

The Rotherham NHS Foundation Trust
**Annual Report
and Accounts**
2015/16

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2015/16

Presented to Parliament pursuant to Schedule 7,
paragraph 25 (4) (a) of the National Health Service Act 2006

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OUR MISSION
*To improve the health
and wellbeing of the
population we serve,
building a healthier
future together*

OUR VISION
*To be an outstanding
Trust, delivering excellent
healthcare at home, in our
community and in hospital*

Foreword from the Chairman and Chief Executive



Welcome to The Rotherham NHS Foundation Trust's Annual Report and Accounts for 2015/16.

Undoubtedly it is a challenging time for the NHS both nationally and locally here in Rotherham.

The Trust was inspected by the Care Quality Commission (CQC) in February 2015 and was given an overall score of 'requires improvement', but scored 'good' for 'caring' across all our services. We took immediate action and, during the year, we have been delivering an improvement action plan with our community and hospital teams to make positive changes for patients across our services.

We have faced considerable operational pressures during the year, which was reflected in our overall performance against the 4 hour access (A&E) target. Whilst succeeding against the 95% target for the first quarter of the year, we did not achieve this during the last three quarters, and we ended the year with annual performance of 90.59%, against a target of 95%.

Nationally, the 4 hour access target was not achieved and we ended the year ranking 53 nationally out of a total of circa 140 organisations, a similar position to the two previous years. This target remains a key focus for the Trust.

A new state-of-the-art Urgent and Emergency Centre is being constructed on the Rotherham Hospital site and is due to open in spring 2017. This will transform the way in which urgent and emergency care is delivered to our patients, helping to ensure that they receive the right care, at the right time, when they need it.



We have made significant progress in integrating our community and acute services through an innovative transformation programme with the Rotherham Clinical Commissioning Group (CCG). We are now working closely with health and social care professionals including community nurses, therapists, GPs, social workers, the hospice and the voluntary sector, and in June 2016 we are launching a locality pilot, which will further enhance and streamline services for Rotherham patients.

We have achieved an overall reduction in harm experienced by our patients, compared with the previous year, and we compared favourably against national figures (see the Quality Report for more details). Successful implementation in both hospital and community settings of the Stop the Pressure campaign, and the Falls Reduction Campaign (which began in September 2015), supported this achievement.

In terms of mortality, the Trust began 2015/16 as an outlier compared to our peers but our new Medical Director has led the work to improve our understanding of the issues underpinning our mortality rates, to the extent that we have seen a reduction and we have introduced enhanced governance arrangements and processes to support further improvement in this area.

During 2015/16 we have further developed our Clinical Strategy, together with exploring opportunities through acute care collaboration to support improved resilience and sustainability of services.

Financially, 2015/16 has been extremely challenging and we did not achieve our plan in full. We planned to achieve a £1.9M deficit but we ended the year £6.9M adverse to plan, with a deficit of £8.8M. The major reason for this was the significant premium pay spend (for example, locum doctors and agency staff). Whilst some progress has been made to address this, it remains an important priority for 2016/17, alongside our recruitment and retention plans.

Another contributing factor for this deficit was our failure to secure £1.5M of potential income as a result of poor coding, which surfaced during the year. Coding is a complex process, but in simple terms, ensures that the Trust is paid for the activity it undertakes. During the year we have addressed the problem and successfully achieved full coding and payment for activity from November 2015.

We achieved a Cost Improvement Programme (CIP), of £12.9M recurrent savings, and £12.6M in-year savings which represents a good performance compared with our peer organisations. In 2016/17, we are planning to deliver a surplus of £6.6M which is predicated on a number of factors, including the delivery of £10.5M CIP and the receipt of £6.5M Sustainability and Transformation Funding.

During the year we secured a £15M loan to support our ambitious capital programme and, in addition to the construction of our urgent and emergency care centre, significant work was undertaken to improve our hospital environment for our patients. This included improved bathroom facilities, a move towards more dementia friendly wards and improved energy efficiency measures. Also as a result of generous donations, we were delighted to be able to open an additional Purple Butterfly Suite which will support end of life patients and their families, which was funded by the Rotherham Hospital and Community Charity.

Whilst we have made considerable progress as an organisation, we are still subject to the NHS Improvement (formally Monitor) enforcement and licence conditions in relation to financial and strategic planning. (See our Annual Governance Statement for further details.)

As a member of the Rotherham Together Partnership and one of the town's major employers and service providers, during the year we have been active in helping to develop a vision for the borough as a great place to live, work or visit. All Rotherham agencies are now working more effectively to improve the arrangements for safeguarding of children and we have been preparing a Sustainability Transformation Plan (STP) for health services in Rotherham.

We have been working together for three years with six other Acute Trusts in South Yorkshire, Mid Yorkshire, North Derbyshire and North Nottinghamshire to improve collaboration and the provision of sustainable services. During this year we have been specifically collaborating with South Yorkshire and Bassetlaw partners on a Sustainability and Transformation Plan (STP) for the next five years to be submitted nationally at the end of June 2016.

Our colleagues are vital to our success and therefore, colleague engagement is central to our strategy. To support this, we have embraced Listening into Action (LIA) as our preferred method of staff engagement for the second year and will continue to embed LIA during 2016/17 by working with new teams to support further improvements in patient care.

None of what we have achieved this year would have been possible without the commitment and dedication of our colleagues throughout the organisation, and without the support of our external stakeholders including the public, our patients and their families.

We are looking forward to working with our colleagues and stakeholders to deliver our recently reviewed vision "to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital".



Martin Havenhand
Chairman



Louise Barnett
Chief Executive

Performance Report

The following Performance Report is prepared in accordance with sections 414A, 414C and 414D¹ of the Companies Act 2006.

Overview of Performance

The purpose of this Overview section is to provide a short summary containing sufficient information for readers of the Annual Report and Accounts to understand the Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during 2015/16.

Chief Executive's Statement

As anticipated, 2015/16 was a very challenging year, not only for the Trust, but for the NHS as a whole.

Overall, the strategic aim of the organisation is to be a stand-alone Trust which, through collaboration, aims to achieve clinical and financial sustainability, in terms of the future of services for the population we serve at home, in the community and in hospital, whilst delivering high quality care each and every day.

In terms of financial performance, whilst we did not achieve our financial plan in full, we did slightly reduce the underlying deficit of the Trust. In addition, we made significant savings and invested in our estate and new models of care, which are fundamental to improving resilience of services and future sustainability.

The Sustainability and Transformation Plan (STP), Working Together Programme (WTP) and Acute Care Collaboration Vanguard, bring together in various configurations Health and Social Care partners across South Yorkshire, Bassetlaw and North Derbyshire, with the aim of providing sustainable health services for not only Rotherham, but the wider population. These programmes provide the mechanism through which we will continue to explore and progress steps to improve resilience and sustainability of services. In 2015/16 the Trust made good progress in further building effective relationships with stakeholders, however further work will be required in future years in order for the Trust to achieve its strategic aim.

Our governance frameworks continue to improve and enabled us to quickly identify historic issues with coding and patient waiting times when they became apparent in-year; we were able to quickly put in place more robust systems, providing a sounder framework in these areas moving forwards.

Overall whilst some elements of our plan were not delivered in full and we have some way to go in achieving sustainability and all of our quality and operational priorities, in terms of governance, quality, operational performance, transformation and stakeholder engagement, 2015/16 has provided a stronger position from which to start the new financial 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 it is regulated by the sector regulator, NHS Improvement, formerly Monitor.

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

Purpose and Activities of The Rotherham NHS Foundation Trust

The principal activity of the Trust during the year has been the provision of acute and community healthcare services to the population of Rotherham and the surrounding areas of South Yorkshire. The Trust provides a broad based portfolio of acute and community care services through a clinical division structure comprising: Integrated Medicine, Emergency Medicine, Surgery, Family Health and Clinical Support Services.

Operating within the healthcare acute and community sector, the Trust serves a local population of around 257,000 with an annual income of in excess of £240m. The organisation is the second largest employer within the local economy and has a diverse workforce of just over 4,200 employees of whom around 900 substantive staff work in the community and circa 3270 substantive staff work in the hospital.

The hospital has 403 inpatient beds on its main site on Moorgate Road, Rotherham in addition to the 20 inpatient beds within the Oakwood Community Unit also located on the Moorgate Road site.

The Trust also provides orthopaedic and neurological rehabilitation services at the nearby Park Rehabilitation Centre and Breathing Space locations in addition to a number of outpatient, day case and inpatient services. Colleagues from the Trust work as part of multidisciplinary and multi-agency teams providing intermediate care from the Rotherham Intermediate Care Centre. In addition the Trust provides a national Photopheresis treatment service for adults and children, the third largest such service in Europe.

The merger with Rotherham Community Health Services gave the Trust the opportunity to provide integrated health care to patients in their own homes and in easily accessible community locations through the district nursing and school nursing teams, Contraception and Sexual Health Service and Care Home Liaison Team to name but a few.

The Trust also helps improve the health and well-being of the people of Rotherham from a number of other locations. Amongst them, the Rotherham Community Health Centre, which is located close to Rotherham town centre, provides rehabilitation services, community healthcare services, audiology and ear care services, GP services (including a walk-in centre provided by Care UK) and community dental services.

Breathing Space is an in-patient and out-patient facility. It incorporates 20 in-patient beds providing respite and rehabilitation for patients suffering acute episodes of respiratory illness and patients with neurological conditions requiring rehabilitation.

The Trust's drive to improve health and well-being is not confined to the residents of Rotherham. Colleagues provide ophthalmic services to the population of Barnsley from Barnsley General Hospital and community dental services to the populations of Barnsley, Doncaster and Rotherham from the New Street Health Centre in Barnsley and the Flying Scotsman building in the middle of Doncaster. In addition occupational health services are provided by the Trust's Health and Wellbeing team to other organisations.

The Rotherham NHS Foundation Trust's Business Model

The business model of The Rotherham NHS Foundation Trust is that of a public benefit corporation whose principal purpose is to provide health services to the population of Rotherham and surrounding areas designed to prevent, diagnose or treat illness and promote and protect public health.

Vision, Mission, Values and Strategic Objectives

During the year the vision, mission, values and five strategic objectives of the organisation remained consistent with those of 2014/15 and were as follows:

Our Vision To ensure patients are at the heart of what we do, providing excellent clinical outcomes and a safe and first class experience.	Our Mission To improve the Health and Wellbeing of the population we serve, building a healthier future together.	Our Values Respect Compassion Responsible Together Right First Time Safe
Our Strategic Objectives     	Excellence in healthcare Engaged, accountable colleagues Trusted, open governance Strong financial foundations Securing the future together	

¹ Except for sections 414



Patients

Excellence in healthcare



Colleagues

Engaged, Accountable
Colleagues



Governance

Trusted, open governance



Finance

Strong financial
foundations



Partners

Securing the future
together

Putting our patients at the heart of what we do

- Care and compassion
- Every patient and their family is special
- Always ensuring we meet essential standards of care
- Embracing the future and leading the way

Amazing colleagues delivering patient care every single day

- Ensuring this is a really great place to work
- Listening to you and supporting you to make decisions
- Developing you to be the best you can be
- Facing our challenges together

Being open and transparent about what we do

- Being responsible and accountable
- Learning when things don't go well
- Supported by clear policies and structures
- Always compliant giving patients confidence in all we do

Using our money and resources wisely

- Better understanding the costs of delivering services
- Making savings safely and becoming more efficient
- Investing in quality and improving our facilities
- Value for money and planning for the future

Understanding the needs of our community

- Working with others to improve the health and wellbeing of our community
- Looking ahead
- Building partnerships to achieve clinical and financial sustainability
- Embracing innovation

Early in 2016/17 the vision of the Trust was revised to ensure it was reflective of the organisation's current position and aspirations. During 2016/17 the values of the organisation will be subject to a consultation involving colleagues to further refine them and align them with the strategic objectives.

Progress against delivery of 2015/16 Strategic Objectives

The table below describes the progress made against the 2015/16 strategic objectives. Delivery of the strategic objectives was underpinned by a set of key priorities for 2015/16.

Strategic Objective	Key Priority	Actions
Patients	Quality Priorities 2015/16	<ul style="list-style-type: none"> ● Outcomes against all the priorities can be found in the Quality Report
	Improvement and actions from CQC inspection reports	<ul style="list-style-type: none"> ● Developed and implemented CQC action plan ● Action plan was followed throughout 2015/16 and developed into Quality Improvement Plan for 2016/17
	Performance against statutory and contractual requirements	<ul style="list-style-type: none"> ● A&E four hour access target was not achieved for the year, with an outturn of 90.59% ● RTT targets achieved ● Cancer targets achieved ● C.Diff target achieved
	Development of Clinical Strategy	<ul style="list-style-type: none"> ● Further development of strategy led by the Medical Director ● Establishment of Clinical Transformation Group ● Clinical Strategy development and collaborative working being progressed through STP, Working Together Programme and Acute Care Collaboration Vanguard ● Progress with community transformation plan, now moving to year 3

Strategic Objective	Key Priority	Actions
Colleagues	Improving Colleague Engagement	<ul style="list-style-type: none"> Successful Listening into Action campaign Eight Speak Up guardians appointed Updated whistleblowing policy launched Levels of engagement monitored through LIA pulse check and staff survey to support improvement Successful annual awards ceremony with increased number of nominations
	Reducing Sickness Absence	<ul style="list-style-type: none"> Some improvement in sickness absence (4.4%) Improvement in long term sickness
	Reducing reliance on premium pay spend	<ul style="list-style-type: none"> Overseas nursing recruitment successful Substantive medical appointments made to a number of key roles Reduction in the percentage of nursing agency spend Reduction in reliance on non-clinical premium spend Improved pay controls and scrutiny with further actions to be taken in 2016/17
	Improving Capacity & Capability	<ul style="list-style-type: none"> Board of Directors development programme Senior Leadership development programme
Governance / Finance	Addressing NHS Improvement Financial Enforcement	<ul style="list-style-type: none"> Majority of requirements previously addressed Risk Framework revised however, revised rating not achieved Underlying deficit remaining, with steady improvement year on year
Governance	Reduction of historic audit recommendations	<ul style="list-style-type: none"> Significant reduction through greater accountability
	Strengthening Performance Framework	<ul style="list-style-type: none"> Divisional performance meetings standardised to ensure consistency between divisions Reconfiguration of divisional structure to improve performance Increased scrutiny and support to address suboptimal performance Substantive appointment to Head of Performance role Further development of Trust Board dashboard and data quality standard
	Successful Level 2 Information Governance Toolkit	<ul style="list-style-type: none"> Level 2 not achieved; training target of 86.63% against required 95% Better performance on previous year with all other Key Indicators
Governance / Patients	Improving Clinical Governance	<ul style="list-style-type: none"> Revised Risk Management Strategy introduced in December 2015 Improved mortality rates Appointment of substantive Medical Director provides robust leadership
Finance	Delivery of Cost Improvement Programme	<ul style="list-style-type: none"> £12.9M recurrent, £12.6M in year savings achieved
	Liquidity & Underlying Deficit	<ul style="list-style-type: none"> Capital loan secured from ITFF Underlying deficit not yet cleared
	Delivery of capital programme	<ul style="list-style-type: none"> £13.5M delivered against plan of £14.1M: Refurbishment and reconfiguration of a number of ward areas Emergency Centre build began



The key issues and risks that could affect the foundation trust in delivering its objectives

Details of the key risks and issues that could affect the foundation trust in delivering its objectives are referenced in detail in the Annual Governance Statement.

