.8M, and £1.2M from Local Incentive Schemes. Prior to the final validation of the evidence of the CQUIN schemes the Trust is expecting to receive 95% of the annual allocation.

The Trust underwent a Quality and Use of Resources Assessment, led by NHS Improvement, in September 2018, the outcome of which was a combined rating of 'requires improvement' provided by the CQC. Whilst areas of outstanding practice were recognised in the report, areas for improvement included the opportunity to improve overall pay costs per weighted activity unit, better alignment between job planning for medical staff, with the organisation's needs and priorities, and improving procurement costs per £100M.

The Procurement team, along with their counterparts across the South Yorkshire and Bassetlaw Integrated Care System (ICS), were shortlisted for the National GO Procurement Awards for their work in standardising some of the products used at the Trust, particularly in relation to minimally invasive surgery. This has resulted in the Trust saving around £2,000 per month and this saving is expected to increase to around £4,000. In addition, in 2018/19 the Procurement Team achieved level 2 of the NHS standards of procurement, having previously been at level 1, and the Finance Department achieved level 1 of the NHS future focused finance standards. The finance and procurement departments are one of only a small number of Trusts in the north to be accredited in both areas giving increased assurance in our governance and compliance approach.

Information Governance

The Senior Information Risk Owner (SIRO) is responsible for leading the area of information governance, and is supported by the Medical Director as Caldicott Guardian. The Trust complies with the Data Protection Act 2018 and has in place a Data Protection Officer.

The Information Governance Committee is responsible for monitoring and controlling risks relating to data security. The Information Governance Committee reports to the Trust Management Committee, which in turn reports to the Board.

The Trust has in place standard operating procedures and policies for the reporting of personal data security breaches to the Information Commissioner's Office within a 72-hour deadline. This reporting of incidents is through the Data Security and Protection Incident Reporting tool, which informs NHS Digital, DHSC, the ICO and other regulators.

Information Governance security related incidents were reported via NHS Digital's incident reporting tool during the financial year 2018/19. There were two reportable Data Security Incidents during the year, both relating to the disclosure of a small amount of personal information; the ICO determined that no further action was required by the Trust.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Annual Quality Report 2018/19 has been developed in line with relevant national guidance and legislative requirements. The Quality Report meets the NHSI requirement to produce the report on an annual basis, in a prescribed format. Assurance over the content and quality of the information in the report is achieved as follows:

- The Chief Nurse leads on the production of the Quality Report at Board level.
- Plans for the achievement of the main quality priorities are developed and reviewed by the Clinical Governance Committee with assurance provided to the Board via the Quality Assurance Committee;
- Consultation regarding future quality priorities is carried out with internal and external stakeholders, including the Council of Governors, and fed back to the Clinical Governance Committee, Trust Management Committee and Quality Assurance Committee before the quality priorities are set for the coming year.
- The content of the draft report is reviewed by the Board and sent for internal and external consultation, including the Council of Governors. The Trust Management Committee reviews the final content of the report before it is presented to the Trust Board.
- The Trust has a range of policies and procedures in place to support the achievement of the quality priorities and the management and use of its data and the information derived from it.

- The data used within the Quality Report is a combination of NHS Digital generated information, and carries inherent limitations.

All core information is subject to review and approved by appropriate Trust senior management before distribution internally or national return submission. The NHS Digital indicator portal is also used in the preparation of accounts to ensure that nationally reported figures align with those being reported internally. In addition, the Trust has a dedicated data quality team whose remit is to operate the Trust's data quality assurance framework. Finally, the Trust's Internal Audit function is also actively engaged in the validation of the data used in the preparation of the Accounts. Further details of the Trust's data quality processes can be found in the Quality Report on page 57.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditor, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the External Auditor in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I gain assurance from the following third party sources:

- reports from the Internal and External Auditor and the local counter fraud specialist
- patient and staff surveys
- service accreditations
- external peer reviews and benchmarking
- Royal College / Deanery inspections
- Annual NHS Staff Survey
- Outcomes of external Well Led reviews
- Outcomes of Care Quality Commission reviews / inspections

The Trust's regular reporting to NHSI provides additional assurance with regard to compliance with our licence conditions.

The key considerations of my review of the effectiveness of the system of internal control can be summarised as follows:

- The Board has been actively involved in developing and reviewing the Trust's risk management processes including receiving and reviewing reports from the Risk Analysis Group and Audit Committee. The Board has also reviewed the Board Assurance Framework (BAF) as well as monitoring performance objectives via the integrated Board report and tracking of the annual plan objectives.
- The Risk Management Committee oversees the effectiveness of all the Trust's risk management arrangements including the on-going development of the risk register including all key clinical and non-clinical risks highlighted by other committees.
- The Audit Committee has been a directing force in relation to reviewing the system of internal control particularly with regard to corporate risk and counter fraud. The Audit Committee also has a key role in the oversight of the Trust's key financial challenges.
- Internal Audit has reviewed and reported upon financial reporting, clinical audit and risk management processes, based on an audit plan approved by the Audit Committee. The work included identifying and evaluating controls and testing their effectiveness. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.
- Executive Directors and the Board of Directors were directly involved in producing and reviewing the BAF.

Internal audit provides consistent support and advice with regard to the system of internal control, including the on-going development of the Trust's risk management processes. Head of internal audit opinion has provided a limited assurance opinion on the effectiveness of risk management, internal control and governance processes that are designed to support achievement of the Trust's objectives.

Areas of weakness that were highlighted by the Internal Auditor appear below:

Hygiene Code:

Whilst the audit found some areas of non-compliance, immediate action was taken to rectify these: non-secured waste collection bins were made inaccessible, and local auditing of hand hygiene practices undertaken, and colleagues reminded of their personal responsibilities, to ensure compliance. Minor cleanliness issues were highlighted with regard to one area in particular, which has since been refurbished.

Budgetary Control and CIPs:

The Trust received a limited audit in Q2 of the 2018/19 financial year with regards the Appraisal Review of Budgetary Control and Cost Improvement Programme relating to 2017/18. A subsequent audit in Q3 on Financial Management gave a reasonable assurance rating and reflected that over the previous 12-month period the financial management at the Trust has been strengthened with robust methodologies, frameworks, governance and staff arrangements.

Compliance with GDPR and Data Security and Protection (DSP) Toolkit:

Having completed the vast majority of internal audit recommendations, the Trust is undertaking work to complete its information flows, which was the area primarily responsible for limited assurance opinions for both its GDPR and DSP Toolkit audits. An action plan for completion of the four outstanding mandatory evidence items for the DSP Toolkit by the end of July 2019, was submitted and accepted by NHS Digital in March 2019.

Further work on reviewing and updating all appropriate Trust policies, to ensure that they comply with the requirements of GDPR, is currently ongoing and due to be completed by the end of September 2019.

Further audits will be undertaken in 2019/20 in both areas.

Bank and Agency – non medical:
A number of policies and procedures have been updated, which has closed gaps in assurance relating to inefficient processes that had been highlighted by the audit. Monthly local audits are also taking place to ensure that bank staff continue to adhere to recruitment requirements and processes, thus ensuring a more robust framework.

Conclusion

The Trust took a more strategic approach to internal audit for the financial year which highlighted a number of areas where additional work is required. In addition, whilst it is recognised that there are a number of areas where improvement is required within the Trust which have been highlighted in this document, there are **no significant control issues** that have been identified. The Board has in place governance assurance processes which enable the identification and control of risks reported through the assurance framework and continues to review and update these on a regular basis to further strengthen and enhance the identification and mitigation of risk, developing and implementing action plans where appropriate to improve assurance.