Preparation of Accounts and Going Concern

The Trust's accounts have been prepared under a direction issued by NHS Improvement, the Foundation Trust regulator.

The audited accounts of The Rotherham NHS Foundation Trust during 2015/16 appear within the Financial Review section of this document. Where necessary, references to and additional explanations of amounts included in the financial statements, are also included in this section.

After making enquiries, the Directors have a reasonable expectation that The Rotherham NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts². However, the Trust recognises the challenges and the need to take steps regarding the underlying deficit and the need for collaboration for sustainability. The Trust has a strategic commitment to working with partners to achieve that sustainability.

2 For further details regarding 'Going Concern' please see the Financial Review section of this Annual Report and Accounts.

Performance Analysis

Development and Performance of the Trust during the Year

The Trust began 2015/16 subject to an NHS Improvement enforcement undertaking and a licence condition in relation to only one remaining area: financial and strategic planning. From 1 April 2016 NHS Improvement replaced the previous regulator of the Foundation Trust sector, Monitor. Hence any reference to NHS Improvement in this Annual Report and Accounts relating to the period prior to 1 April 2016 refers to Monitor.

Significant action continued during the year in relation to the remaining enforcement undertaking and licence condition with a view to achieving compliance as soon as practicable.

The Trust began the year with a strong team of Non-Executive Directors led by an experienced Chair and complemented by substantively appointed Executive Directors with the exception of the role of Medical Director. During the first quarter the Trust was successful in substantively appointing a Medical Director who joined the organisation in July 2015 thereby achieving the organisation's objective of recruiting an experienced and permanent executive team.

Recruitment to the role of Director of Human Resources (following the departure of the post holder who left at the end of December 2015) was also successful with the new substantively appointed Director taking up her position in April 2016.

In addition the clinical division structure was further strengthened with the creation of the Emergency Care division and the appointment of Deputy Heads of Nursing within the Integrated Medicine and Family Health divisions.

The capacity and capability of the workforce to deliver the Trust's strategic objectives remained key during 2015/16. The modular Senior Leadership programme ran throughout the year and was positively evaluated by participants. In addition, members of the Board of Directors participated in regular Board development sessions. Improved processes for talent management were also introduced.

Performance against Key Performance Measures

In terms of performance against key healthcare targets, the picture during 2015/16 was mixed. The Trust met its access targets in relation to 18 weeks (Referral to Treatment or RTT) and 62 day GP cancer referrals. However, despite determined and ongoing efforts to meet the challenging A&E 4 hour access target, the Trust was unable to meet the target in quarters 2, 3 and 4 of 2015/16. An improvement trajectory against this key indicator has been agreed with the regulator of acute Trusts, NHS Improvement, and the Trust remains committed to deliver this important aspect of patient experience.

In terms of the Quality Account priorities for 2015/16, the position at the end of the financial year was that improvements had been made for almost all indicators. Highlights in terms of the Trust's performance against the Quality Account priorities included:

- Some clinical areas exceeding 600 consecutive days without any avoidable grades 2 to 4 pressure ulcers;
- Zero cases of MRSA bacteraemia;
- Fewer cases of clostridium difficile (C. diff) than the Trust's target.

The only Quality Account priority against which the Trust did not evidence the required improvement was priority 4 within the Patient Experience category relating to complaints management; consequently an improvement action plan for this priority is ongoing.

Performance against the Trust's key operational and quality measures is overseen by the relevant corporate committees, for example improvements in the quality of care provided are scrutinised by the Quality Assurance Committee and those relating to access targets are monitored by the Finance & Performance Committee. In addition a monthly Integrated Performance Report is reviewed in the public Board of Directors meetings at which the Executive Directors are held to account for the Trust's performance by the Non-Executive Directors.

Underpinning this corporate-level analysis of performance are monthly performance meetings held by the Executive Directors with the multi-disciplinary leadership teams of each of the five clinical divisions. In turn these Divisions hold regular performance meetings with the leadership teams of each of their constituent clinical service units.

The joint development of the new Emergency Centre in conjunction with Rotherham Clinical Commissioning Group (CCG) gathered pace in year with the creation of separate task and finish groups designed to develop and implement the project's plans in relation to aspects such as workforce and IT. The Emergency Centre remains on course to open in summer 2017, significantly enhancing the experience of patients who require urgent emergency and out of hours care through the co-location of both Accident & Emergency and GP out of hours services. The Trust remains committed to the innovative model of patient care which is envisaged, and which will be achieved through the integration of the A&E and GP out of hours' workforces along with partners such as Social Services and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).

On a monthly basis Contract Quality Meetings are held between the Trust and Rotherham CCG to monitor the performance of the Trust across both quality and operational performance measures. An annual programme of 'Clinically-led visits' has been in place for a number of years. Rotherham CCG decide which aspects of the care provided by the organisation they wish to inspect and, on a roughly monthly basis, clinicians from the CCG inspect the Trust's services including speaking to patients, carers, relatives and colleagues working in each service. The results of each of these visits are fed into the Operational Quality, Safety & Experience Group to ensure that any learning or improvements from each visit is implemented.

Regular meetings are also held between members of the Board of Directors and representatives of NHS Improvement.

At the beginning for the year the Board of Directors agreed the following 5 priority areas for the acute and community transformation programme 2015/16:

1. Emergency access and admissions;
2. Structured and systematic management of patient beds (acute care and intermediate care);
3. Embedding supported discharge pathways and site management of patient flow;
4. In-reach and outreach programmes of care for community and hospital staff respectively;
5. Closer ties and integrated working with social and primary care.

As a result 2015/16 has been a year for laying foundations within the community nursing service which is now successfully operating in 7 localities. There is clarity on the long term vision for integrated acute and community working, and an animated video was been created which depicts the vision not just for Trust services but for the Rotherham health economy as a whole.

The 'locality pilot' is also now becoming established, with a cross-stakeholder team meeting every three weeks, which includes the Trust, Rotherham Metropolitan Borough Council, Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), Rotherham CCG and Voluntary Action Rotherham. This has seen the selection of the Health Village as the locality pilot, scoping out of a single location for the team to work from, nominations from partners on locality team members, and initial drafting of the job description for the pilot locality lead.

In addition to the locality pilot, work continues on finalising the organisation's 2016/17 strategy for Acute and Community Transformation. This will see the continuation of the main priority areas from year 1 and will see the embedding of basic working practices alongside the development of new ways of working and service models.

The five priorities under which the programme will continue in 2016/17 are:

Priority 1: Emergency Access and Admissions

Recruitment to and development of the Emergency Department workforce, embedding good practice ways of working, alignment of assessment units, investment in ambulatory emergency care and development of a frailty unit.

Priority 2: Structured Management of Inpatient Bed Base

Embedding of the SAFER care bundle, structure of weekend and out of hours working (7 days a week), establishment of medical workforce model for inpatient wards, launch of a Hospital at Night model.

Priority 3: Admission and Discharge Pathways

Review of Intermediate Care pathways and settings, launch of a Complex Discharge / Transfer of Care team, closer alignment with care homes and care home providers.

Priority 4: Integration of Acute and Community Care Pathways

Launch of the locality pilot, appointment and development of the community physician role, implementation and development of Integrated Rapid Response team and Care Coordination Centre.

Priority 5: Site and Operations Management

Establishment of escalation, ward configuration programme, embedding of the site team and site meetings and management of the flex bed base.



The implementation of Service Line Management was completed in year and a revised and enhanced performance management framework was embedded. This framework aims to ensure that decision making is as close to the patient as possible whilst ensuring accountability is retained by clinicians.

Sickness absence management remained a key focus in year as did the drive to reduce expenditure on premium pay and agency usage. Vendors were appointed for both nursing and medical staff during 2015/16 and clinical colleagues were encouraged to join the Trust's bank to further reduce expenditure via external agencies. In addition the Trust introduced new procedures for the procurement of all agency and temporary staff (clinical and non-clinical) in order to ensure compliance with the agency caps introduced by NHS Improvement in year.

Progress was also made in other areas, a number of which are listed below:

- Mental health provision was strengthened as our Trust and RDaSH enhanced their partnership for the benefit of patients.
- The Trust became one of only four hospitals across Europe to be a demonstration site for improved energy efficiency under Project Streamer.
- In June Kate Granger who created the 'Hello my name is..' campaign visited the Trust as part of her national tour.
- Students from the National Citizen Service (NCS) raised almost £1,000 for Rotherham Hospital and Community Charity.

The Trust had a planned deficit of £1.9M for the 2015/16 financial year including a cost improvement target of £12.9M. The year-end position against the £1.9M deficit was £8.8M deficit, adverse to the plan by £6.9M. The key reason for non-delivery of the target was an increased reliance on non-substantive workforce, particularly agency staff, in key clinical specialties such as Emergency and Acute care, Dermatology, and Gastroenterology in order to fill vacant posts.

As the Trust moves into the 2016/17 financial year, one of the priorities for the organisation is to reduce agency spend, thereby reducing premium costs. The Trust has also been working closely with the regulator on agency spend.

Whilst performance against the planned deficit was disappointing, the Trust did perform well against the Cost Improvement Plan (CIP) target, and compared to the sector average. The Trust set a very stretching CIP in 2015/16 recognising both the opportunities available for improvement and also the underlying deficit of the Trust. During 2015/16, The Trust delivered £12.9M recurrent CIP (£12.6M in year), 5.5% of controllable costs compared to a sector average of 3.1%. As the Trust moves into the 2016/17 financial year it will continue to look to improve its efficiency and productivity, and will engage fully with the recently produced Lord Carter review³.

The Capital programme for 2015/16 was a plan of £14.1M, with £13.5M spent. This was supporting investment in key areas such as medical equipment, IT infrastructure, and Estate maintenance. On top of these schemes during the 2015/16 the Trust continued with the investment in the new Emergency Care centre and refurbished a number of ward areas.

During the year the Trust successfully recruited to its key senior finance posts on a substantive basis, and improved and strengthened its internal financial controls and corporate governance arrangements.

The Trust continues to face the challenge of eliminating the underlying deficit. This has been further reviewed at the end of 2015/16, indicating positive improvement over recent years from approximately £9M in 13/14 to an underlying recurrent budget deficit of £6.5M in 2015/16. The plan for 2016/17 aims to erode this further to achieve a reduced underlying deficit of between £4.4M and £6.5M. This plan is very challenging and is not without risk. Some of the risks within the 2016/17 financial year, which will be closely monitored, include:

- Access to the Sustainability and Transformation Fund with delivery of its conditions, including delivery of each of the remedial trajectory key performance targets;
- Delivery of the CIP for 2016/17;
- Delivery of the clinical activity contract including full receipt of CQUIN funding;
- Ability to reduce reliance on premium pay spend including agency cap through effective recruitment to key substantive roles and workforce re-design;
- Successful partnership working through the acute care collaboration Vanguard and increased resilience to support introduction of new models of care;
- Implication of the new junior doctors contract;
- Capital programme;
- Acute and community integration, locality working models including multi agency working;
- Further transformation across emergency and elective pathways.

Workforce, Equality and Human Rights

The Trust is proud of being a friendly and professional place to work; endeavours to create an environment where colleagues are engaged and accountable and recognises that this translates into better quality care for patients.

The workforce is the Trust's most important asset and the organisation aims to engage with colleagues and listen to their views. The Listening into Action (LiA) programme has enabled the engagement with colleagues across the Trust to identify and implement positive changes for patients.

During 2015/16 the Trust recruited 100 nursing colleagues from Spain, Croatia and Romania. Eighty-eight colleagues were retained, who are now working at the Trust alongside locally recruited nurses.

The Trust is keen to be an organisation where colleagues are proud to work and want to stay to develop their careers. The Deputy Chief Nurse is leading a work stream on retention for nursing colleagues. Successful Proud Awards took place again this year, receiving more than 330 nominations, 170 of which came from patients or members of the public. On the day, 31 awards were given out across 21 categories. A weekly Proud newsletter has also been developed celebrating colleagues' achievements and there is a hashtag #trftproud which is used on social media to highlight good news.

During the year, the Trust ran a successful Senior Leadership Programme, as well as leadership courses for new and existing line managers. A suite of bespoke courses for local directorates and divisions to spot and develop in house leadership talent were also provided.

A total of 17 apprentices successfully completed their apprenticeships during 2015/16 and 10 of them went on to be employed by the Trust, with 6 undertaking further training in the NHS. The Estates and Facilities Department supported seven unemployed people from

Rotherham through a Prince's Trust training programme, at the end of which all seven succeeded in gaining employment with the Trust.

The level of sickness absence from 1 April 2015 until 31 March 2016 was 4.44% for the year. This represents a slight reduction compared to the rate during 2014/15. The monthly sickness absence percentage improved during 2015/16, with two months running at below 4% and December 2015's sickness level was 4.86% - a significant reduction from the previous December. Further detail relating to sickness absence during 2015/16 can be found in the Staff Report section of this Annual Report.

The Workplace Health and Wellbeing service has introduced a number of measures to improve colleagues' health, including five workshops on different aspects of staying healthy and a workplace health and wellbeing initiative encouraging people to sign up and become more active. Stress management has remained a priority during 2015/16 and a number of stress management workshops have been run, in addition to counselling and other support available. Colleagues have the opportunity to have a discussion about wellbeing during their PDRs and we also offer a personal health check, including elements such as blood pressure testing, cholesterol, weight, diet and general health and lifestyle advice.

The Public Sector Equality duty

The Board of Directors and the Council of Governors of TRFT are committed to promoting equality, diversity and human rights and achieving the elimination of unlawful discrimination.

This is achieved by ensuring that the Trust values equality, diversity and human rights through all aspects of service provision and employment.

To make our vision a reality, we are determined to promote equality of access and identify and eliminate any inequalities in everything we do. We also reaffirm our commitment to ensure that our own colleagues are treated fairly, with dignity and respect, and afforded equality of opportunity to develop to their full potential.

The Trust is required to publish information to demonstrate its compliance with the Public Sector Equality Duty. This report was reviewed and updated in January 2016 and is available on the Trust's website.

During 2015, the Trust launched the Workforce Race Equality Standard and plans to launch the Equality Delivery System 2 (EDS2) during 2016/17.

Directors and Senior Managers⁴

Chairman and Non-Executive Directors: 4 male and 3 female.
Executive Directors: 3 male, 2 female and one vacant.

Employees

As at 31 March 2016, 3528 females and 699 males⁵ were employed by The Rotherham NHS Foundation Trust.

Social and Community Issues

The Trust belongs to the Local Strategic Partnership (LSP) which brings together representatives of local public bodies, such as the police, local council, local colleges and representatives of voluntary organisations and businesses. The LSP agrees priorities for Rotherham and works together to make sure that progress is made against these priorities on behalf of the people of Rotherham.

The Trust's Chief Executive and Executive Directors regularly attend the Rotherham Health and Wellbeing Board ensuring that the Trust is a key part of the development of health and social care services across the Borough. During the year, colleagues also attended a number of meetings of the Rotherham Health Select (Overview and Scrutiny) Commission to inform its Chair of the Trust's progress in the implementation of its plans.

The Trust's Governors and Members continue to support this agenda to ensure that our work accurately reflects the needs of the community. We work in collaboration with local partners, such as Voluntary Action Rotherham, and Healthwatch Rotherham to enable local people to engage with the Trust and get the most from their local health service.

We actively support local and national charities, including supporting national awareness-raising days, Self-Care Week and the Rotherham Hospital Charity.

During 2015/16, the Health Information service has dealt with more than 1700 enquiries from patients and the public, including more than 360 enquiries for Macmillan Cancer Support. The Trust supported a range of public health campaigns, including Yorkshire Smokefree, who undertook 10 promotions this year. Information on stopping smoking was also provided to around 100 people.

Events in the Community Corner raised funds of more than £2,850 throughout the year and there have been leaflet and poster displays for around 100 different health issues, for example Diabetes awareness, Heart Month and Blue September.

A total of 175 promotions and events were held in the Health Information and Community Corner this year.

Overseas Operations

The Trust does not have any overseas operations.

Any important events since the end of the financial year affecting the Foundation Trust

Cheryl Clements took up her post as the substantive Director of Workforce on 18 April 2016.

Performance Report signed by the Chief Executive, as Accounting Officer:



Louise Barnett
24 May 2016

³ Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. An independent report for the Department of Health by Lord Carter of Coles, February 2016

⁴ For the purposes of this Annual Report it has been determined that the term 'Senior Manager' as defined in Monitor's NHS Foundation Trust Annual Reporting Manual for 2015/16, p. 126 refers to Executive and Non-Executive members of the Trust's Board of Directors only.



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	
Mark Edgell	Non-Executive Director	
Lynn Hagger	Non-Executive Director	
Chris Holt	Chief Operating Officer	
Alison Legg	Non-Executive Director	
Tracey McErlain-Burns	Chief Nurse	
Barry Mellor	Non-Executive Director	
Simon Sheppard	Director of Finance	
Conrad Wareham	Medical Director	Appointed 20 July 2015

Directors who served during the year, but who had left office before year end

Donal O'Donoghue	Interim Medical Director	15 December 2014 - 15 July 2015
Lynne Waters	Executive Director of HR	Until 30 November 2015
Ken Hutchinson	Interim Executive Director of HR	1 December 2015 – 23 February 2016

Directors' biographies can be found within the Governance Report, together with details of Directors' attendance at Board and Board Committees.

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 Foundation Trust Annual Reporting Manual 2015/16 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 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.
- 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 Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

As far as each Director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware.

The Directors have taken all the steps they ought to as a director 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.

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 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 and to prevent unforeseen bank charges. Additionally the fiscal climate has meant that this approach has become of greater importance to the Trust and as such this is reflected in the performance when measured against the 30 day target.

Enhanced Quality Reporting

Quality Governance is a combination of structures and processes at and below Board level to lead on Trust-wide quality performance including:

- Ensuring required standards are achieved;
- Investigating and taking action on sub-standard performance;
- Planning and driving continuous improvement;
- Identifying, sharing and ensuring delivery of best-practice; and
- Identifying and managing risks to quality of care.

Through the organisational structure which was further developed during 2015/16 to consolidate and focus activity across the Trust, the Trust continues to drive further improvements in the quality of care provided to patients.

The Trust has had regard to NHS Improvement's Quality Governance Framework in arriving at its overall evaluation of its performance, internal control and Board Assurance Framework. During the comprehensive CQC inspection in February 2016 the Trust was found to 'require improvement' in relation to the 'Well-led' domain. Work has therefore continued during the year to make improvements in the following key areas:

- Engagement of staff especially within community services;
- Further development of the Board Assurance Framework;
- Incident reporting, investigation and sharing of learning;
- Maintenance of dynamic and 'live' risk registers;
- Embedding of governance infrastructure within the clinical divisions.

The Trust seeks to ensure that its strategy, capabilities and culture,

processes and structure, and measurements are mapped against NHS Improvement's Quality Governance Framework. During 2016/17 the Trust will commission a formal external evaluation of the extent to which the key elements of NHS Improvement's Quality Governance Framework are embedded within the Trust as required by the sector regulator, NHS Improvement.

Members of the Board of Directors (Executive and Non-Executive Directors) have routinely attended the quarterly scheduled Council of Governors meetings to ensure that they develop an understanding of the views of Governors and Members.

In February 2015 the Care Quality Commission (CQC) undertook a routine, announced inspection of the Trust. The CQC inspectors reviewed services across the eight acute and four community 'core services' as follows:

Acute Core Services:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical Care
- Maternity & Gynaecology
- Services for children and young people
- End of life care
- Outpatients & diagnostic imaging

Community Core Services:

- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- Community end of life care

The Trust's overall rating from this inspection was 'Requires Improvement'. For each of the CQC's 5 key questions the Trust's overall ratings were as follows:

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

A comprehensive improvement action plan was created as a result of the inspection findings and was approved by Board of Directors in July 2015. Progress updates against the improvement action plan are presented on a monthly basis to the public part of the Board of Directors meetings. These monthly updates and the improvement action plan itself are available on the Trust's internet site.

In addition to the announced inspection of the Trust's acute and community services, during the same week in February 2015 the CQC also undertook a review of services for Children Looked After and Safeguarding (CLAS) in Rotherham. This was a joint review involving the Trust; NHS England; Rotherham, Doncaster and South Humber NHS Foundation Trust and Rotherham Clinical Commissioning Group and Rotherham Metropolitan Borough Council.

The Care Quality Commission CLAS review lines of enquiry are centred on:

- 1) The experiences and views of children and their families.
- 2) The quality and effectiveness of safeguarding arrangements within health economies.
- 3) The quality of health services and outcomes for children who are looked after and care leavers.
- 4) Health leadership and assurance of local safeguarding and looked after children arrangements.

The outcome following the CQC CLAS Inspection is provided by way of a narrative report and no ratings are provided. In total 24 recommendations were made. A SMART Action Plan addressing all 24 recommendations was produced. The action plan has been monitored via a monthly Challenge Meeting led by Rotherham CCG and to date the Trust's actions have progressed well and as per plan with no exceptions to report.

Patient Care

The Trust is using its foundation trust status to develop its services and improve patient care in a number of ways.

The governance structure of the foundation trust specifically acknowledges clear lines of accountability to the community and the patients which it serves. Direct representatives of those individuals, together with colleagues and partner member representatives, are found in members of the Trust's Council of Governors. As well as holding meetings in public, a variety of other activities are undertaken so that Governors may fulfil their duty of representing the views of members in their constituencies and the public in general. More details of Governors' activities can be found in the Governance Report.

A number of departments request feedback directly from patients regarding the service they have received to enable the Trust to improve and develop services. This feedback is in addition to that received via Patient Surveys, PLACE inspections and the Friends and Family test.

More details on stakeholder engagement can be found in the Quality Report.

As detailed in the Performance Analysis section of this Annual Report the Trust met its access targets in relation to 18 weeks and 62 day GP cancer referrals. However, despite determined and ongoing efforts to meet the challenging A&E 4 hour access target, the Trust was unable to meet the target in quarters 2, 3 and 4 of 2015/16. An improvement trajectory to improve the Trust's performance against this key target has been agreed with the regulator of acute Trusts, NHS Improvement and the Trust remains committed to deliver this important aspect of patient experience.

In terms of the Quality Account priorities for 2015/16, the position at the end of the financial year was that improvements have been made for all indicators with the exception of those related to complaints. Again, an improvement action plan for the complaints indicators is ongoing.

The Trust has two committees charged with the responsibility for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets relating to the quality of care. These are the Quality Assurance Committee (QAC) which is the board-level committee and the Operational Quality, Safety & Experience Group (OQSEG) which is the operational committee.

The role of the QAC is to provide assurance to the Board of Directors that there is an effective system of quality governance, risk management and internal control in place within the organisation as regards:

- Patient experience;
- Clinical effectiveness;
- Safety of patients and service users; and
- Clinical and research governance

In addition, QAC also provides the Board with assurance on matters relating to quality, safety, the effectiveness of care, and by doing so, provides the Board with assurance as to the Trust's on-going suitability for compliance with applicable statutory and regulatory standards, in particular, those of the CQC and NHS Improvement.

The role of OQSEG is to oversee the operational delivery of high quality healthcare through the work of a number of sub-groups relating to clinical effectiveness; medication safety; health and safety; infection prevention and control; patient experience; patient safety; safeguarding (adults and children) and the screening programmes.

Consequently both QAC and OQSEG provide scrutiny relating to the organisation's performance against:

- Commissioning for Quality and Innovation (CQUIN) scheme targets;
- Standards relating to key safeguarding service provision requirements such as training and partnership working;
- Indicators related to a number of safeguarding requirements such as training, supervision, compliance of completion of HR processes such as DBS checks and compliance of standards regarding assessment of looked after children;
- Compliance with mandatory and statutory training (MAST) requirements;
- Reviews, inspections or accreditations undertaken by external agencies for example the Care Quality Commission and the Health & Safety Executive;
- Midwifery Supervision Annual Review;
- Development of Nursing Metrics; and
- Safer Nursing Care Tool and review of nursing establishments.

The Commissioning for Quality and Innovation (CQUIN) scheme includes nationally mandated and locally agreed goals for improving quality of patient care. During 2015/16 the Trust achieved 85% of its CQUIN targets. The schemes agreed with Rotherham Clinical Commissioning Group and the Trust's year-end position is detailed within the Quality Report.



In addition to these, a set of Acute and Community Transformation schemes, some of which included progress toward delivering 7 day services, were also agreed for implementation during 2015/16. The scheme titles are listed below:

Acute Transformation & 7 Day Working		Community Transformation Schemes & 7 Day Working	
Scheme		Scheme	
Time to Consultant first review		Community Unit	
Frail Elderly (Medical Staffing)		Falls & Bone Health	
Multi-disciplinary Team Review		Care Coordination Centre	
Shift Handovers		Integrated Rapid Response Service	
Diagnostics - Pharmacy		Integrated Community Nursing Service	
Diagnostics – Radiology		Therapy Support – Waterside Grange	
Diagnostics – Therapies			
Access to a Specialist Opinion			

The Trust's performance in relation to the priorities contained in its Quality Account for 2015/16 is detailed within the Quality Report section of this Annual Report.

The Trust has continued to provide its full range of Acute and Community services during 2015/16.

During the year the Trust has developed, piloted and implemented a locality based model for delivery of community services. This brings huge benefits to patients through using a multi-disciplinary team approach. The teams are comprised of GP's, Practice Nurses, District Nurses, Community Nurses, Therapists, Phlebotomists and other disciplines and their purpose is to provide a holistic package of care. The team works together within their allocated locality to manage patients requiring a range of community care interventions. There are 7 localities in total across the Rotherham community. This method of working ensures the different disciplines of staff caring for the patient are aware of their overall clinical needs. This seeks to reduce unnecessary duplication of work requiring fewer visits wherever possible. The ultimate aim of this locality based model is to deliver a better patient experience, through keeping patients safe and well in their own homes.

This also has financial benefits for the Rotherham health economy as patients receiving care in their home setting are less likely to require expensive hospital admission.

Health information is made accessible to patients, colleagues and visitors via a dedicated area located within the main entrance of Rotherham General Hospital. The Health Information service is a key component in supporting the achievement of the Trust's strategic objectives by equipping people with the knowledge and skills to utilise information to manage and improve their own health and to make informed decisions about their care.

During 2015/16, the Health Information service has dealt with more than 1700 enquiries from patients and the public, including more than 360 enquiries for Macmillan Cancer Support. The Trust supported a range of public health campaigns, including Yorkshire Smokefree, who undertook 10 promotions this year. Information on stopping smoking was also provided to around 100 people.

A total of 175 promotions and events have been held in the Health Information and Community Corner this year providing a wealth of information to patients, carers, colleagues and other visitors to the Trust. These have included Parkinson's awareness week in April 2015; two stroke awareness events in May and October 2015; Head and Neck cancer awareness week in September 2015 and the hosting of 21 different stalls over four days during Self-Care week in November 2015.

Service improvements have been made throughout the year. Those relating to the CQC's comprehensive inspection and CLAS inspection were described earlier in the Directors Report. Unannounced 'dip samples' during which colleagues led by the Chief Nurse checked the extent to which changes resulting from both inspections had been sustainably implemented were undertaken in the autumn and winter of 2015/16. These included both the hospital site and community locations including Breathing Space and Kimberworth Place as well as the Rotherham Community Health Centre.

Feedback from individual complaints was used to improve services to patients as did feedback from the national patient surveys. These improvements included:

- Work to improve bathroom facilities to safeguard against breaches of the mixed sex accommodation regulations;
- Reduction in noise in inpatient areas at night including changes to lighting and the offering of warm drinks;
- Review of cleaning schedules to increase cleaning provision
- Regular care surveys undertaken by the Dementia Lead Nurse

Feedback from the Friends and Family Test has demonstrated positive performance throughout the year, above the planned trajectories. The Friends and Family steering group has been well attended by nursing colleagues from across the organisation and has undertaken some significant work in order to increase response rates to the test.