Signed:

Louise Barnett
Chief Executive
22 May 2019

The Rotherham NHS Foundation Trust

Annual Accounts for the year ended 31 March 2019

Foreword to the accounts

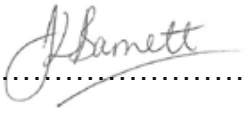
The Rotherham NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by The Rotherham NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

The Accounts of The Rotherham NHS Foundation Trust for the period ending 31 March 2019 follow. The four primary statements; the Statement of Comprehensive Income (SOCI), the Statement of Financial Position (SOFP), the Statement of Changes in Taxpayers' Equity (SOCITE), and the Statement of Cashflows (SCF) are presented first. These are followed by the supporting notes to the accounts.

Note 1 outlines the Foundation Trust's accounting policies. Subsequent notes provide further detail on the four primary statements and are cross referenced accordingly.

The financial statements (Accounts) were approved by the Board on 22 May 2019 and signed on its behalf by:

Signed 

Name **Louise Barnett**
Job title **Chief Executive**
Date **22 May 2019**

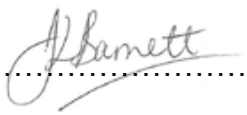
Statement of Comprehensive Income for year ending 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	**228,870**	218,174
Other operating income	4	**24,669**	23,930
Total operating income from continuing operations		**253,539**	242,104
Operating expenses	5.1	**(270,238)**	(264,650)
Operating surplus/(deficit) from continuing operations		**(16,699)**	(22,546)
Finance income	10	**64**	27
Finance expenses	11	**(2,257)**	(1,343)
PDC dividends payable		**(1,260)**	(1,833)
Net finance costs		**(3,453)**	(3,149)
Gains/(losses) of disposal of non-current assets		**(55)**	-
Surplus/(deficit) for the year from continuing operations		**(20,207)**	(25,695)
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	12	**225**	-
Surplus/(deficit) for the year		**(19,982)**	(25,695)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	**-**	(2,122)
Revaluations and impairments of property, plant and equipment	16	**-**	15,306
Other recognised gains and losses		**-**	(1,743)
Total comprehensive income/(expense) for the period		**(19,982)**	(14,254)
Allocation of profits / (losses) for the period:			
Surplus / (Deficit) for the year attributable to the Foundation Trust		**(19,982)**	(25,695)
Total comprehensive income (expense) for the year attributable to the Foundation Trust.		**(19,982)**	(14,254)

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	**9,333**	9,746
Property, plant and equipment	14	**120,179**	118,725
Trade and other receivables	22	**17**	30
Total non-current assets		**129,529**	128,501
Current assets			
Inventories	21	**3,577**	3,652
Trade and other receivables	22	**13,888**	11,521
Cash and cash equivalents	23	**1,461**	1,400
Total current assets		**18,926**	16,573
Current liabilities			
Trade and other payables	24	**(23,696)**	(22,475)
Borrowings	27 - 29	**(5,743)**	(3,403)
Provisions	30	**(568)**	(205)
Other liabilities	26	**(1,353)**	(1,224)
Total current liabilities		**(31,360)**	(27,307)
Total assets less current liabilities		**117,095**	117,767
Non-current liabilities			
Borrowings	27 - 29	**(75,780)**	(59,829)
Provisions	30	**(912)**	(958)
Total non-current liabilities		**(76,692)**	(60,787)
Total assets employed		**40,403**	56,980
Financed by			
Public dividend capital		**76,808**	73,403
Revaluation reserve		**43,136**	32,945
Income and expenditure reserve		**(79,541)**	(49,368)
Total taxpayers' equity		**40,403**	56,980

The following notes 1 - 37 form part of these accounts.

Signed  .....

Name **Louise Barnett**
Position **Chief Executive**
Date **22 May 2019**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	73,403	32,945	(49,368)	**56,980**
Surplus/(deficit) for the year			(19,982)	**(19,982)**
Other recognised gains and losses*		10,191	(10,191)	**-**
Public dividend capital received	3,405			**3,405**
Taxpayers' and others' equity at 31 March 2019	**76,808**	**43,136**	**(79,541)**	**40,403**

**See additional information on reserves below this table.*

Statement of Changes in Taxpayers Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	73,403	19,668	(21,837)	71,234
Surplus/(deficit) for the year			(25,695)	(25,695)
Other transfers between reserves		(133)	133	-
Net Impairments		(2,122)		(2,122)
Revaluations - PPE		15,306		15,306
Other recognised gains and losses		(1,743)	-	(1,743)
Other reserve movements	-	1,969	(1,969)	-
Taxpayers' and others' equity at 31 March 2018	73,403	32,945	(49,368)	56,980

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised, unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

At the last trust valuation at 31st March 2018 the trust componentised its asset base. From 1st April all revaluation reserve balances are recognised at component level. Due to historical negative balances at component level a transfer from Revaluation Reserve to Income and Expenditure Reserve is required to realise the historical losses arising. This accounts for those components where historical downwards valuations against the Revaluation Reserve occurred where at component level a zero balance was held, and the reserve was treated as a whole. This does not represent a change in accounting policy, but is the implementation of componentisation within the Revaluation Reserve.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows For the Year Ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus/(deficit) (including discontinued operations)		**(16,474)**	(22,546)
Non-cash income and expense:			
Depreciation and amortisation	5.1	**7,115**	6,690
Impairments and reversals	6	**-**	3,367
(Increase)/decrease in trade and other receivables		**(2,355)**	887
(Increase)/decrease in inventories		**75**	(468)
Increase/(decrease) in trade and other payables		**1,697**	(1,728)
Increase/(decrease) in other liabilities		**129**	(1,070)
Increase/(decrease) in provisions		**314**	(76)
Other movements in operating cash flows		**-**	(48)
Net cash generated from/(used in) operating activities		**(9,499)**	(14,992)
Cash flows from investing activities			
Interest received		**64**	27
Purchase of intangible assets		**(772)**	(480)
Purchase of property, plant, equipment and investment property		**(6,261)**	(4,529)
Net cash generated from/(used in) investing activities		**(6,969)**	(4,982)
Cash flows from financing activities			
Public dividend capital received		**3,406**	-
Movement on loans from the Department of Health		**16,908**	22,210
Capital element of finance lease rental payments		**(126)**	(31)
Interest on loans		**(1,948)**	(1,148)
Interest element of finance lease		**(154)**	(3)
PDC dividend (paid)/refunded		**(1,557)**	(1,157)
Net cash generated from/(used in) financing activities		**16,529**	19,871
Increase/(decrease) in cash and cash equivalents		**61**	(103)
Cash and cash equivalents at 1 April		**1,400**	1,503
Cash and cash equivalents at 31 March	23	**1,461**	1,400

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Rotherham NHS Foundation Trust ('the Trust') is a public benefit corporation authorised, in England, by Monitor (trading as NHS Improvement) in accordance with the National Health Service Act 2006. The Trust provides healthcare mainly to the region. The address of the Trust is Moorgate Road, Rotherham, S60 2UD.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

The Rotherham NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust has delivered a financial outturn for 2018/19 of £19,982k deficit against a planned deficit of £20,345k, showing a favourable variance of £363k, the performance in the year required working capital loan financing support to be provided of £20,283k.

The Board of Directors has approved a breakeven financial plan for 2019/20, which will not require further deficit loan support. By signing up to this control total, the trust will be in receipt of Sustainability Transformation Funding (STF) and Financial Recovery Funding (FRF), but will require loans in lieu of receipt of payment of these funding streams which are payable in arrears. This will enable the Trust to meet its debts as they fall due over the foreseeable future, which is defined as the period of 12 months from the date the accounts are signed. Plans are in place to draw down this funding which is built into the 2019/20 plan and notified to NHSI and the Department of Health and Social Care, although these are agreed on a monthly basis.