Night 'walkabouts' are led by the Chief Nurse, Patient Safety 'walkabouts' are led by the Assistant Director for Patient Safety and Risk and Quality Assurance 'walkabouts' are led by the Assistant Chief Nurse (Vulnerabilities). Each type of walkabout happens on a regular basis and the feedback is provided to the Patient Safety Group, Patient Experience Group or Operational Quality Safety, and Experience Group depending on the focus of the visit. Each Group identifies the good practice to be shared and where necessary monitors the actions to be taken to ensure improvements are achieved.

Throughout the year the Trust has been working to improve the way in which it manages complaints.

Face-to-face meetings in real time with patients and their families are now promoted as the first line to resolving concerns. There has been an increase in the number of complainant meetings which has led to a reduction in formal complaints.

Where formal complaints have been made and investigated, focus on learning from these patient experiences has been driven through developing and sharing action plans to reduce the likelihood of the same problems occurring in future. This gives other parts of the organisation the opportunity to learn and improve patient experience.

Information on how to make a complaint has now been displayed around the trust in 3 key languages for the Rotherham area: Polish, Urdu and Romanian. A Task and Finish Group has been operating during the year working with colleagues across the Trust to enhance and develop the complaints process.

In order to further enhance patient experience during 2015/16 the Trust has invested significantly in the estate most notably with the commencement of the construction of the new Emergency Centre, due for completion in May 2017.

In addition the organisation has undertaken the following ward and patient environment improvements:

- Upgrade of Ward A5 (an investment of £60K)
- Transferred Fitzwilliam Ward to Ward A2 (an investment of £275K)
- Transferred Ward B3 to Fitzwilliam Ward (an investment of £142K)
- Transferred Discharge Lounge to Ward B10 (an investment of £142K)
- Transferred Ward B1 to Wards B2/B3 (an investment of £374K)
- Transferred A&E to Ward B1 (an investment of £175K)
- Created three additional bedrooms in the Community Hospital (an investment of £70K)
- Reconfiguration of the Surgical Assessment Unit on Ward B5 (an investment of £100K)
- Creation of a second Purple Butterfly (end of life care) room on Ward A2 (an investment of £64K)
- Commenced rollout of the ward access control system, providing secure access to ward areas for authorised personnel only
- Completion of a new Children's Dental Suite on B floor (an investment of £300K)
- Upgraded maternity delivery theatre ventilation, recovery and triage facilities (an investment of £350K).

Other notable schemes relating to maintaining the estate during the financial year include:

- Commenced upgrade of Pharmacy Aseptic Suite to meet compliance with pharmacy manufacturing standards and retain accreditation (an investment of £950K)
- Completion of passive fire protection works to C level (an investment of £200K)
- Replacement of Sub-station D generators (an investment of £400K)
- Clinical Sterile Services Department washer disinfector and sterilizer replacements (an investment of £430K)
- Replacement of emergency and general light fittings (an investment of £100K)
- Provision of an 122 space staff car park which will free up parking spaces to be used as public parking for visitors

During 2015/16 the Trust has continued to work in well-established partnerships with both Barnsley Hospital NHS Foundation Trust for the delivery of Ophthalmology services and Doncaster & Bassetlaw NHS Foundation Trust for the delivery of Ear, Nose & Throat (ENT) and Oral Maxillofacial services. Management of these services across the sites is embedded and has been in place for a number of years.

Throughout 2015/16 the Trust has continued to pursue further partnership working arrangements through the Working Together Programme and independently with other organisations with regard to specific service issues. Whilst the Trust has not entered into any formal arrangements during this year, it is likely to progress these arrangements further during 2016/17.

The Trust is actively engaging with other local services across the health economy to further develop and/or enhance service delivery. The organisation is working particularly closely with Social Care colleagues at Rotherham Metropolitan Borough Council on an initiative to facilitate multi-system, multi-disciplinary working. The ultimate aim is to ensure all patient needs, both clinical and social, are managed collectively at the right time during the patient pathway. The intended outcome of pursuing and progressing this collaborative working is to enhance the patient experience by reducing the number of hand-overs between different service providers, therefore reducing potential delays.

The Trust actively engages with Public Health both at RMBC and NHS England in supporting health awareness messaging and in addition works with the voluntary sector to provide support where appropriate.

During 2015/16 the Trust has actively engaged with Rotherham's Health & Wellbeing Board and Overview & Scrutiny Committee.

In addition the following consultation activities have been undertaken:

- For Learning Disabilities Services: involving in Speak Up (an advocacy organisation); Rotherham Parents and Carers Group (a service user group) to inform and improve practice; Community Learning Disability Team (provided by RDASH) to ensure partnership working and epilepsy services at the Royal Hallam Care.
- For Dementia Care: involving the Alzheimer's Society; the Dementia Café; Friends of Early Onset Dementia in Rotherham and the Dementia Action Alliance. Partnership and agency working has been undertaken with these agencies to review the situation in Rotherham in relation to Dementia care and support.
- For Safeguarding: partnership working with Rotherham Clinical Commissioning Group; NHS England; South Yorkshire Police; RMBC and RDASH. The Trust has also engaged in collaborative working in relation to safeguarding standards.
- A whole health economy approach was taken to the CQC Children and Looked After Inspection and subsequent action plan development and monthly challenge meetings.
- Tissue Viability Services: Trust representatives participate in a regional group led by NHS England to enable a more consistent approach to the prevention and management of pressure ulcers and investigation.
- The Trust works closely with local universities, the Deanery and other learning establishments to ensure all its colleagues (both clinical and non-clinical) have the opportunity to develop professionally.

Patient and Public Involvement activities during the year have included:

- Breast Care Open Day
- Ophthalmology Open Day
- Secondary Breast Cancer Pledge Launch
- National Patient Surveys
- Responses to the Friends and Family Test
- Dementia Carer surveys
- Feedback from HealthWatch Rotherham
- Quality Assurance Walkabouts – involvement of members of the Council of Governors
- Volunteers

Remuneration Report

The Remuneration Report summarises the Trust's Remuneration Policy and particularly, its application in connection with the Executive Directors. The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the revised NHS Foundation Trust Code of Governance, specific parts of Sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11, Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") as interpreted for the context of NHS foundation trusts and part 2 and 4 of schedule 8 of the Regulations as adopted by NHS Improvement in the NHS Foundation Trust Annual Reporting Manual 2015/16.

This report contains details of how the remuneration of senior managers is determined.

'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. For the purposes of this report, the term 'senior manager' applies to the Chair, Non-Executive Directors and all Executive Directors only, whether substantive or interim.

Annual Statement on Remuneration from the Chair of the Remuneration Committee

During the previous financial year (2014/15) the Remuneration Committee considered that a new, up-to-date and simpler pay framework, which did not include bonus or performance-related payments, would be more suitable for use whilst the new Executive Director team was being recruited.

The Committee moved away from using the previous Pay Framework which had been used for a number of years and instead, executive salary amounts were based on annual benchmarked data, including that provided by NHS Providers. This new pay and reward framework continued to be used throughout 2015/16.

With the exception of the Chief Executive and the Executive Directors, all non-medical substantive employees of the Trust, are remunerated in accordance with the national NHS pay structure, Agenda for Change. Substantive medical colleagues are remunerated in accordance with national terms and conditions of service for doctors and dentists.

Remuneration for Non-Executive Directors is determined by the Council of Governors.

The aims of the revised framework were 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.

An annual salary review took place for all executive director posts during 2015/16. No pay awards were made.

Colleagues on Agenda for Change terms and conditions were subject to the following changes coming into effect 1 April 2015:

- Staff on pay spine point number 1 at 31 March 2015, moved onto pay spine point number 2, on 1 April 2015.
- Pay spine point number 2 was increased to £15,100, consolidated (3.1%).
- Pay spine point values 3 to 8 (inclusive) increased by 1% and by an additional £200, consolidated.
- Pay spine points 9 to 42 increased by one per cent, consolidated.
- The values of pay spine points 43 to 54 (inclusive) were unchanged.
- The provisions for incremental pay progression continued to apply, except that colleagues on pay spine points 34 to 54 were not eligible for incremental pay progression for the financial year.



Barry Mellor
Chair, Remuneration Committee



Senior Managers' Remuneration Policy

The Future Policy 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.

Guidance issued by the Cabinet Office, sets a maximum salary of £142,500 as the Civil Service threshold 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 £142,500 (annualised) was exceeded in the case of four executive directors during the financial year. Two of these occasions relate to directors who served on an interim basis only where actual remuneration during the financial year did not amount to the threshold amount.

In relation to the annualised remuneration of two substantive executive directors, both 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.

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.

Future Policy Table (1)

Single total figure table		2015/16		2015/16		2015/16		2015/16		2014/15		2014/15		2014/15		2014/15		2014/15							
Name of senior manager	Job title (and period of office if relevant)	Salary & fees (in bands of £5k)		All taxable benefits (total to the nearest £100)		Annual performance-related bonuses (in bands of £5k)		Long-term performance-related bonuses (in bands of £5k)		All pension-related benefits (in bands of £2.5k)		Total (bands of £5k)		Salary & fees (in bands of £5k)		All taxable benefits (total to the nearest £100)		Annual performance-related bonuses (in bands of £5k)		Long-term performance-related bonuses (in bands of £2.5k)		All pension-related benefits (in bands of £2.5k)		Total (bands of £5k)	
		£000s (Band of £5k)		£000s (nearest £100)		£000s (Band of £5k)		£000s (Band of £5k)		£000s (Band of £2.5k)		£000s (Band of £5k)		£000s (nearest £100)		£000s (Band of £5k)		£000s (Band of £2.5k)		£000s (Band of £5k)		£000s (Band of £5k)			
L Barnett	Chief Executive	175	- 180	-	-	-	-	65.0	- 67.5	245	- 250	175	- 180	-	-	-	-	150.0	- 152.5	330	- 335				
T McErlain-Burns	Chief Nurse	115	- 120	-	-	-	-	20.0	- 22.5	140	- 145	115	- 120	-	-	-	-	-	-	115	- 120				
S Sheppard	Director of Finance	115	- 120	-	-	-	-	52.5	- 55.0	170	- 175	45	- 50	-	-	-	-	75.0	- 77.5	120	- 125				
C Holt	Chief Operating Officer	125	- 130	-	-	-	-	57.5	- 60.0	185	- 190	60	- 65	-	-	-	-	20.0	- 22.5	85	- 90				
C Wareham	Medical Director (from 20/7/2015)	115	- 120	-	-	-	-	30.0	- 32.5	150	- 155	-	-	-	-	-	-	-	-	-	-				
L Waters	Executive Director of HR (until 31/12/2015)	90	- 95	-	-	-	-	90	- 95	90	- 95	-	-	-	-	-	-	-	-	100	- 105				
K Hutchinson	Interim Executive Director of HR (1/12/2015 to 23/2/2016)	40	- 45	-	-	-	-	40	- 45	-	-	-	-	-	-	-	-	-	-	-	-				
D O'Donoghue	Interim Medical Director until 15 July 2015	100	- 105	-	-	-	-	100	- 105	85	- 90	-	-	-	-	-	-	-	-	85	- 90				

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, but are not excessively above benchmarked norms.

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.

In relation to Conrad Wareham, the amount of remuneration received during 2015/16 relates solely to his role as Medical Director.

Future Policy 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		2015/16		2015/16		2015/16		2015/16		2015/16		2014/15		2014/15		2014/15		2014/15		2014/15		2014/15							
Name of senior manager	Job title (and period of office if relevant)	Salary & fees (in bands of £5k)		All taxable benefits (total to the nearest £100)		Annual performance-related bonuses (in bands of £5k)		Long-term performance-related bonuses (in bands of £5k)		All pension-related benefits (in bands of £2.5k)		[Extra column-not expected to be used; rename this if used]		Total (bands of £5k)		Salary & fees (in bands of £5k)		All taxable benefits (total to the nearest £100)		Annual performance-related bonuses (in bands of £5k)		Long-term performance-related bonuses (in bands of £2.5k)		All pension-related benefits (in bands of £2.5k)		[Extra column-not expected to be used; rename this if used]		Total (bands of £5k)	
		£000s (Band of £5k)		£s (nearest £100)		£000s (Band of £5k)		£000s (Band of £5k)		£000s (Band of £2.5k)		£000s (Band of £5k)		£000s (Band of £5k)		£s (nearest £100)		£000s (Band of £5k)		£000s (Band of £5k)		£000s (Band of £2.5k)		£000s (Band of £5k)		£000s (Band of £5k)			
M Havenhand	Chairman	50	-	55	-	-	-	-	-	-	-	-	50	-	55	-	45	-	50	-	-	-	-	-	45	-	50		
G Atmarow	Non Executive Director	15	-	20	-	-	-	-	-	-	-	-	15	-	20	15	-	20	-	-	-	-	-	-	15	-	20		
A Legg	Non Executive Director	15	-	20	-	-	-	-	-	-	-	-	15	-	20	15	-	20	-	-	-	-	-	-	15	-	20		
M Edgell	Non Executive Director	15	-	20	-	-	-	-	-	-	-	-	15	-	20	15	-	20	-	-	-	-	-	-	15	-	20		
L Hagger	Non Executive Director	15	-	20	-	-	-	-	-	-	-	-	15	-	20	15	-	20	-	-	-	-	-	-	15	-	20		
B Mellor	Non Executive Director	15	-	20	-	-	-	-	-	-	-	-	15	-	20	15	-	20	-	-	-	-	-	-	15	-	20		
J Barnes	Non Executive Director	15	-	20	-	-	-	-	-	-	-	-	15	-	20	15	-	20	-	-	-	-	-	-	15	-	20		

The Non-Executive Director remuneration framework, agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2015/16 has been consistent with this framework. No additional payments are made for any additional duties carried out.

The Non-Executive Directors declined to consider any pay rise during 2015/16.

Non-Executive Directors, including the Trust Chairman, are subject to fixed term appointments.

Pension Entitlements of Executive Directors

Total Pension Entitlement		2015/16		2015/16		2015/16		2015/16		2015/16		2015/16		2015/16		2015/16		2015/16		2015/16			
Name of senior manager	Job title (and period of office if relevant)	Real increase in pension at pension age		Real increase in pension lump sum at pension age		Total accrued pension at pension age at 31 March 2016		Lump sum at pension age related to accrued pension at 31 March 2016		Cash Equivalent Transfer Value at 1 April 2015		Real increase in Cash Equivalent Transfer Value		Cash Equivalent Transfer Value at 31 March 2016		Employer's contribution to stakeholder pension							
		£000s (Band of £2,500)		£000s (Band of £2,500)		£000s (Band of £5k)		£000s (Band of £5k)		£000s		£000s		£000s		£000s		£000s		£000s			
L Barnett	Chief Executive	2.50	5.00	0.00	2.50	30.00	35.00	80.00	85.00	402	35	442											
T McErlain-Burns	Chief Nurse	0.00	2.50	2.50	5.00	50.00	55.00	150.00	155.00	900	26	937											
S Sheppard	Director of Finance	2.50	5.00	0.00	2.50	30.00	35.00	90.00	95.00	435	27	467											
C Holt	Chief Operating Officer	2.50	5.00			5.00	10.00			62	29	92											
C Wareham	Medical Director (from 20/7/2015)	0.00	2.50			0.00	5.00			26	26												

Details of pension entitlements of executive directors are shown above.

Donal O'Donoghue, Ken Hutchinson and Lynne Waters did not receive any pension entitlements.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of the Cash Equivalent Transfer Value (CETV) figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Annual Report on Remuneration

Contracts of Employment and Payments for Loss of Office

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.

There is no entitlement to any additional remuneration in the event of early termination for any of the executive directors.

Director of Human Resources: Lynne Waters' role as an Executive Director ended on 30 November 2015 when she relinquished the role. However, her employment terminated on 31 December 2015. Ken Hutchinson served as Interim Executive Director of Human Resources from 1 December 2015 until 23 February 2016, having previously served as Interim Associate Director of HR.

Medical Director: Mr Donal O'Donoghue undertook the role of Medical Director on an interim basis until 15 July 2015. Dr Conrad Wareham was appointed as the substantive Medical Director from 20 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.

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 in April 2015.

It has 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 were received by the Committee from third parties that may have materially assisted with their consideration of any matter.

The committee met five times during the financial year; membership and attendance details are shown in the table below.



	Barry Mellor (Chair)	Lynn Hagger	Mark Edgell	Alison Legg	Joe Barnes	Gabrielle Atmarow	Martin Havenhand
April 2015	Y	Y	Y	Y	Y	N	N
June 2015	Y	Y	Y	Y	Y	Y	N
June 2015	Y	Y	Y	Y	Y	Y	Y
October 2015	Y	Y	Y	Y	Y	Y	Y
February 2016	Y	N	Y	Y	Y	Y	Y
Attendance	5/5	4/5	5/5	5/5	5/5	4/5	3/5

Disclosures required by the Health and Social Care Act

As indicated in the Annual Statement of Remuneration, there is no performance-related element of pay to senior managers' remuneration. However, all colleagues, including senior managers, are subject to an annual review of performance against agreed objectives and / or standards.

Details relating to the expenses of the Executive and Non-Executive Directors are set out in the table below.

Total number of Directors in office during 2015/16	Number of Directors receiving expenses during 2015/16	Aggregate sum of expenses paid to Directors during 2015/16	Aggregate sum of expenses paid to Directors during 2014/15
15	3	£2,796.10	£1,409.55

Details relating to the expenses of the Governors are set out in the table below.

Total number of Governors in office during 2015/16	Number of Governors receiving expenses during 2015/16	Aggregate sum of expenses paid to Governors during 2015/16	Aggregate sum of expenses paid to Governors during 2014/15
27	7	£750	£1,276.60

Fair Pay Multiple

The Trust is obliged to provide details of Fair Pay Multiple which requires disclosure of the median remuneration of the Trust's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director, whether or not this is the Chief Executive or Accounting Officer.

The calculation is based on full time equivalent staff at the reporting period end. The highest paid director has been identified based on total pay for each director for the year and has been calculated on an annualised basis:

Median salary	£25,994
Mid-Point of Highest Paid Directors' Salary Band	£262,500
Ratio – Median to Highest Paid Director	10.10

The ratio above has been calculated by annualising the salary received by an Interim Director who was in post during the financial year, from 1 April until 15 July 2015 only. As the level of remuneration has been annualised, the ratio is distorted to show a more significant variance than if the remuneration of a substantive director had have been used. Reasons for the appointment of an interim are provided in more detail in the Off Payroll Engagements section of the Staff Report.

Remuneration Report signed by the Chief Executive:

Louise Barnett
24 May 2016





Staff Report

Analysis of Staff: Average Number of Employees (WTE⁶ basis)

As at the end March 2016 the breakdown of Trust employed staff by type was as follows:

	Permanent Number	Other Number	2015/16	2014/15
			Total Number	Total Number
Medical and dental	292	-	292	302
Ambulance staff	-	-	-	-
Administration and estates	1,015	-	1,015	778
Healthcare assistants and other support staff	682	-	682	277
Nursing, midwifery and health visiting staff	1,118	-	1,118	1,534
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	411	-	411	564
Healthcare science staff	72	-	72	72
Social care staff	-	-	-	-
Agency and contract staff	-	181	181	229
Bank staff	183	-	183	100
Other	-	-	-	3
Total average numbers	3,773	181	3,954	3,859
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

Analysis of Staff: Gender of Staff

As at the end March 2016 the breakdown of Trust employed staff by gender was as follows:

	Male	Female	Total
Executive Directors	3	2	5
Non-Executive Director	4	3	7
Employees	699	3528	4227
Total	706	3533	4239

6 WTE = Whole Time Equivalent.

Sickness Absence Data

The Trust aimed to achieve a sickness absence rate of 4% or less during 2015/16, however whilst there was a slight reduction in year, the absence rate was 4.44% for 2015/16 compared to 5.2% for 2014/15.

Figures showing average sick days per FTE, rather than overall sickness absence as a percentage, are below, with data having been provided by the Health & Social Care Information Centre (HSCIC), and based on the 2015 calendar year:

Figures converted by DH to Best Estimates of Required Data Items		Statistics Produced by HSCIC from ESR Data Warehouse		
Average FTE 2015	Adjusted FTE days lost to Cabinet Office Definitions	FTE Days Available	FTE Days Lost to Sickness Absence	Average Sick Days per FTE
3,579	37,866	1,306,349	61,428	10.6

Note:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column, by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

This is one of the areas that the Strategic Workforce Committee seeks assurance for on a month by month basis.

All recruitment, including promotion, is handled in line with the Trust's 'Recruitment, Selection and Promotion Policy' which addresses a number of key factors relating to disability, for example:

- All recruiting managers and panel members must undertake the Trust's recruitment and selection training to ensure the best people are recruited fairly and on merit.
- The Rotherham NHS Foundation Trust is committed to equality of opportunity and welcomes applications from everyone regardless of ethnicity, disability, gender, age, faith or sexual orientation. The Trust seeks to establish a workforce as diverse as the population it serves.
- Applicants who disclose a disability and request an interview under the Guaranteed Interview Scheme will be short-listed provided that they meet the essential criteria of the person specification. This is in accordance with the Two Ticks symbol (Positive about Disability).
- Panels are required to ensure that the needs of applicants with disabilities are met and appropriate arrangements are put in place prior to the interview date.

With help from the Workplace Health and Wellbeing team and the Human Resources team, managers make workplace modifications for staff to ensure reasonable steps are taken to enable disabled colleagues to not only continue in their role with the Trust but also to seek promotion opportunities.

The Trust also works proactively where applicable with outside agencies to help support the continued employment and promotion of staff within our employment.

Our Learning and Development Department acts as a contact point for special requirements for training provided by the Trust. Reasonable adjustments are made to support colleagues who disclose a disability which may mean they require extra support with their learning and development.

The Trust communicates with colleagues with regards to matters that affect them in a number of ways: through global emails, monthly team brief cascades, screen saver messaging and numerous newsletters such as Listening into Action (LiA). The Trust also provides colleagues with the opportunity to communicate in a two way manner -for example, with the Chief Executive via the 'Dear Louise' process.

The Trust consults with its employees and their representatives in a number of ways: through the Joint Partnership Forum which is the joint meeting between Trust representatives and union colleagues. During the financial year the Trust entered into seventeen consultations with colleagues and their representatives, with the vast majority reaching a mutually agreeable way forward.

The Workplace Health & Well Being service is located discretely behind the main Woodside building, offering professional specialist nurse, counselling and proactive occupational health services.

During 2015/16 the Health & Well Being service has continued to deliver high quality interventions to all Trust colleagues, supporting a healthier, fitter workforce and reducing sickness absence. The services also successfully regained the Safe, Effective, Quality Occupational Health Service (SEQOSH) accreditation.

Some of the Health & Well Being service's key achievements during the year included:

- The recruitment of a Health and Well Being Advisor to deliver training and individualised support on proactive health care;
- Training for line managers on how to deal with mental health issues plus training on 'a proactive approach to dealing with stress';
- A change in counselling opening hours to accommodate more clients;
- Triage referral service to help prioritise employee appointments;
- Delivery of over 220 colleague health MOT's;
- Fast track access to musculoskeletal services;
- Recruitment of an additional Specialist Nurse to support timely response to manager referrals;
- Setting up a page on the internal intranet system to support 'resilience' including access to a free iResilience report;
- The launch of the 'High Five' training programme that includes sessions on diet and exercise, dealing with work place pressures and stress, smoking cessation and also a session back care.

Countering fraud, bribery and corruption

Under Service Condition 24.2 of the NHS Standard Contract 2016/17, the Trust is required to ensure that NHS funds and resources are safeguarded against those minded to commit fraud, bribery or corruption and to put in place and maintain appropriate anti-crime arrangements that are fully compliant with NHS Protect standards for providers.

The Trust has a nominated Counter Fraud Specialist (CFS) who is responsible for carrying out a range of activities that are overseen by the Audit Committee. Fraud risk assessments are undertaken throughout the year and used to inform an annual programme of counter fraud activities that is undertaken within four key areas defined within NHS Protect standards for providers:

Strategic Governance. This sets out the 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. This sets out the 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 crime against the NHS.

Prevent and Deter. This sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.

Hold to Account. This sets out the requirements in relation to detecting and investigating fraud, bribery and corruption, obtaining sanctions and seeking redress.

During the reporting year, activity in the counter fraud arena has focussed on activities to ensure compliance with NHS Protect standards for providers and to raise awareness of the potential for fraud, bribery and corruption to occur and the correct reporting arrangements for suspicions.

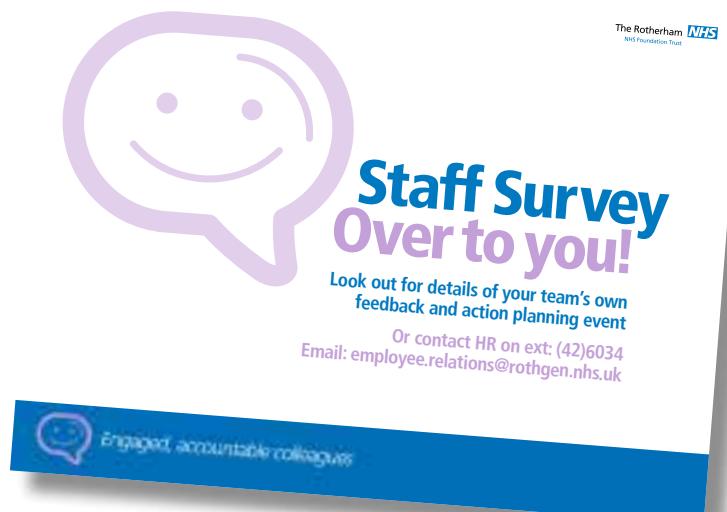
Where fraud is identified or suspected it is formally investigated in accordance with the Trust's Fraud, Bribery and Corruption policy, which was reviewed and updated during the year. During 2015/16, thirteen referrals of suspected fraud, bribery or corruption were made to the CFS.

Staff Survey Results

In order to fulfil the Trust's ambition of being an employer of choice and having 'engaged, accountable colleagues' there is a need to develop a culture built on engagement. In order to achieve engagement the organisation must:

- Ensure that the Trust is a really great place to work (employer of choice);
- Listen to colleagues and support them to make decisions;
- Develop colleagues to be the best they can be; and to
- Support colleagues to face our challenges together.

Our colleagues are our biggest asset and are at the heart of everything the Trust does; they have a tremendous influence on patient experience. A contented workforce creates a pleasing environment for satisfied patients and one that enables and empowers people to contribute their fullest to delivering excellent services. A number of initiatives are in place for sourcing staff feedback and some are shown below:



Friends and Family Test for Staff

Every quarter colleagues are surveyed to determine how likely they are to recommend the Trust as a place to work and as a place to receive treatment. A variety of online and paper based surveys are used and the results are utilised to support on-going actions.

Moving Forward Together

To ensure the Trust works in an open and transparent way its business plan was shared with colleagues through a series of Moving Forward Together briefing sessions during 2015/16. All of our colleagues were encouraged to have their say and play their part in delivering the organisation's plan. The Moving Forward Together briefings were formed from the Trust's five year strategic plan, delivered to NHS Improvement. Through the briefings, colleagues were reminded of the Trust's operational structure, mission, vision and core values. The Trust's strategic objectives and priorities were described as was how all colleagues can work together to deliver excellent care for patients.

The briefing sessions were led by the Chief Executive, Louise Barnett, and the Trust Chairman, Martin Havenhand, and all colleagues were invited to attend a session. The sessions ran between September 2014 and March 2015.

Dear Louise

The 'Dear Louise' process is a way for colleagues to email the Chief Executive directly with any queries or ideas they may have.

38 Dear Louise submissions from colleagues were received and responded to during the year. Common themes include suggestions for improvements to services for patients and sharing successes and ideas for making the Trust a better place. Others are related to environmental issues, access to training and concerns about Trust-wide processes.

Team Brief

Team brief is carried out monthly and cascaded through the organisation, following its presentation by the Chief Executive and Executive Director team in the hospital and in the community. It has been running in its current form since October 2014 when the five current strategic objectives were launched and is themed under each of those objectives. Colleagues are encouraged to ask questions, comment on the key items and to share the information with those with whom they work.



Listening into Action

2015/16 was the second year of using the Listening into Action (LiA) national staff engagement programme. LiA aims to fundamentally shift the way colleagues feel empowered to further enhance patient care. Year 2 focused on ten clinically led work streams, aligned to the strategic and transformation agenda.

In addition, four executive director-led LiA engagement sessions identified key areas of work needed to 'unblock' operational issues that were found to impact on the ability of colleagues to efficiently execute activities that ultimately impact on care delivery.

Ten teams ran clinically-led work streams. Each team had clinical and managerial leaders, supported by a dedicated LiA sponsor group. This group is further engaged with the Executive Directors. The 10 LiA teams engaged with colleagues from across the Trust to identify a variety of actions designed to improve care delivery and process:

1. Acute Medical Unit: Increase bed base, improve frail elderly/ambulatory care.
2. 24/7 Teletracking: Further develop clinical prioritisation and patient flow.
3. Hydration and Nutrition: Increase knowledge, skills and application of good nutrition and hydration of patients and high risk patients.
4. Acute Kidney Injury (AKI): increase easy identification of AKI and development of care bundle to support effective management and communication of care needs.
5. End of Life Care: To maximise early referral to community services and tailor specialised referral.
6. Theatre Utilisation: To further improve utilisation and care pathways.
7. Intermediate Care Beds: To develop timely discharge pathways.
8. Inappropriate Patient Moves: Reduction in bed moves - none after 9pm.
9. Deteriorating Patients: Increase multidisciplinary identification of ill patients and active treatment.
10. Domestic Service Review: Freeing clinical time to care through revision of Trust cleaning regimes.