As with any financial plan, there are potential risks to its delivery, although the Board is confident that these can be successfully mitigated via use of earmarked reserves and contingencies.

Having considered the material uncertainties and the Trust's financial plans, together with the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare these accounts on a going concern basis. The accounts do not include any adjustments that would result if the Trust was unable to continue as a going concern.

1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of The Rotherham NHS Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying The Rotherham NHS Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Management make judgements in determining when substantially all the significant risks and rewards of ownership of financial assets and lease assets are transferred to other entities.

1.2.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Income estimates

In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year. Included in the income figure is an estimate for open spells, patients undergoing treatment that is only partially complete at twelve midnight on 31 March. The number of open spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which belongs to the current year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

- Expense accruals

In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

- Impairment of property, plant and equipment

The Trust has undertaken an annual impairment exercise of its Property, Plant and Equipment. Following a professional valuation carried out at 31 March 2018, the Trust has considered items such as; indices movements, deterioration of assets and its further estates plans to support its impairment assessment. It is the judgement of management following this review that there is not an indication of impairment.

- Recoverability of receivables

In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for expected credit losses.

- Provisions

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

Note 1.3 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within The Rotherham NHS Foundation Trust.

Note 1.4 Income (Revenue from Contracts with Customers)

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3(b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
- as per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- the Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date and
- the FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Note 1.5 Expenditure on Employee Benefits

1.5.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.5.2 Retirement Benefit Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS body commits itself to the retirement, regardless of the method of payment.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018, the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

NEST Pension Scheme

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably, and either
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
• items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.7.2 Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use and where there are no restrictions preventing access to the market at the reporting date, are valued at fair value under IFRS 13.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost, modern equivalent asset basis

Where applicable, assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.7.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.7.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.7.5 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.7.6 Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.7.7 De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met;

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’ and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued except where 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7.8 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7.9 Useful Economic lives of property, plant and equipment

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	90
Dwellings	-	-
Plant & machinery	5	15
Transport equipment	7	9
Information technology	2	20
Furniture & fittings	10	10

Note 1.8 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.9 Intangible assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are only recognised if, and only if, all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

1.9.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

1.9.3 Subsequent Expenditure

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

1.9.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9.5 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - internally generated		
Software	5	20
Licences & trademarks	5	10

Note 1.10 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or would be otherwise determined by reference to quoted market prices, where possible, or by valuation techniques where relevant. (See IFRS 9 B5.1.2A.)

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Note 1.13.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Note 1.13.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

At present the Trust does not hold any financial assets or financial liabilities held for trading.

Note 1.13.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Note 1.13.4 Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, theTrust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

A provision matrix approach is adopted, as one of the recommended methodologies, to calculate lifetime expected credit losses of trade receiveables at the reporting date. The Trust does not currently hold any lease receivables or contract assets.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Note 1.13.5 Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished - that is, the obligation has been discharged or cancelled or has expired.

Note 1.13.6 Financial Liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

The Trust has reviewed all its main contracts and concluded that any derivatives the contracts may have are 'closely related' and therefore do not warrant separate disclosure or accounting.

Note 1.13.7 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

Note 1.14 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is apportioned between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Contingent rents are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

Clinical negligence costs
NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within the Trust's Accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHSR and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. It represents the DHSC's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the Secretary of State can issue new PDC to, and requirement repayments of PDC from, the Trust. PDC is recorded at the value received.

A annual charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts.

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. The PDC dividend calculation is based upon the Trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of Income and Capital Gains within categories covered by this but the Trust is potentially within the scope of Corporation Tax in respect of activities where income is received from a Non Public Sector source.

However, the Trust has evaluated that it is has no Corporation Tax Liability, as all activities are either ancillary to healthcare or below the de minimis level of profit at which tax becomes payable.

Note 1.20 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies

As public sector bodies are deemed to operate under common control, business reconfigurations with the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place.

For functions that have been transferred to the Trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

 IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
 IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
 IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

The Trust has considered the above new standards, interpretation and amendments to published standards that are not yet effective and concluded that, with the exception of IFRS 16 that is dealt with below, they are currently either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures. This conforms with the FT ARM 2018/19, which requires that any amendments to standards are applied in accordance with the applicable timetable, with early adoption not permitted.

It is anticipated that IFRS 16 Leases will impact the Trust accounts presentationally to the extent that existing operating leases that are for over 1 year will be reclassified, on implementation, to finance leases. Current rental costs will be replaced in the Accounts with finance costs and depreciation costs. The Trust's Non-Current Asset value would also increase as these assets are taken onto the Statement of Financial Position, with an equal and opposite liability. (Refer to Paragraph 1.14.) This is likely to result in an increase to annual public dividend capital charges in future years, and may cause uneven I&E profiling over the life of the lease, due to the higher finance costs (and lower principal repayments) incurred in the early years of the lease.

Note 2 Operating Segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Trust revenue derives within the UK. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust Board of Directors, which includes non-executive directors. The Board of Directors review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with graphical line charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		**Total**	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Income	**257,201**	242,104	**257,201**	242,104
Retained Deficit	**(19,982)**	(25,695)	**(19,982)**	(25,695)
Segment net assets	**40,403**	56,980	**40,403**	56,980

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2018/19	2017/18
	£000	£000
Acute services		
Elective income	**33,703**	33,065
Non elective income	**61,316**	53,621
First outpatient income	**17,057**	18,784
Follow up outpatient income	**14,610**	13,415
A & E income	**11,237**	9,472
High cost drugs income from commissioners	**11,262**	10,308
Other NHS clinical income	**33,480**	34,127
Community services		
Community services income from CCGs and NHS England	**43,695**	43,373
Community services income from other commissioners	**1,852**	971
All services		
Agenda for Change pay award central funding*	**2,656**	-
Other clinical income**	**1,189**	1,038
Total income from activities	**232,057**	218,174

(See footnotes under 3.2 below)

Note 3.2 Income from patient care activities (by source)

	2018/19	2017/18
Income from patient care activities received from:	**£000**	£000
NHS England	**19,653**	17,626
CCGs	**198,609**	188,239
Department of Health*	**2,656**	-
NHS trusts	**(30)**	29
NHS other	**156**	20
Local authorities	**9,585**	9,216
Non-NHS: overseas patients (chargeable to patient)	**23**	34
NHS Injury Cost Recovery scheme***	**981**	825
Non NHS: other**	**424**	2,185
Total income from activities	**232,057**	218,174
Of which:		
Related to continuing operations	***228,870***	*218,174*
Related to discontinued operations	***3,187***	*-*

**Additional Agenda for Change pay award funding of £2.656m was received in 2018/19 separately to contract income to fund the implementation of a new Agenda for Change pay structure for all NHS staff. In 2018/19 the impact of pay changes will be built into NHS tariff prices and this separate disclosure line will not be required.*

***In 2017/18 £35,000 was disclosed as Private Patient income that related to Patients' appliances. This spend has been recategorised under Other Clinical income in 2018/19, with 2017/18 restated for comparative purposes. The Private Patient Income line has been removed as not applicable for this Trust.*

****NHS injury scheme income is subject to an allowance for impaired contract receivables of 21.89% in 2018/19 (22.84% in 2017/18) to reflect expected rates of collection.*

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS Trust)

	2018/19 £000	2017/18 £000
Income recognised this year	**23**	34
Cash payments received in-year	**10**	15
Amounts added to provision for impairment of	**15**	19

There was no Overseas Visitors income written off in year (2017/18 £0).