Each of these teams held their Trust-wide listening events, engaging with the workforce to surface ideas and promote inclusivity in driving and delivering change to improve patient experiences of care. The only exception was team 8 'Inappropriate Patient Moves'. This piece of work was superseded by a dedicated piece of work undertaken by the Chief Nurse, detailed in the implementation of the professional guidance document entitled Nursing and Midwifery Standards of Professional Leadership for all In-patient Environments (night-time).

The success of the 2015/16 work streams was celebrated at the Trust LiA 'Pass It On Event' in April 2016.

Through the LiA network the Trust was privileged and proud to welcome Dr Kate Granger, founder of the #hellomynameis campaign, who endorsed the Trust's approach to production of a sign language video of colleagues signing their names.

This national campaign has been adopted by the Trust recognising the importance of a personal introduction and its impact on patient care.

Staff Survey – Summary of Performance

There is an annual requirement for all NHS Trusts to survey their colleagues asking a number of key questions, these results are then compared nationally. As an organisation, this information is then utilised to make changes to improve the working lives of colleagues.

The Trust is obliged to survey a sample of a minimum of 850 of its employees (about 20% of Trust colleagues). However, in 2015 the Trust undertook to conduct a full census of all eligible employees and achieved a 42% response rate.



	2015/16		2014/15		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Response rate	42%	Trust	National Average	Trust	National Average
42%		42%	42%	44%	42%

The top five ranking scores are shown on the table below.

	2015/16		2014/15		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Top 5 Ranking Scores	Trust	National Average	Trust	National Average	+ / -
Percentage of staff appraised in the last 12 months	94%	86%	95%	85%	-1%
Percentage of staff witnessing potentially harmful errors, near misses or incidents	24%	29%	28%	34%	-4%
Percentage of staff working extra hours	68%	72%	67%	71%	+1%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public	24%	27%	25%	29%	-1%
Percentage of staff experiencing discrimination at work in the last 12 months	7%	10%	8%	11%	-1%

During 2016/17, key themes will be identified from the results and tangible actions will be generated and planned for utilising the Listening into Action methodology. This will ensure that efforts are not only prioritised effectively but that those colleagues close to the required changes, feel empowered to take action.

	2015/16		2014/15		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Bottom 5 Ranking Scores	Trust	National Average	Trust	National Average	+ / -
Percentage of staff/colleagues reporting most recent experience of bullying or abuse	20%	38%	40%	38%	-20%
Percentage of staff agreeing that their role makes a difference to patients/service users	88%	91%	86%	91%	+2%
Staff motivation at work*	3.80	3.92	3.68	3.86	+2.2
Percentage of staff reporting good communication between senior management and staff	24%	30%	25%	30%	-1%
Staff recommendation of the organisation as a place to work or receive treatment.*	3.52	3.71	3.42	3.67	+0.1

*These figures are not expressed as a percentage. They are an amalgamation of two or more standards and represent a numerical Likert scale with 1 being very poor and 5 being excellent.

The areas of action identified will be prioritised over the next 2 years.

A sample of colleagues will be surveyed in 2016/17 in order to benchmark activity and outcomes. The results from this will be used to refocus and steer further actions. In addition to these actions, any divisional hotspots will be identified and any areas not identified in the Trust themes will be worked on through a targeted divisional action plan. The progress made through Listening into Action work streams will be monitored at board level via the Strategic Workforce Committee.

Expenditure on Consultancy

During 2015/16 the Trust spent £275,000 on consultancy. A number of consultancy costs were amalgamated to produce the total figure. Projects ranged from IT Support Services, Workforce Planning, Building and Engineering, Energy Supplies and Emergency Care Management.

Off Payroll Engagements

Table 1: For all off payroll engagements as of 31 March 2016, for more than £220 per day, that last longer than 6 months, see the below table:

No. of existing engagements as of 31 March 2016	6
Of which:	
No. that have existed for less than one year at time of reporting.	3
No. that have existed for between one and two years at time of reporting.	3
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

The Trust confirms that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months, see below:

No. of existing arrangements as of 31 March 2016	
No. of new engagements, or those that reached 6 months in duration between 1 April 2015 and 31 March 2016	14
No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and NI obligations	0
Of which:	
No. for whom assurance has been requested	0
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

The Trust has engaged a number of interims without including contractual clauses allowing the Trust to seek assurance as to their tax obligations. A number of those concerned (+ 20%) have already provided assurance to the Trust that they are paying the appropriate amount of taxes.

However, actions have been taken to ensure that existing policies are reviewed to ensure that all future and existing contracts provide the appropriate clauses allowing the Trust to seek assurance as to tax obligations.

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility between 1 April 2015 and 31 March 2016, see table below:

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	2
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.	8

With regard to the figure of 2 above:

Medical Director: The Trust advertised for the substantive post and used recruitment agencies on a number of occasions. However, these searches were unsuccessful at the time of advertising. Therefore, in view of the nature of the statutory role, an appointment was made on an interim basis only (i.e. December 2014 to July 2015) until the current substantive post holder was recruited.

Executive Director of HR: The Trust had a period of time that required cover between the two substantive post holders (i.e. December 2015 to March 2016).

Compulsory Redundancies

The following exit packages were utilised during 2015/16:

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
≤£10,000	1	0	1
£10,001 – £25,000	1	0	1
£25,001 – £50,000	2	0	2
£50,001 – £100,000	0	0	0
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	4	0	0
Total resource cost	£100,513	£0	£100,513

During the financial year four people were made redundant as a result of reduction in service activity levels and organisational restructure; the Trust made attempts to redeploy the affected colleagues but it was not possible to place them into alternative roles.

The following exit packages were utilised during 2014/15:

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
≤£10,000	-	-	-
£10,001 - £25,000	5	-	5
£25,001 - 50,000	1	-	1
£50,001 - £100,000	4	-	4
£100,001 - £150,000	3	-	3
£150,001 - £200,000	2	-	2
>£200,000	-	-	-
Total number of exit packages by type	15	-	15
Total resource cost (£)	£1,130,000	£0	£1,130,000

Following a workforce review, these fifteen posts were disestablished for one of two reasons. Firstly, establishment / services changes, secondly to reduce the Trust's wages bill. All staff affected went through consultation with redeployment being explored but unfortunately suitable alternative employment could not be found for these colleagues.

There were no other (non-compulsory) departure payments made during 2015/16 or 2014/15.





The Board of Directors



Martin Havenhand
Chairman



Louise Barnett
Chief Executive



Gabrielle Atmarow
Non-Executive Director



Alison Legg
Non-Executive Director



Barry Mellor
Non-Executive Director



Joe Barnes
Non-Executive Director



Mark Edgell
Non-Executive Director



Lynn Hagger
Non-Executive Director



Simon Sheppard
Director of Finance



Tracey McErlain-Burns
Chief Nurse



Lynne Waters
Executive Director of HR



Christopher Holt
Chief Operating Officer



Conrad Wareham
Medical Director

Governance and Organisational Structure

Board of Directors

The Board of Directors uses best practice standards as part of its governance framework. It is a unitary Board with collective responsibility for all aspects of the performance of the Trust, including financial performance, clinical and service quality, management and governance. The Board is legally accountable for the services provided by the Trust, and 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 Plan
- Ensuring that its services provide safe, clean, professional care for patients
- Ensuring robust governance arrangements are in place supported by an effective assurance framework that supports sound systems of internal control
- Ensuring rigorous performance management which ensures that the Trust continues to achieve all local and national targets
- Seeking continuous improvement and innovation
- Measuring and monitoring the Trust's effectiveness and efficiency
- Ensuring that the Trust, at all times, is 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 is also responsible for establishing the values and standards of conduct for the Trust and colleagues in accordance with NHS values and accepted standards of behaviour in public life, including selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).

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.

The Board receives monthly updates on performance and delegates management, through the Chief Executive, 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, to the highest standards and in keeping with its values.

Composition of the Board of Directors

Our Trust Board of Directors comprises both full-time Executive and part-time Non-Executive Directors. The Non-Executive Directors are appointed from the Trust's membership (by the Governors) for their broad business experience.

The Non-Executive appointments include specific appointments that have financial and/or commercial experience, existing knowledge of the NHS, educational backgrounds, voluntary and charitable sector experience.

It is considered that all the Non-Executive Directors are independent in character and that they are free from material business or other relationship which may interfere with their judgement.

The Board incorporates a mixture of skills, knowledge and experience

which is considered suitable for the challenges facing its members. Taking into account the wide experience of the whole Board of Directors, the balance and completeness of the Board of Directors is considered to be appropriate.

All Executive and Non-Executive Directors undergo annual performance evaluation and appraisal. The performance appraisal for the Non-Executive Directors is undertaken by the Chairman in conjunction with the Lead Governor. The performance appraisal and objective setting for the Chairman is undertaken jointly by the Senior Independent Director and the Lead Governor. Both appraisal processes are informed by a collective view on individual Non-Executive Director 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.

Board performance is evaluated further through focussed discussions at Board Development away days, seminar sessions and on-going, in-year review of the Board Assurance Framework.

The Board Assurance Framework, which has undergone further development throughout 2015/16, provides a comprehensive review of the performance of the Trust against the agreed plans and strategic objectives.

Meet the Board of Directors

The descriptions below of each Director's expertise and experience demonstrates the balance and relevance of the skills, knowledge and expertise that each of the Directors bring to the Trust.

Non-Executive Directors

All Non-Executive Directors of the Board of Directors are considered to be independent. The Trust's policy in relation to Non-Executive Directors is that they are appointed 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 service 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 would be subject to annual review in accordance with the Code of Governance.

Martin Havenhand, Chairman

Martin has a wealth of Executive and Non-Executive experience from both the public and private sectors and he has previously successfully served in Chair and Governor roles.

He brings to the Trust extensive experience and knowledge of the South Yorkshire community which is invaluable as TRFT continues to develop and enhance local health care services for the future.

He is currently a Non-Executive Director at Yorkshire Water Services Ltd.

Gabrielle Atmarrow

Non-Executive Director and Senior Independent 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 in the Department of Health.

She has a strong commitment to the achievement of the highest standards for the patient experience wherever care is delivered.

As a former Non-Executive Director of the West Yorkshire Workforce Development Confederation and former Honorary Senior Lecturer/Lecturer at the Universities of Sheffield and Leeds, Gabrielle has long held a keen interest in the education and development of those who wish to realise their full potential.

Since 2009 she has been a member of the Board of Governors of Leeds Metropolitan University. Gabrielle was appointed as a Justice of the Peace in 2008 and serves as a magistrate on the Leeds Adult Bench. She views this responsibility as both humbling and a privilege.

Alison Legg, Non-Executive Director and Vice Chair of the Trust Board

Alison was a partner for 15 years in Chartered Accountants KPMG LLP until the end of 2008. She headed up the firm's Transaction Services team, based in Leeds, specialising in corporate mergers and acquisitions work which involved the analysis and evaluation of businesses, big and small, prior to their purchase or sale.

Alison started her career as a Chartered Accountant with KPMG in their Sheffield office in 1978, after graduating in science from Sheffield University. Her financial experience is wide ranging, including a period as Finance Director for a Sheffield based national distribution business from 1987 to 1990.

Since her early retirement Alison has joined the board of Marsden Building Society, based in the North West, as a Non-Executive director and she is also a Trustee of two Yorkshire based charities – Eureka! The National Children's Museum in Halifax and St. Anne's Community Trust, a housing trust focussing on the needs of individuals with learning difficulties or mental health problems, based in Leeds.

Mark Edgell, Non-Executive Director

Mark joined The Rotherham NHS Foundation Trust as a Non-Executive Director on 1 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 until his resignation.

Mark has a first degree in economics and geography and a Masters in public sector economics. After initially working in retail management, Mark trained and worked as a public sector economist before moving into local politics. He currently works at a senior level in local government – a post that precludes political activity.

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 meets its challenges, both now and in the future.

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 or The Rotherham NHS Foundation Trust, in his previous role as Chief Executive of NHS Logistics (later NHS Supply Chain). He says that one of his proudest moments was NHS Logistics winning the Health Service Journal Award for Improving Patient care with E-technology. Barry's recent position has been as Commercial Director for Sheffield City Council and as Chair of the Yorkshire & Humber Strategic Procurement Group, he has been actively involved in the transfer of Public Health and has worked closely with Rotherham Council.

Joe Barnes, Non-Executive 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.

Joe spent most of his career with British Coal and the Coal Pension Funds; he is a qualified accountant and provides consultancy services (on a very small scale these days) to businesses and pension funds.

Lynn Hagger, Non-Executive Director

After careers in social work and legal practice, Lynn became a legal academic with lectureships at the Universities of Manchester, Liverpool and now Sheffield. She has taught administrative / public law, contract, environmental and European law and specialised in healthcare law and ethics at undergraduate and postgraduate level.

She 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.

She was Chair of Sheffield Children's NHS Foundation Trust for nine years and more recently served as a Non-Executive Director at Leeds Teaching NHS Trust where she was Chair of the Quality Committee.

Executive Directors

Louise Barnett, Chief Executive

Louise Barnett is Chief Executive of The Rotherham NHS Foundation Trust and chair of the Yorkshire and Humber Regional Leadership Council.

She has more than 20 years' experience in human resources and organisational development and has held board level roles in both the public and private sectors. She was previously Interim Chief Executive at Peterborough and Stamford Hospitals NHS Foundation Trust and Non-Executive Director at Sherwood Forest Hospitals NHS Foundation Trust.

Tracey McErlain-Burns, Chief Nurse

Tracey qualified as a registered nurse in 1984 and has worked in a number of health sectors including the acute and community sectors, strategic health authorities and clinical commissioning.

Throughout her career she has held a number of positions including: Director of Hospital Services, Executive Lead for HR and Information Technology and acting Chief Executive.

In addition to being a Registered Nurse Tracey has completed a Diploma in Nursing and achieved becoming a Master of Business Administration (MBA), via Durham University.

Her experience includes being part of team commissioned to undertake a review of health services in Cyprus in the year 2000, and attending INSEAD in France to complete a Clinical Strategist programme. Tracey is highly visible and enjoys engaging with patients and colleagues to improve services within our own Trust and across the Rotherham health and social care partnerships.

Chris Holt, Chief Operating Officer

Chris Holt joined TRFT in October 2014 from Mid Staffordshire NHS Foundation Trust where he held responsibility for ensuring the safe and effective day-to-day operational performance of the organisation between 2011 and 2014. His experience covers both the private sector and also primary and secondary healthcare in England and Scotland.

Chris is passionate about improving hospital experience and care for patients and wants to see patients' needs at the heart of decision making by working closely with patients, staff and local partners to ensure that the Trust continues to deliver excellent services and a safe and first class experience for all.

Simon Sheppard, Director of Finance

Simon Sheppard joined TRFT 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, 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.

Lynne Waters, Executive Director of Human Resources

(Until 30 November 2015 on a substantive basis).

Mrs Waters joined the Trust in November 2014 as substantive Executive Director of Human Resources. She brings over 20 years' experience from a varied and successful HR career in the private sector. She lists leadership development, people and change management and employee engagement amongst her key skills.

Ken Hutchinson, Executive Director of Human Resources

(From 1 December 2015 until 23 February 2016 on an interim basis)

Ken joined the NHS on the Management Training Scheme in 1977 and progressed to his first HR Director post in West Cumbria in 1988. He held other HR Director posts at Teaching Hospitals in Leeds and Birmingham and became an independent practitioner in 2004. He has worked for several NHS organisations and occupied HR Director posts on an interim basis.

Ken holds a BA Joint Honours in Economics and Economic History from Newcastle University, a Master of Arts Degree from Ealing College, London. He is a Lay member of the Employment Tribunals Panel, a Fellow of Chartered Institute of Personnel and Development, a Fellow of Institute of Leadership and Management and a Non-Executive Director of the Association of Respiratory Technology and Physiology.

Attendance at Board of Directors' Meetings 2015/16

	Martin Havenhand (Chair)	Gabrielle Atmarow	Joe Barnes	Mark Edgell	Lynn Hagger	Alison Legg	Barry Mellor		Louise Barnett	Chris Holt	Tracey McErlain-Burns	Donal O'Donoghue	Simon Shepherd	Conrad Wareham	Lynne Waters	Ken Hutchinson
2015																
April	Y	Y	Y	Y	Y	Y	Y		Y	N	Y	Y	Y		Y	
May	Y	Y	Y	Y	Y	Y	Y		Y	N	Y	Y	Y		Y	
June	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	N	Y		Y	
July	Y	Y	Y	Y	Y	Y	Y		Y	N	Y	Y	Y	Y	Y	
August	Y	Y	Y	N	Y	N	Y		Y	Y	Y		Y	Y	Y	
Sept	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y	
Oct	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y	
Nov	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y	
Dec (extra)	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y		N
Dec	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y		Y
2016																
Jan	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y		Y
Feb	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y		Y
Mar	Y	Y	Y	N	N	Y	Y		Y	N	Y		Y	N		
Attendance	13/13	13/13	13/13	13/13	11/13	12/13	12/13	13/13	13/13	9/13	13/13	3/4	13/13	9/10	8/8	3/4

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 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.

The contact details above may be used by members who wish to communicate with directors.

Committees of the Board

The Board of Directors has the following committees, the Terms of Reference of each can be found on the Trust's website: (http://www.therotherhamft.nhs.uk/key_documents/)

Audit Committee

Committee membership and meetings

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 who is considered to be an independent Non-Executive Director.

Two further Non-Executive Directors are members of the Audit Committee, both of whom are considered to be independent.

The Director of Finance and Company Secretary both attend every meeting, and in addition, other Executive or Operational Directors attend meetings as required to discuss operational issues.

During 2015/16 the Committee has continued the practice established in January 2014 whereby two members of the Council of Governors have been invited as observers to the Audit Committee.

Attendance at Audit Committee Meetings 2015/16

Audit Committee	Joe Barnes (Chair)	Lynn Hagger	Alison Legg
2015			
May	Y	Y	N
June	Y	Y	Y
July	Y	Y	Y
2016			
Jan	N	Y	Y
Feb	Y	Y	Y
Attendance	4/5	5/5	4/5

The following areas are considered to be the significant issues considered by the Audit Committee during 2015/16:

- Annual Governance Statement 2014/15
- Annual Report and Accounts 2014/15
- Quality Account and Report 2014/15
- Head of Internal Audit Opinion 2014/15
- External Audit ISA 260 review 2014/15
- Internal Audit (TIAA) annual work plan 2015/2016
- NHS Protect (counter fraud provided by 360 Assurance) annual work plan 2015/16
- External Audit (KPMG) annual work plan 2015/16
- Board Assurance Framework
- Trust's Risk Register
- Annual assurance on the processes for managing serious incidents
- Annual Review of Standards of Business Conduct

Exceptional items considered were:

- Process for the appointment of External Auditors

Review of:

- Standing Financial Instructions (with Board delegation)
- Standing Orders and Matters Reserved for the Board
- Annual committee effectiveness survey
- Internal and External Auditors effectiveness

The significant risks identified in the External Auditor's (KPMG) audit plan for 2015/16 were:

- The accuracy of the valuation of the Trust's land and buildings; and
- The completeness, existence and accuracy of the balances recorded within the financial statements relating to both NHS and non-NHS income.

The Audit Committee has, through its regular agenda items, critically assessed and reviewed the judgements that have been applied in relation to both of these risks during the year as well as the Trust's compliance with the appropriate accounting standards.

Internal Auditors

During the financial year 2015/16 the Trust has continued to engage with its internal auditors, TIAA, for evaluating and continually improving the effectiveness of its risk management and internal control processes.

External Auditors

The appointment of the Trust's external auditors is a matter that requires the approval of the Council of Governors, as laid down in NHS Improvement's Code of Governance for NHS Foundation Trusts.

In September 2012 the Council of Governors approved the appointment of KPMG as the Trust's External Auditors for an initial period of 3 years with the option to extend the contract for a further one to two years. The value of the contract was £62,400 p.a.

At their meeting in January 2015, the Council of Governors approved the recommendation from the Audit Committee that, for continuity purposes, the current external auditors, KPMG, should be reappointed to serve for an additional year until October 2016. Due to procurement timeframes, in January 2016 the Audit Committee and the Council of Governors began the appointment process to ensure that the organisation has an external auditor in place when the current contract ends.

NHS Improvement's NHS Foundation Trust Code of Governance requires that a statement is included in the Annual Report in the event that the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, explaining the recommendation and setting out the reasons why the Council of Governors has taken a different position. During 2015/16 there have been no instances when the Council of Governors has not accepted the Audit Committee's recommendations relating to external auditors.

The annual review of the effectiveness of the external audit function was undertaken by the Audit Committee at its July 2015 meeting and involved a round table discussion involving the three Non-Executive Directors present, the Director of Finance and the Company Secretary and concluded that the provision of the external audit service was sufficient in supporting the Committee in fulfilling its role during the year.

Nominations Committee

The Trust has two Nominations Committees. One has responsibility for Executive Director appointments and the other has responsibility for Non-Executive Director appointments.

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, except in the case of the appointment of a Chief Executive, the Chief Executive.

Before making any recommendation for appointment, the Committee has regard to the balance of qualifications, skills, knowledge and experience required on the Board of Directors as a whole. Each year this committee reviews the size, composition and structure of the Board of Directors to ensure it remains appropriate to deliver its statutory responsibilities.

Martin Havenhand (Chair)	Joe Barnes	Louise Barnett	Mark Edgell	Alison Legg	Barry Mellor	Gabrielle Atmarow	Lynn Hagger
April 2016	Y	Y	Y	Y	Y	Y	N
Nov 2016	Y	Y	Y	Y	N	Y	Y
Attendance	2/2	2/2	2/2	2/2	1/2	2/2	1/2

During the financial year, two substantive executive appointments were made. Stakeholder panels, stakeholder presentations, and formal interviews with Trust Chair / Non-Executive Director leads in place, were all used as part of the recruitment processes.

Salaries relating to Executive Directors' appointments were determined and agreed by the Remuneration Committee. The Remuneration Committee report can be found in the Remuneration Report.

The Chairman undertakes the performance appraisal of the Chief Executive and the Chief Executive carries out the performance appraisals of the Executive Directors.

Non-Executive Director 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 routinely being provided to all Council members.

During 2015/16 the Non-Executive Director composition of the Board remained unchanged. As a consequence, there was no requirement for appointment of a Chair or Non-Executive Director which would have necessitated either support from an external search consultancy or open advertisement.

The performance appraisal for the Non-Executive Directors is undertaken by the Chairman in conjunction with the Lead Governor. The performance appraisal and objective setting for the Chairman is undertaken jointly by the Senior Independent Director and the Lead Governor. Both appraisal processes are informed by a collective view on individual Non-Executive Director performance provided by the Executive Directors.

The Committee met on two occasions during 2015/16. One meeting considered the outcome of the Chair and Non-Executive Directors' annual appraisal and objective setting process. The second considered the reappointment of one Non-Executive Director for a further one-year term of office (to the maximum six-year term) and the appointment of the Senior Independent Director.

Whilst not required to make appointments to any Non-Executive Director posts during 2015/16 the process used to appoint a Non-Executive Director (including the Chair) is as follows:

- Applications invited via External Agency / NHS Jobs / Advertising in National & Local Media / Direct Mail to local organisations for a three week period
- The Governors Nominations and Remuneration Committee and Chair meet to review and long-list the applications
- The long-listed candidates are invited to an open evening
- The Governors Nominations and Remuneration Committee and Chair meet to agree the short-list for interview
- Interviews undertaken by the Chair and Governors
- The Governors' Nominations and Remuneration Committee makes a recommendation to the Council of Governors to approve the appointment of the successful applicants.

In late 2014/15 the Committee undertook the annual review of the remuneration, allowances and other terms and conditions of office of the Trust Chair and other Non-Executive Directors. The Council of Governors approved in April 2015 the recommendation that remuneration would remain unchanged in 2015/16.

Non-statutory Committees of the Board:

Quality Assurance Committee, Finance and Investment Committee⁷ and Strategic Workforce Committee.

The terms of reference of all Board committees now includes a clause requiring that committee effectiveness should be assessed on an annual basis.

In the summer of 2015 feedback from all Board committee members on the effectiveness of all of the board committees was sought ahead of a formal review of each committee's effectiveness led by the Chairman and Chief Executive in conjunction with the Executive Lead and Non-Executive Lead of each of the Board committees.

This effectiveness review led to the revision of the terms of reference of the board committees undertaken in the summer of 2015.

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, 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 3 of the Trust's Constitution (pages 66 and 67) which is available on the Trust's internet site.

The Council of Governors comprises of 16 elected Public Governors, 5 elected Staff Governors and 7 appointed Partner Governors.

⁷ During 2015/16 this committee was renamed "Finance and Performance Committee".

During 2015/16 the members of the Council of Governors were:

Constituency	Name	Term of Office
Public Governors (elected):		
Wentworth North (Covering the electoral wards of Hoobier, Swinton, Wath)	Mrs Ann Ashton	01.06.2013 to 31.05.2016
	Mrs Cynthia Shaw	Re-elected 01.06.2013 to 31.05.2016 Stood down 31.10.2015
Wentworth South (Covering the electoral wards of Rawmarsh, Silverwood, Valley)	Miss Jean Dearden Lead Governor until 31 May 2015	Re-elected 01.06.2014 to 31.05.2015
	Mrs Clair Brierley	01.06.2015 to 31.05.2018
	Mr Leslie Hayhurst	01.06.2014 to 31.05.2017
Wentworth Valley (Covering the electoral wards of Hellaby, Maltby, Wickersley)	Vacancy	
	Mr Graham Barry Jenkinson	Re-elected 01.06.2014 to 31.05.2017
Rotherham South (Covering the electoral wards of Boston Castle, Rotherham East, Sitwell)	Mr Terry Barker	01.06.2013 to 31.05.2016
	Mr Abul Abbas Zaidi	01.06.2013 to 31.05.2016 Stood down January 2016
Rotherham North (Covering the electoral wards of Keppel, Rotherham West,	Mrs Sylvia Bird	Re-elected 01.06.2014 to 31.05.2015
	Mrs Anne Selman	01.06.2012 to 31.05.2015
	Vacancy (x2)	From 01.06.2015
Rother Valley South (Covering the electoral wards of Anston & Woodsetts, Dinnington, Wales)	Mrs Bridget Dixon	Re-elected 01.06.2014 to 31.05.2017
	Mr Gavin Rimmer	01.06.2014 to 31.05.2017
Rother Valley West (Covering the electoral wards of Brinsworth & Catcliffe, Holderness, Rother Vale)	Vacancy	01.04.2015 to 31.05.2015
	Mr David Vickers	01.06.2015 to 31.05.2018
	Mr Dennis Wray Lead Governor from 1 June 2015	Re-elected 01.06.2014 to 31.05.2017
Rest of England (Covering those who live outside the borough)	Miss Jan Frith	01.06.2015 to 31.05.2018
	Vacancy	From 01.06.2015
Staff Governors (elected):		
Professional Nurses and Midwives	Mrs Fiona Smith	01.06.2014 to 31.05.2017 Left the organisation 01.11.2015
Other Health Professionals	Mrs Catherine Ripley	01.06.2013 to 31.05.2016
Medical and Dental	Dr Firas Al-Modaris	Re-elected 01.06.2014 to 31.05.2017
Other Directly Employed Staff	Mrs Sandra Lewis	01.06.2013 to 31.05.2016
Support Staff to Health Professionals	Mrs Tina Senior	01.06.2014 to 31.05.2017
Partner Governor Organisations (nominated/appointed):		
Sheffield Hallam University	Jean Flanagan	01.06.2012 to 31.05.2015 01.06.2015 to 31.07.2015
	Dr Christopher Low	01.08.2015 to 31.07.2018
Sheffield University	Prof Arshad Majid	14.11.2013 to 13.11.2016
Rotherham Partnership	Mrs Carole Haywood	01.09.2013 to 31.08.2016
Voluntary Action Rotherham	Mrs Janet Wheatley	01.06.2011 to 31.05.2014 01.06.2014 to 31.05.2015 01.06.2015 to 31.05.2016

Constituency	Name	Term of Office
Rotherham Ethnic Minority Alliance	Mr Azizzum Akhtar	01.12.2011 to 31.11.2014 01.12.2014 to 31.11.2017 Stood down 31.01.2016
Rotherham Metropolitan Borough Council	Cllr Emma Hoddinott	01.09.2015 to 31.08.2018 RMBC not represented from 01.04.2015
Barnsley and Rotherham Chamber of Commerce		

Council of Governors meeting	Number of meetings held during tenure	Number of meetings attended	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 usually serve a maximum of three terms (nine years in total). The Trust's Constitution outlines that a Governor is eligible to continue in the role subject to annual re-election up to a maximum of 12 years.
Mr Azizzum Akhtar	4	4	
Dr Firas Al-Modaris	4	5	
Mrs Ann Ashton	4	3	
Mr Terry Barker	4	1	
Mrs Sylvia Bird	1	1	
Mrs Clair Brierley	3	1	
Miss Jean Dearden	1	1	
Mrs Bridget Dixon	4	3	
Mrs Jean Flanagan	2	1	
Miss Jan Frith	3	3	
Mr Leslie Hayhurst	4	3	
Mrs Carole Haywood	4	2	
Cllr Emma Hoddinott	2	2	
Mr Graham Barry Jenkinson	4	3	
Mrs Sandra Lewis	4	4	
Dr Christopher Low	2	1	
Prof. Arshad Majid	4	1	
Mr Gavin Rimmer	4	3	
Mrs Catherine Ripley	4	3	
Mrs Anne Selman	1	1	
Mrs Tina Senior	4	2	
Mrs Cynthia Shaw	3	2	
Mrs Fiona Smith	3	1	
Mr David Vickers	3	2	
Mrs Janet Wheatley	4	3	
Mr Dennis Wray	4	4	
Mr Abul-Abbas Zaidi	3	3	

Current Director / Non-Executive Director	Number of meetings attended
Mr Martin Havenhand (Chair)	3
Louise Barnett	4
Tracey McErlain Burns	3
Gabrielle Atmarow	3
Joe Barnes	2
Mark Edgell	3
Lynne Hagger	4
Anna Milanec	4
Chris Holt	2
Alison Legg	3
Simon Sheppard	2
Barry Mellor	1
Conrad Wareham	1

Previous Director / Non-Executive Director	Number of meetings attended
Donal O'Donoghue	1
Lynne Waters	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 register.