Note 4 Other operating income

Note 4.1 Other operating income by nature

	2018/19 £000	2017/18 £000
Research and development	**486**	329
Education and training	**8,826**	7,100
Education and training - notional income from Apprenticeship fund	**251**	-
Charitable and other contributions to expenditure	**5**	5
Non-patient care services to other bodies*	**9,116**	9,436
Provider Sustainability Fund income	**141**	-
Rental revenue from operating leases	**680**	427
Rental revenue from finance leases	**-**	48
Income in respect of staff costs where accounted on gross basis	**1,528**	1,602
Other income	**4,111**	4,983
Total other operating income	**25,144**	23,930
Of which:		
Related to continuing operations	***24,669***	*23,930*
Related to discontinued operations	***475***	-

Further analysis of other Operating Revenue - 'Other income'

Car Parking	**1,193**	957
Estates Recharges (external)	**316**	99
IT Recharges (external)	**457**	513
Pharmacy Sales	**331**	353
Clinical Tests	**835**	787
Catering	**2**	-
Staff Accommodation Rentals	**501**	284
Staff Contributions to Employee Benefit Schemes	**405**	364
Property Rentals	**70**	91
Other income not already covered	**1**	1,535
	4,111	4,983

** Income streams recategorised in 2018/19 have been recategorised similarly in 2017/18. A movement of £5,274k from 'Other income' and 'Non-patient care services to other bodies' is therefore shown in prior year figures. This does not affect the total income in this note.*

Note 4.2 Additional information on revenue from contracts with customers recognised in the period

	2018/19
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,224
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 4.3 Transaction price allocated to remaining performance obligations

As at the year end the Trust has no performance obligations that are either partially or fully unsatisfied that it has not accounted for in revenue recognition in year. Therefore, there are no contracts that commenced prior to the period end, with performance obligations outstanding and income not yet recognised.

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.4 Fees and Charges

HM Treasury requires disclosure of fees and charges income, for example: dental and prescription charges and other income generation activities. This disclosure is of income from charges to service users where full cost for that service exceeds £1,000k and/or is otherwise material to the Accounts. It is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

In 2018/19 the Rotherham NHS Foundation Trust had no fees or charges where the scheme individually resulted in income from that service exceeding £1,000k.

Note 4.5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	**230,868**	217,136
Income from services not designated as commissioner requested services	**26,333**	24,968
Total	**257,201**	242,104

Note 4.6 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of any land or buildings assets in year used in the provision of commissioner requested services. The Trust has disposed of equipment assets with a net book value of £55,000. This disposal will not impact the Trust's ability to continue to meet its obligations to provide commissioner requested services, and was part of an annual verification programme to review equipment in use and review replacement asset requirements.

Note 5.1 Operating expenses

	2018/19	2017/18
	£000	£000
Staff Costs		
Employee expenses - staff and executive directors	**185,242**	172,814
Research and development - staff costs	**259**	240
Remuneration of non-executive directors	**180**	179
Redundancy	**58**	83
Premises and Establishment		
Premises	**11,723**	11,195
Premises (Business rates)	**1,181**	1,162
Establishment	**1,922**	1,843
Rentals under operating leases	**3,782**	2,858
Transport (business travel only)	**812**	662
Transport - other (including patient travel)	**904**	818
Depreciation on property, plant and equipment	**5,931**	5,604
Amortisation on intangible assets	**1,184**	1,086
Net impairments	**-**	3,367
Supplies		
Supplies and services - clinical	**26,715**	28,427
Supplies and services - general	**4,168**	4,033
Drug costs	**17,296**	16,843
Inventories written down	**15**	24
Other Costs		
Clinical negligence	**7,548**	9,308
Consultancy costs	**821**	1,137
Research and development	**56**	36
Increase/(decrease) in credit loss allowance: contract receivables/assets	**280**	0
Increase/(decrease) in credit loss allowance: all other receivables	**5**	(16)
Change in provisions discount rate(s)	**12**	10
Audit fees payable to the external auditor		
audit services - statutory audit	**89**	70
other auditor remuneration (external auditor only)	**10**	8
Legal fees	**101**	97
Internal audit costs	**88**	94
Training, courses and conferences	**404**	344
Education & Training - notional expenditure from Apprenticeship Levy Fund.	**251**	-
Insurance	**218**	210
Other services, eg external payroll	**1,121**	1,331
Losses, ex gratia & special payments	**141**	87
Other	**1,158**	696
Total	**273,675**	264,650
Of which:		
Related to continuing operations	***270,238***	*264,650*
Related to discontinued operations	***3,437***	*-*

Note 5.2 Other auditor remuneration

The Council of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the 3 year period commencing 1 October 2016, with the option to extend for a further two years commencing 1 April 2020. The audit fee for the statutory audit is included in note 5.1.

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	**10**	8
Total	**10**	8

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1000k (2017/18: £1000k).

Note 6 Impairment of assets

In 2018/19 the Rotherham NHS FT reviewed its property assets against the relevant in year indexation to assess that the valuation undertaken as at 31st March 2018 still represents a fair view of the value of the assets. This exercise demonstrated that, had indexation been applied to opening values, the closing values at 31st March 2019 would not be materially different from those recorded in the Trust's books. Therefore, no revaluation adjustments are recognised in year.

In 2017/18 The Rotherham NHS FT completed work on its new Urgent and Emergency Care Centre, which opened on 7th July 2017. At the date of completion, the asset was revalued. Costs incurred in developing the existing and new build exceed its current value, and an impairment of £5,493k was recognised. The net charge to operating costs is £3,521k. Additionally the Trust's previously impaired Mortuary was revalued upwards in the Trust's full revaluation at 31st March 2018, resulting in an impairment reversal to operating costs of £154k.

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	**-**	3,367
Total net impairments charged to operating surplus / deficit	**-**	3,367
Impairments charged to the revaluation reserve	**-**	2,122
Total net impairments	**-**	5,489

Note 7 Employee benefits

	2018/19	2017/18
	£000	£000
Salaries and wages	**145,141**	133,325
Social security costs	**14,045**	12,842
Apprentice Levy	**686**	633
Employer's contributions to NHS pensions	**16,739**	15,848
Pension cost - other	**46**	19
Termination benefits	**58**	83
Temporary staff - agency/contract	**9,076**	10,453
Total gross staff costs	**185,791**	173,203
Recoveries in respect of seconded staff netted off expenditure	**-**	-
Total staff costs	**185,791**	173,203
Of which		
Costs capitalised as part of assets	*232*	*66*
Operating expenditure analysed as:		
Employee expenses - staff and executive directors	**185,242**	172,814
Research and Development	**259**	240
Redundancy	**58**	83
Total staff costs excluding capitalised costs.	**185,559**	173,137

Note 7.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £132k (£123k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration and other benefits

The requirements under section 412 of the Companies Act 2006 to disclose information on directors' remuneration are considered to be satisfied by the disclosures made in the notes to the accounts above and in the Remuneration Report. Directors' other benefits, where relevant, are set out here.

In 2018/19 no advances or credits were granted by the Trust to any of the directors of the Trust. No guarantees were entered into on behalf of the directors of the Trust.

Note 8 Pension costs

The default scheme is the NHS pension scheme, however some employees are not eligible to join and therefore to meet auto enrolment legislation an alternative pension scheme must be provided. Like most NHS providers this Trust procured the government backed, defined contribution, National Employment Savings Trust ("NEST") as the alternative pension scheme. Pension costs for defined contribution schemes are disclosed in Note 7.

Note 9 Operating leases

Note 9.1 The Rotherham NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor. The Trust has a lease agreement with Rotherham, Doncaster & South Humber NHS FT for use at Woodlands which expires in 2108. Future lease receipts due at 31st March therefore capture this future commitment among others.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	**680**	427
Total	**680**	427

	31 March 2019	Restated 31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	**482**	397
- later than one year and not later than five years;	**1,672**	1,410
- later than five years.	**6,364**	6,875
Total	**8,518**	8,682

Note 9.2 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	**3,782**	2,858
Total	**3,782**	2,858

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**3,651**	2,844
- later than one year and not later than five years;	**1,116**	1,417
- later than five years.	**135**	2,274
Total	**4,902**	6,535

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	**63**	25
Interest on loans and receivables	**1**	2
Total	**64**	27

Note 11 Finance Expense

Note 11.1 Loans and interest

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health	**2,100**	1,337
Finance leases	**154**	4
Interest on late payment of commercial debt	**-**	1
Total interest expense	**2,254**	1,342
Unwinding of discount on provisions	**3**	1
Other finance costs	**-**	-
Total	**2,257**	1,343

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2018/19 £000	2017/18 £000
Amounts included within interest payable arising from claims made under this legislation	**-**	1

Note 12 Discontinued Operations

The Rotherham Equipment and Wheelchair Service was transferred to a new provider on 1st February 2019. The Dental Access Service was similarly transferred to a new provider with effect from 1st April 2019 and both are therefore classified as discontinued operations at 31st March 2019. This note discloses the total income and expenditure attributable to these services in 2018/19.

	2018/19 £000	2017/18 £000
Operating income of discontinued operations	**3,662**	-
Operating expenses of discontinued operations	**(3,437)**	-
Total	**225**	**-**

Note 13.1 Intangible assets - 2018/19

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/Gross cost at 1 April 2018 - brought forward	**20,160**	**318**	**20,478**
Additions	**772**	-	**772**
Reclassifications	-	-	**-**
Disposals / derecognition	**(3,163)**	**-**	**(3,163)**
Gross cost at 31 March 2019	**17,769**	**318**	**18,087**
Amortisation at 1 April 2018 - brought forward	10,732	-	10,732
Provided during the year	1,184	-	1,184
Disposals / derecognition	(3,162)	-	(3,162)
Amortisation at 31 March 2019	**8,754**	**-**	**8,754**
Net book value at 31 March 2019	**9,015**	**318**	**9,333**
Net book value at 1 April 2018	**9,428**	**318**	**9,746**

Note 13.2 Intangible assets - 2017/18

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2017 - as previously stated	18,811	1,187	19,998
Additions	343	137	480
Reclassifications	1,006	(1,006)	-
Valuation/gross cost at 31 March 2018	20,160	318	20,478
Amortisation at 1 April 2017 - as previously stated	9,646	-	9,646
Provided during the year	1,086	-	1,086
Amortisation at 31 March 2018	10,732	-	10,732
Net book value at 31 March 2018	9,428	318	9,746
Net book value at 1 April 2017	9,165	1,187	10,352

Note 14.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**6,450**	**105,476**	**-**	**-**	**25,905**	**216**	**5,028**	**180**	**143,255**
Additions	-	3,891	-	-	1,627	-	1,720	202	**7,440**
Disposals / derecognition	-	-	-	-	(8,634)	-	(1,775)	-	**(10,409)**
Valuation/gross cost at 31 March 2019	**6,450**	**109,367**	**-**	**-**	**18,898**	**216**	**4,973**	**382**	**140,286**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**750**	**-**	**-**	**20,169**	**187**	**3,388**	**36**	**24,530**
Provided during the year	-	4,280	-	-	1,094	14	525	18	**5,931**
Disposals/ derecognition	-	-	-	-	(8,579)	-	(1,775)	-	**(10,354)**
Accumulated depreciation at 31 March 2019	**-**	**5,030**	**-**	**-**	**12,684**	**201**	**2,138**	**54**	**20,107**
Net book value at 31 March 2019	**6,450**	**104,337**	**-**	**-**	**6,214**	**15**	**2,835**	**328**	**120,179**
Net book value at 1 April 2018	**6,450**	**104,726**	**-**	**-**	**5,736**	**29**	**1,640**	**144**	**118,725**

Contractual capital commitments not otherwise disclosed in the Accounts are disclosed in Note 32.

Note 14.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - as previously stated	6,450	87,296	1,908	15,383	29,458	216	4,030	180	144,921
Additions	-	1,346	-	1,698	245	-	385	-	3,674
Impairments	(150)	(5,493)	-	-	-	-	-	-	(5,643)
Reversals of impairments	-	154	-	-	-	-	-	-	154
Reclassifications	-	18,376	(1,908)	(17,081)	-	-	613	-	-
Revaluations	150	3,797	-	-	-	-	-	-	3,947
Disposals / derecognition	-	-	-	-	(3,798)	-	-	-	(3,798)
Valuation/gross cost at 31 March 2018	6,450	105,476	-	-	25,905	216	5,028	180	143,255
Accumulated depreciation at 1 April 2017 - as previously stated	-	7,651	639	-	22,768	172	2,834	19	34,083
Provided during the year	-	3,785	34	-	1,199	15	554	17	5,604
Reclassifications	-	673	(673)	-	-	-	-	-	-
Revaluations	-	(11,359)	-	-	-	-	-	-	(11,359)
Disposals / derecognition	-	-	-	-	(3,798)	-	-	-	(3,798)
Accumulated depreciation at 31 March 2018	-	750	-	-	20,169	187	3,388	36	24,530
Net book value at 31 March 2018	6,450	104,726	-	-	5,736	29	1,640	144	118,725
Net book value at 1 April 2017	6,450	79,645	1,269	15,383	6,690	44	1,196	161	110,838

Contractual capital commitments not otherwise disclosed in the Accounts are disclosed in Note 32.

Note 14.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned	6,300	101,208	-	-	5,232	15	2,835	328	**115,918**
Finance leased	150	2,408	-	-	919	-	-	-	**3,477**
Donated	-	721	-	-	63	-	-	-	**784**
NBV total at 31 March 2019	**6,450**	**104,337**	**-**	**-**	**6,214**	**15**	**2,835**	**328**	**120,179**

Note 14.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned	6,450	101,463	-	-	5,646	29	1,640	144	115,372
Finance leased	-	2,514	-	-	10	-	-	-	2,524
Donated	-	749	-	-	80	-	-	-	829
NBV total at 31 March 2018	6,450	104,726	-	-	5,736	29	1,640	144	118,725

Note 15 Donations of property, plant and equipment

The Rotherham NHS Foundation Trust has received no new donations of property, plant and equipment in the financial year.

Note 16 Revaluations of property, plant and equipment

During 2017/18 and in line with IAS16, the Trust's land and buildings were revalued as at 31st March 2018 by an independent valuer. Between valuations management review and asset verification exercises are undertaken to assess the need for impairments.

The last valuation was carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. Non operational property, including land was valued to market value.

In order to meet the underlying objectives established by International Financial Reporting Standards and the application of IAS 16 changes, those buildings which qualify as specialised operational assets and therefore, fall to be assessed using the depreciated replacement cost approach have been valued on a modern substitute basis i.e. the valuation approach assumed that the existing asset will be replaced by an asset of modern design and size which is suitable for delivering those services currently being provided where appropriate. Therefore, we have continued to assume that the modern equivalent asset does not require a site as extensive as the actual Rotherham Hospital site. We have recognised that an 8 hectare site is sufficient and the modern equivalent development is in a more appropriate location closer to the M1 and M18 motorway interchange.

Note 17 Investment Property

The Rotherham NHS FT holds assets which are rented to other organisations and are not held for primary healthcare provision purposes. These were however deemed to support service provision and as such have not been categorised as Investment Property. They are the Lodge, the Creche and the former staff residencies.

Note 18 Investments in associates and joint ventures

In 2018/19 The Rotherham NHS Foundation Trust have no investments in associates and joint ventures.

Note 19 Other investments / financial assets (non-current)

In 2018/19 The Rotherham NHS Foundation Trust has no other investments or financial assets.

Note 20 Disclosure of interests in other entities

The Rotherham Hospital & Community Charity

The Trust has considered the need to consolidate Charitable Funds (The Rotherham Hospital & Community Charity) within the main Trust accounts and concluded, although the Trust continues to meet the criteria within the accounting standard, the value of the Charitable Funds is not material and will not therefore be consolidated within the Trust's main accounts.

The table below summarises the Charitable Funds Statement of Financial Activities and Balance sheet.

	31 March 2019 £000	31 March 2018 £000
Total incoming resources	**164**	173
Resources expended	**(140)**	(200)
(Losses)/Gains on revaluation and disposals	**2**	(8)
Net movement in funds	**26**	(35)
Total Assets	**394**	373
Total Liabilities	**(6)**	(11)
Total Charitable Funds	**388**	362
Total funds made up of:		
- Restricted /endowment funds	**222**	144
- Unrestricted funds	**166**	218

The 2018/19 Charitable Funds accounts have not yet been subject to independent review. The 2017/18 Charitable Funds accounts were finalised in January 2019.

Note 21 Inventories

	Drugs £000	**Consumables £000**	**Energy £000**	**Total £000**
Carrying value at 1 April 2018	**822**	**2,720**	**110**	**3,652**
Additions	14,353	12,153	42	**26,548**
Consumed	(14,299)	(12,206)	(103)	**(26,608)**
Write-downs	(15)	-	-	**(15)**
Carrying value at 31 March 2019	**861**	**2,667**	**49**	**3,577**
Carrying value at 1 April 2017	523	2,530	131	3,184
Additions	14,511	11,536	22	26,069
Consumed	(14,188)	(11,346)	(43)	(25,577)
Write-downs	(24)	-	-	(24)
Carrying value at 31 March 2018	822	2,720	110	3,652

Note 22.1 Trade and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables due from NHS bodies (invoiced)*	**2,862**	
Contract receivables due from related WGA parties (invoiced)*	**414**	
Contract receivables due from non-WGA bodies (invoiced)*	**2,253**	
Contract receivables (IFRS15) not yet invoiced	**5,441**	
Trade Receivables *		5,082
Accrued income*		2,357
Allowance for impaired contract receivables	**(873)**	
Allowance for impaired other receivables	**(25)**	(613)
Deposits and Advances	**48**	-
Prepayments (non-PFI)	**2,851**	4,260
VAT receivable	**403**	365
Other receivables	**514**	70
Total current trade and other receivables	**13,888**	11,521
Non-current		
Other receivables	**17**	30
Total non-current trade and other receivables	**17**	30

**Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.*

Note 22.2 Provision for impairment of receivables

2018/19	Contract Receivables £000	All other reecivables £000
Allowances for credit losses at 1 April - brought forward (before IFRS 9 and IFRS 15 implementation)		**613**
Impact of IFRS9 and IFRS 15 implementation on 1 April 2018 balance	**593**	**(593)**
New allowances arising	**530**	**13**
Changes in existing allowances	**(16)**	**2**
Reversals of allowances (where receivable is collected in-year)	**(234)**	**(10)**
At 31 March	**873**	**25**

2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables £000
At 1 April as previously stated	656
Increase in provision	(16)
Amounts utilised	(27)
Unused amounts reversed	-
At 31 March	613

The level of allowance for credit losses (doubtful debts) is based upon analysis of the type of debtors, the age of the debt and any specific intelligence relevant to individual debtors; for example, Injury Cost Recovery Scheme debts are provided for per the national guidance.

Note 23 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**1,400**	1,503
Net change in year	**61**	(103)
At 31 March	**1,461**	1,400
Breakdown of cash and cash equivalents		
Cash at commercial banks and in hand	**136**	252
Cash with the Government Banking Service	**1,325**	1,148
Total cash and cash equivalents as in SoCF	**1,461**	1,400

The Trust's cash balances are largely held in the Government Banking Service Royal Bank of Scotland account and also a HSBC account, both of which are considered low risk institutions.

Note 23.1 Third party assets held by the Trust

At 31st March the Trust held less than £1k cash or cash equivalents which relate to monies held on behalf of patients or other parties.

Note 24 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
NHS Trade payables	**2,963**	2,563
Amounts due to other related parties	**(16)**	136
Other trade payables	**7,309**	6,043
Receipts in advance*	**939**	895
Capital payables	**659**	489
Social security costs	**1,975**	1,846
VAT payable	**92**	48
Other taxes payable	**1,533**	1,425
Accrued interest on DHSC loans**	**-**	349
Accruals	**8,195**	8,337
PDC dividend payable	**47**	344
Total current trade and other payables	**23,696**	**22,475**

The Trust held no non-current trade and other payables at the period end.

** Where income has been received in advance of service provision, the negative receivable is reclassified as a payable at the 31st March. These relate to activity with CCGs and NHSE.*

***Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within Note 27 Borrowings. IFRS 9 is applied without restatement therefore comparatives have not been restated.*

Note 25 Other financial liabilities

The Trust holds no other financial liabilities.

Note 26 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income	**1,353**	1,224
Total other current liabilities	**1,353**	1,224

The Trust held no non-current other liabilities at the period end.

Note 27 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health	**5,595**	3,375
Obligations under finance leases	**148**	28
Total current borrowings	**5,743**	3,403
Non-current		
Loans from the Department of Health	**72,368**	57,179
Obligations under finance leases	**3,412**	2,650
Total non-current borrowings	**75,780**	59,829

Note 28 Finance Leases

The Trust does not have any finance lease receivables. This disclosure presents obligations under finance leases where the Trust is the lessee. Finance lease payables appear within Borrowings in the Statement of Financial Position.
In year rentals associated with a long term lease for Park Rehabilitiation Centre and two equipment leases are categorised as finance lease obligations. The assets are held on the Trust's balance sheet (SOFP).

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**7,897**	2,678
of which liabilities are due:		
- not later than one year;	**305**	28
- later than one year and not later than five years;	**1,221**	62
- later than five years.	**6,371**	2,588
Finance charges allocated to future periods	**(4,337)**	
Net lease liabilities	**3,560**	2,678
of which payable:		
- not later than one year;	**148**	28
- later than one year and not later than five years;	**651**	62
- later than five years.	**2,761**	2,588

No minimum sublease payments are to be received at the reporting date.
No contingent rent was recognised as an expense in the period.

Note 29 Reconciliation of liabilities from financing activities

	Loans from DHSC £000	**Finance Leases £000**	**Total £000**
Carrying value at 1 April 2018	60,554	2,678	**63,232**
Cash movements:			
Financing cash flows - payments and receipts of principal	16,908	(127)	**16,781**
Financing cash flows - payments of interest	(1,948)	(154)	**(2,102)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	349	-	**349**
Transfers by absorption			**-**
Additions	-	1,009	**1,009**
Application of effective interest rate	2,100	154	**2,254**
Carrying value at 31 March 2019	**77,963**	**3,560**	**81,523**

Note 30.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Pensions - injury benefits* £000	Legal claims £000	Other £000	Total £000
At 1 April 2018	**560**	**473**	**130**	**-**	**1,163**
Change in the discount rate	6	6	-	-	**12**
Arising during the year	9	6	85	384	**484**
Utilised during the year	(45)	(31)	(51)	-	**(127)**
Reversed unused	-	-	(55)	-	**(55)**
Unwinding of discount	-	3	-	-	**3**
At 31 March 2019	**530**	**457**	**109**	**384**	**1,480**
Expected timing of cash flows:					
- not later than one year;	44	31	109	384	**568**
- later than one year and not later than five years;	179	122	-	-	**301**
- later than five years.	307	304	-	-	**611**
Total	**530**	**457**	**109**	**384**	**1,480**

** In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within [other provisions / early departure costs]*

The Pensions (early departure) provision relates to the ongoing costs of making early payment of pensions. Legal claims relate to liabilities to third parties (administered by NHS Resolution). The main uncertainty in terms of the timing of the cash flows relates to the pensions provision as assumptions need to be made (in accordance with guidance) as to the estimated length of life of the pensioners and the consequent cost to the Trust. These are discounted per the guidance along with Injury Benefits provisions. At present there is no expectation that the Trust will receive any reimbursement in respect of these provisions.

Note 30.2 Clinical negligence liabilities

At 31 March 2019, £68,042k is included in the provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS FT (31 March 2018: £49,061k).

Note 31 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	**(40)**	(40)
Net value of contingent liabilities	**(40)**	(40)

The Trust held no contingent assets at the period end.

Note 32 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	**803**	122
Intangible assets	**14**	-
Total	**817**	122

Capital commitments as at 31 March 2019 include Measured Term Contract order commitments and small capital schemes where costs are committed under contract, but which are not included elsewhere in the accounts.

Note 33 Financial instruments

Note 33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has low exposure to interest rate fluctuations as it has borrowings only from the Department of Health at fixed rates of interest.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under annual service agreements with Clinical Commissioning Groups and Local Authorities, which are financed from resources voted annually by Parliament. The Trust finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Foreign currency risk

The Trust has negligible foreign currency income or expenditure.

Note 33.2 Financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial assets as at 31 March 2019 under IFRS 9	***Held at Amortised Cost*** **£000**	***Held at fair value through I&E*** **£000**	***Held at fair value through OCI*** **£000**	***Total*** **£000**
Trade and other receivables excluding non financial assets	10,603			**10,603**
Cash and cash equivalents at bank and in hand	1,461	-	-	**1,461**
Total at 31 March 2019	**12,064**	**-**	**-**	**12,064**

Assets as per SoFP as at 31 March 2018	*Loans and receivables* £000	*Assets at fair value through the I&E* £000	*Held to maturity* £000	*Available-for-sale* £000	*Total* £000
Trade and other receivables excluding non financial assets	6,707	-	-	-	6,707
Cash and cash equivalents at bank and in hand	1,400	-	-	-	1,400
Total at 31 March 2018	8,107	-	-	-	8,107

Note 33.3 Financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	**Held at amortised cost £000**	**Held at fair value through the I&E £000**	**Total £000**
Loans from the Department of Health and	77,963		**77,963**
Obligations under finance leases	3,560		**3,560**
Trade and other payables excluding non financial liabilities	19,110		**19,110**
Total at 31 March 2019	**100,633**	**-**	**100,633**

Liabilities as per SoFP as at 31 March 2018	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Borrowings excluding finance lease and PFI	60,554		60,554
Obligations under finance leases	2,678		2,678
Trade and other payables excluding non	17,917		17,917
Total at 31 March 2018	81,149	-	81,149

Note 33.4 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	**24,853**	21,320
In more than one year but not more than two years	**26,989**	5,108
In more than two years but not more than five years	**34,530**	39,383
In more than five years	**14,261**	15,338
Total	**100,633**	81,149

Note 34 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	**Total value of cases £000**	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	**1**	**2**	-	-
Fruitless payments	**-**	**-**	1	30
Bad debts and claims abandoned	**57**	**7**	59	(5)
Stores losses and damage to property	**13**	**66**	3	25
Total losses	**71**	**75**	63	50
Special payments				
Compensation payments	**15**	**58**	9	12
Ex-gratia payments	**17**	**7**	17	19
Total special payments	**32**	**65**	26	31
Total losses and special payments	**103**	**140**	89	81

There were no compensation payments received in recovery of losses above.

Note 35 Events after the reporting period

There have been no significant events after the reporting period date.

Note 37 Related parties

Note 37.1 Register of Interests

The Rotherham NHS Foundation Trust is corporate body established by order of the Secretary of State for Health.

The Trust is required, under International Accounting Standard 24 'Related Party Disclosures', to disclose any related party transactions. The objective of IAS 24 is to draw attention to the possibility that the reported financial position and results may have been affected by the existence of related parties and by material transactions with them. In the cases reported as related parties in year, all payments shown have been made by the Trust to the organisations concerned and not to the individual officers.

During the year the Trust has had transactions with a number of organisations with which key employees/directors of the Trust have some form of relationship. Only those bodies, outside the Department of Health & Social Care parent body, are detailed below and are not considered material. See Note 37.2 in respect of Department of Health & Social Care.

	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	Receipts from Related Party £000	Receipts from Related Party £000	**Payments to Related Party £000**	Payments to Related Party £000
Magna Enterprises Ltd	0	0	**10**	0
Total related party transactions	**0**	0	**10**	0

There was £nil owed, or due at the 31st March in respect of these transactions.

The relationships are:

- A non-executive member of the Board is also a Director/Trustee with Magna Enterprises Ltd.

Note 37.2 Other Related Parties

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. The Government Accounting Manual interprets this such that Department of Health and Social Care group bodies must disclose the Department of Health and Social Care as the parent department and provide a note of the main entities within the public sector with which the body has had dealings. During the year, the Trust has had a significant number of material transactions with other entities within the public sector. These entities are listed below:

- Rotherham Metropolitan Borough Council
- Her Majesty's Revenue and Customs (HMRC)
- NHS Pension Scheme

Independent auditors' report to the Council of Governors of The Rotherham NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, The Rotherham NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

We have audited the financial statements, included within the Annual Report and Accounts 2018/19 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2019; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Taxpayer's Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 to the financial statements (Accounting Policies) concerning the Trust's ability to continue as a going concern.

The Trust anticipates that it will receive external financial support to ensure that it is able to meet its liabilities as they fall due and provide ongoing healthcare services. However, the nature of any financial support, including whether such support will be forthcoming or sufficient is not yet known.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Explanation of material uncertainty

The current year's deficit of £19.9m compares to an original plan of £20.3m deficit. At the end of 2018/19 the Trust had a cash balance of £1.4m, largely due to the drawdown of working capital loans in the year, and the net cash outflow from operations of £9.4m.

For 2019/20 the Trust Board has agreed a financial plan that is breakeven. Based on the financial plan for 2019/20, the Trust will require further financial support from the Department of Health and Social Care to ensure that it is able to meet its liabilities as they fall due and provide ongoing healthcare services. In particular, the Trust's financial plans show that it will require loans in lieu of the receipt of the payment of certain elements of funding which are payable in arrears.

In addition, elements of its future funding (Sustainability and Transformation Funding) are contingent on the Trust achieving its financial plan. If the Trust does not achieve that plan it would require additional external financial support.

We also note the level of external borrowing in the form of Department of Health and Social Care loans of £77.9m as at 31 March 2019, and that there is currently no realistic prospect of paying these back without additional funding beyond current levels.

What audit work we performed

In considering the appropriateness of the Going Concern basis in the preparation of the financial statements we obtained the 2019/20 financial plan and cash flow forecasts, and:

- compared the assumptions within the Trust's financial plan against assumptions provided by Monitor/ NHSI and our experience in the health sector;
- understood the Trust's Cost Improvement Plan target of £9.3m;
- considered the Trust's prospects of paying back the £77.9m of Department of Health external loans as being relatively low based on current funding arrangements;
- assessed the reasonableness of the plan assumptions and carried out a sensitivity analysis over this plan; and
- considered the reliance that the Trust has on external support to deliver its 2019/20 plan.

Our audit approach

Context

The 2018/19 financial year is the third year that PwC has audited the Trust. In the year the Trust experienced financial pressure delivering a £19.9m deficit for the year, which was slightly lower than the original planned deficit of £20.3m. External borrowing from the Department of Health has also risen from £60.5m to £77.9m during the year.

The licence condition placed on the Trust on 23 April 2013 by Monitor, regarding financial planning remains in force. Within the prior year the Trust received a follow up inspection from the Care Quality Commission ("CQC") which, although acknowledging the Trust's progress and improvements made, gave a rating of 'requires improvement'. These matters have been considered within our audit approach.

Our audit for the year ended 31 March 2019 was planned and executed having regard to the fact that the Trust's operations and relative financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview

- Overall materiality: £4,577,400 which represents 2% of total revenue.
- This was our third year audit of the Trust; in considering our approach we considered the Trust's financial performance and clinical performance to identify the areas of greatest risk for the audit process.
- Financial sustainability and going concern
- Risk of fraud in revenue and expenditure recognition and management override of controls;
- Financial standing and sustainability;
- Valuation of Property, Plant and Equipment

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to financial sustainability and going concern, described in the Material Uncertainty relating to going concern section above, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	How our audit addressed the Key audit matter
Risk of fraud in revenue and expenditure recognition and management override of control *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of revenue and expenditure and notes 3 to 5 for further information.* We focussed on this area because there is a heightened risk due to: • The Trust being under increasing financial pressure: the deficit for the year is £19.9m, and whilst the Trust is actively looking at ways to maximise revenue and reduce cost, there is an incentive for management to manipulate the timing of recognition of both revenue and expenditure. • For 2019/20 the Trust Board has agreed a financial plan resulting in a deficit of £35k, the achievement of which will continue to place pressure on the Trust. Given the continued financial support required by the Trust over that period, there remains an increased incentive to misreport the Trusts position. Given these incentives, we considered the key areas of focus to be: • Recognition of revenue and expenditure; • Manipulation through journal postings; and • Items of income or expenditure whose value is dependent upon estimates.	*Revenue* For income and expenditure transactions close to the year-end we tested, on a sample basis that the transaction and the associated income and expenditure had been posted to the correct financial year end by tracing them to invoices or other documentary evidence. Our testing did not identify any balances which had been recorded in the incorrect period. For a sample of income contracts from NHS England and Clinical Commissioning Groups ("CCG"), we obtained and agreed the income received during the year to a signed contract with no exceptions noted. For a sample of income recognised in relation to over performance against contract (i.e. the 'the true up' income) we agreed to year end settlements with no exceptions noted. *Expenditure* For invoices received/ balances paid for a period after the year-end we tested, on a sample basis that the transactions and the associated expense had been posted to the correct financial year by tracing them to other documentary evidence or invoices. Our testing did not identify any items incorrectly recorded. We tested a sample of operating expenses through to invoice to ensure that this had been correctly accounted for. No differences were identified that required amendment within the financial statements. *Intra- NHS balances* We obtained the Trust's mismatch reports received from NHS Improvement ("NHSI"), which identified balances (debtor, creditor, income or expenditure balances) that were different with the counterparty. We checked that management had investigated all differences over £300k (based on the National Audit Office's reporting criteria). We read correspondence with the counterparties, which was consistent with these results. We then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements. Our testing identified a number of errors with the Trust's treatment of balances, and those errors identified which were individually over £250k were amended for in the financial statements. The balances that remained unadjusted do not have a material impact to the year-end financial statements of the Trust. *Manipulation through journal postings* We selected a sample of manual and automated journal transactions that had been recognised in both income and expenditure, focusing in particular on those with unusual account combinations. We traced these journal entries to supporting documentation (for example, invoices, good received notes and cash receipts and payments) to check that the transaction was valid and had been correctly accounted for within the financial statements. Our testing identified no issues that required further reporting. *Management estimates* We evaluated and tested management's accounting estimates, focussing on; accruals, provisions, deferred income; and Property, Plant and Equipment Valuation (see specific area of focus below). We evaluated and challenged the key accounting estimates on which management's estimates were based and the basis of their calculation on a sample basis by comparing the assumptions used by management in the calculation of their estimate with independent

Key audit matter	*How our audit addressed the Key audit matter*
	assumptions and investigating any differences. Our testing identified no matters that required amendment within the financial statements of the Trust.
Valuation of Property, Plant and Equipment *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to Property, Plant and Equipment and note 12 for further information.* We focussed on this area because Property, Plant and Equipment ('PPE') represents the largest balance in the Trust's statement of financial position. All PPE assets are measured initially at cost with Land and Buildings being subsequently measured at fair value, through full valuations every 5 years and interim valuations after three years, with interim impairment assessments being carried out by management to see if there is an indication of impairment. .	We evaluated and challenged the assumptions and methodology in the fixed asset register. We have also challenged the useful economic lives of the fixed assets. We also checked and found that the valuation of land and buildings per the valuation report had been accurately reflected in the financial statements and that the gains and impairments have been accurately reflected in the correct area within the Statement of Comprehensive Income and reserves. We physically verified a sample of assets across land, buildings and other categories to check existence and, in doing so, assessed whether there was any indication of physical obsolescence which would indicate potential impairment. We found no issues from this testing.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the accounting processes and controls, and the environment in which the Trust operates.

In establishing our overall audit approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£4,577,400 (2018: £4,834,000)
How we determined it	2% of revenue (2018: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £228,870 (2018: £242,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial

statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2018/19 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 140, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of The Rotherham NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2019 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

The scope of our work in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The scope of our work is determined by the requirements outlined in Auditor Guidance Note 3 'Auditors' Work on Value for Money Arrangements' ("AGN 03") issued by the National Audit Office in November 2017. We tailored the scope of our work to address the evaluation criterion specified in AGN 03, that in all material respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

Adverse conclusion

As a result of the matters described below, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2019.

Basis for adverse conclusion and key matters

Under AGN 03 we are required to report those matters that, in the auditors' professional judgement, were of most significance in forming the conclusion on whether the Trust had in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources and include the most significant assessed risks of failing to put in place proper arrangements that were identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our work on arrangements to secure value for money as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified relating to this work.

Licence Conditions

On the 23 April 2013 and subsequently amended in June 2013, September 2013 and June 2015, Monitor issued enforcement action against the Trust.

This related to breaches surrounding financial planning, governance and the Electronic Patient Records System. Compliance certificates, in relation to Electronic Patient Records and governance breaches, were subsequently issued by Monitor in July 2014 and January 2015 respectively.

As at 31 March 2019 the Trust still remains subject to enforcement action in relation to financial planning breaches.

The above issue is evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

We reviewed the latest Monitor findings on the NHS website confirming what the breaches relate to and the status of each.

Financial performance and financial specific measures

In the year the Trust delivered a deficit of £19.9m which was in line with the revised plan, though £0.4m adrift of the original deficit plan of £20.3m. Cash outflow from operations was £9.5m and external borrowing with Department of Health is at £77.9m (2018: £60.5m).

During the year there was a cash outflow from operations of £9.5m, and the level of external borrowing from the Department of Health has increased to £77.9m, the repayment of which would require additional external funding beyond current levels.

The above issue is evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Refer to the material uncertainty in relation to going concern paragraph for the details of the audit work performed in relation to this key matter.

CQC inspection results

During 2018/19, the Board of Directors commissioned an external Well-led review undertaken and completed in-year. This review identified some areas that needed to be focussed on.

The Trust also received an inspection from the Care Quality Commission (CQC) during 2018/19 and the CQC assessment of Well-led remained at 'requires improvement'.

We obtained and reviewed the latest CQC report on Rotherham NHS website, this report showed that the CQC assessment of Well-led remained at 'requires improvement'.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 141, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Trust's performance, business model and strategy is not materially consistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on page 173, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Ian Looker (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Leeds
29 May 2019

Acknowledgements

The Rotherham NHS Foundation Trust would like to thank everyone who provided the information for this report, who gave their consent to be photographed, who gave permission for their comments to be included, and to everyone who assisted in ensuring clarity throughout this publication.