The register of governor's interests is available to view on the Trust's website (http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Meet_the_Council_of_Governors/) or by requesting a copy from the Company Secretary.

Ms Anna Milanec, 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 public.governors@rothgen.nhs.uk. Alternatively they may write to the Governor at the following address:

Name of Governor
C/O Ms Anna Milanec, 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 2015/16 there were over 17,000 Members of The Rotherham NHS Foundation Trust (TRFT), this includes both public and staff members.

As a Foundation Trust, the Trust works closely with its Membership and continues to involve and engage Members in the Trust's strategic direction through a sustained, two-way communications plan.

The Trust has two Membership constituencies:

A 'public constituency'
A 'staff constituency'

To become a public Member, the person must be at least 16 years of age and live within the Trust's constituency area (consisting of seven local electoral wards and a 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 not opted out of Trust Membership.

TRFT Membership composition to 31 March 2015

Public

Rother Valley South	1,116
Rother Valley West	1,404
Rotherham North	1,651
Rotherham South	2,158
Wentworth North	1,263
Wentworth South	1,790
Wentworth Valley	1,789
Rest of England	1,628
Out of Trust Area	11
Total	12,810

Staff

Medical and Dental	311
Professional Nurses and Midwives	1,296
Other Health Professionals	543
Support Staff to Health Professionals	882
Other Directly Employed NHS Staff	1,275
Total	4,307

Total TRFT Membership: 17,117

Boundaries for public Membership

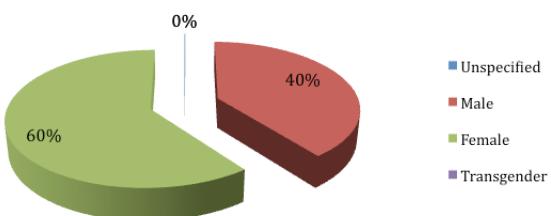
- Rotherham South (Boston Castle, Rotherham East & Sitwell)
- Rotherham North (Kepple, Rotherham West, Wingfield)
- Wentworth South (Rawmarsh, Silverwood, Valley)
- Wentworth North (Hoover, Swinton, Wath)
- Rother Valley West (Brinsworth and Catcliffe, Holderness, Rother Vale)
- Wentworth Valley (Hellaby, Maltby, Wickersley)
- Rother Valley South (Anston and Woodsetts, Dinnington, Wales)
- Rest of England (covers all areas not within RMBC boundaries)
Rotherham NHS Foundation Trust constituency boundaries
(reflecting Rotherham Metropolitan Borough Council area assembly boundaries)

Public Members are able to contact their local Governor by sending an email to: public.governors@rothgen.nhs.uk indicating the name of the Governor they wish to contact in the subject line of the email. In a similar manner staff members are able to contact their Governor by sending an email to: staffgovernors@rothgen.nhs.uk, also including the name of the Governor they wish to contact in the subject line of the email.

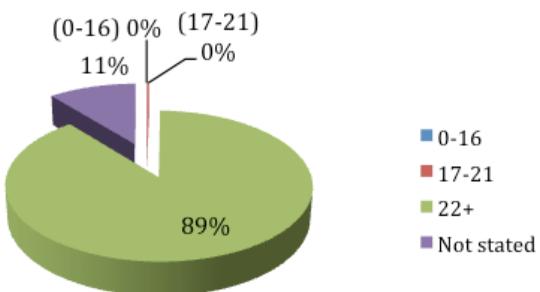
Public Members are able to contact the Trust's Directors through a variety of mechanisms: via the public Board of Directors meetings or the public Council of Governors meetings; via their Governor; via the Trust's feedback@rothgen.nhs.uk email address or via the Trust's switchboard.

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 as possible. As at 31 March 2016 the Trust's Membership was composed as follows:

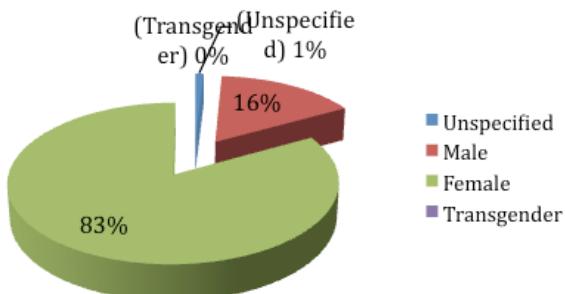
Public Member Gender Chart



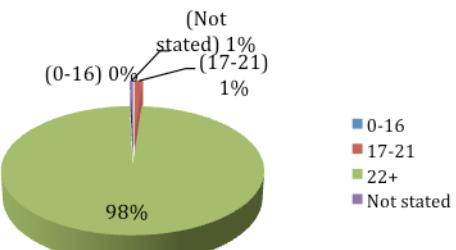
Public Members Age Range Chart



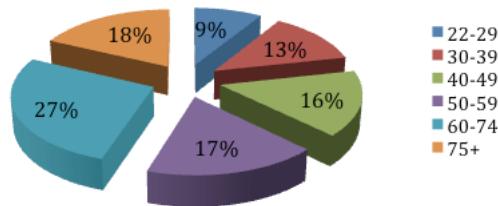
Staff Member Gender Chart



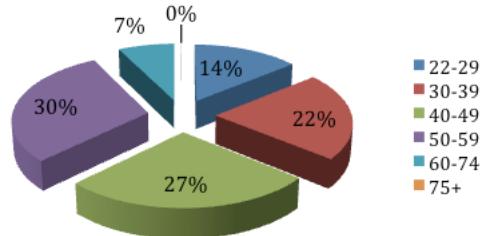
Staff Members Age Ranges Chart



Public Members Age 22+ Chart



Staff Members Age 22+ Chart



Source: 2014 Population Projections, CACI Ltd

Membership Breakdown	Public	Staff	Total
Ethnicity	12,810	4,307	17,117
White - English, Welsh, Scottish, Northern Irish, British	4,404	3,532	7,936
White - Irish	17	14	31
White - Gypsy or Irish Traveller	0	0	0
White - Other	15	38	53
Mixed - White and Black Caribbean	2	5	7
Mixed - White and Black African	1	3	4
Mixed - White and Asian	1	12	13
Mixed - Other Mixed	8	7	15
Asian or Asian British - Indian	35	69	104
Asian or Asian British - Pakistani	181	34	215
Asian or Asian British - Bangladeshi	3	2	5
Asian or Asian British - Chinese	6	9	15
Asian or Asian British - Other Asian	20	26	46
Black or Black British - African	24	34	58
Black or Black British - Caribbean	6	10	16
Black or Black British - Other Black	13	7	20
Other Ethnic Group - Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	71	33	104
Not stated	8,003	472	8,475

A key driver in recent years has been a shift in focus from improving the visibility of membership to building on the service we offer Members through more accessible engagement and to continue to raise the profile of the Trust and its membership base within the local community.

To this end, the Membership team continue to produce a monthly e-newsletter for Members. We are now able to share much more timely information and keep Members up-to-date with Trust news and events all year round.

Our Members have been sent newsletters including subjects such as introductions to new members of the Trust Board, service developments such as those that have enabled patients to be part of innovation and monitor their own health, self-care and where to seek appropriate help should they need medical attention, Trust developments such as updates on the new Emergency Centre build, information on our Trust's Charity and health awareness events held at the Trust.

Newsletters have also been used to invite Members to attend meetings and events such as Council of Governor meetings, the Annual Members Meeting and to Community Health Meetings on topics such as 'exploring the management of Parkinson's disease'

Our e-newsletters have also given us the opportunity to invite Members to become more involved in the life of the Trust, by sharing all of the fantastic achievements of our colleagues and services at the Trust, encouraging Members to take part in our annual Staff Proud Awards by nominating a member of staff in our Public Recognition Category and sharing details of how to apply to become a Governor in our 2016 Council of Governors Elections.

Our annual edition of Your Choice has traditionally been our most popular method of communication we have with our entire Membership base. It was published in February 2016, so we could include more information about our annual Council of Governors Elections with a Governor Profile section from our Lead Governor outlining the role of the Governor, encouraging Members to stand in the forthcoming elections and vote.

Early in the financial year the bi-monthly Community Health Meetings held in community venues around the local area continued. However, these have been paused to enable a review of their effectiveness and maximise public and Members attendance.

Our Governors' Surgeries continue to be a vital way in which Members can speak with our Governors. The Governors seek views from people attending Trust sites about their visit and answer questions from members of the public and staff. The Surgeries are hosted quarterly at Rotherham Hospital and at Rotherham Community Health Centre by the Governors and the feedback from these sessions is seen by senior management within the Trust with any chances for quality improvement in terms of care or patient experience acted upon.

Further work will be undertaken during 2016/17 to improve upon the effectiveness of Membership engagement with the appointment of a new Head of Communications and Engagement. Stakeholder engagement will also be reviewed and refreshed during 2016/17.

Disclosures as set out in the NHS Foundation Trust Code of Governance

The Board of Directors has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation.

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.

The way in which the Trust applies the principles within the Code of Governance are set out in this report, and the Directors consider that during 2015/16, the Trust has been largely compliant with the Code.

NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance, which should be submitted as part of the Annual Report (as referenced in the NHS Foundation Trust Annual Reporting Manual).

D2.3 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, external data provided by the NHS Provider's annual salary report has been considered and the Non-Executive Directors expressed their intentions to decline any proposed pay award.

B5.6 The Governors canvassed the opinion of members and the public on the Trust's forward plan for 2015/16 including its objectives, priorities and strategy via their Governors' Surgeries and Governors' Forum meetings and their views have been communicated to the Board of Directors including at the joint Council of Governors and Board of Directors meeting in December 2014.

During 2015/16 the Governors have not exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more Directors to attend a Governors meeting for the purpose of obtaining information about the foundation trust's performance since the Directors always attend the quarterly Council of Governors' meetings.

B6.1 At the end of every Board of Directors meeting one of the Executive or Non-Executive Directors provides feedback evaluating the meeting. The performance of Audit Committee was evaluated against the NHS Audit Committee Handbook published by HFMA.

B6.2 No external evaluation of the Board of Directors or the governance of the Trust was undertaken during the year.

B6.5 During 2015/16 the Council of Governors has not assessed their collective performance in accordance with this provision, this is planned for 2016/17.

C3.9 No non audit services were provided during 2015/16 by the Trust's external auditors, KPMG.

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 2015/16.

Regulatory Ratings

The Trust has been subject to a red governance rating for the whole of the period, continuing the trend from the previous year. Whilst some enforcement action has been lifted by the regulator, continuing financial planning breaches determine that this rating will be in place until such a time that the regulator is satisfied that such breaches have been addressed and required actions are complete.

With regard to key healthcare targets, the Trust has complied with all, except for the 4 hour access target, which has been discussed at length elsewhere in this report. An improvement trajectory for the 4 hour access target has been submitted to the regulator as part of the Trust's plan submission for 2016/17.

After Q1, the regulator changed the way in which the existing Continuity of Service Rating was calculated, introducing a new four-level Financial Sustainability Risk Rating. This change was made in order to better reflect the challenging financial context in which all foundation trusts are operating and to strengthen the regulatory regime.

The deterioration in the risk ratings from plan to actual can be accounted for by lack of adherence to the financial plan, mainly caused by the organisation's reliance on premium pay spend.

2015/16	Annual Plan	Q1	Q2	Q3	Q4
Continuity of Service Rating	2	1			
Financial Sustainability Risk Rating			1	1	1
Governance Rating	Red	Red	Red	Red	Red

2014/15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of Service Rating	2	2	1	3	2
Governance Rating	Red	Red	Red	Red	Red





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.

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 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 NHS Foundation Trust Annual Reporting 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 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; 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 NHS Improvement's NHS Foundation Trust Accounting Officer Memorandum.



Signed:
Louise Barnett, Chief Executive
24 May 2016



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 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 2016 and up to the date of approval of the annual report and accounts.

Background to the preparation of the Annual Governance Statement:

Regulatory Action

In April 2013 the Trust agreed a series of undertakings with NHS Improvement. Pursuant to section 106 of the Health and Social Care Act 2012, the Trust had been required to take specific actions relating to financial planning, governance breaches, and breaches relating to the electronic patient records system.

Whilst the latter two breaches were lifted during the previous financial year, and progress has been made in relation to the outstanding financial planning breaches, they 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), and a red governance rating, remained in place at the end of the 2015/16.

As Accounting Officer, I have overall accountability for risk management within the organisation, for meeting all relevant statutory requirements, and for ensuring adherence to guidance issued by regulators, which include NHS Improvement and the Care Quality Commission.

Capacity to Handle Risk

Each member of the executive team has an area of responsibility which supports me in this role.

The Chief Nurse is responsible for ensuring that an appropriate Trust wide risk management policy is in place that aligns with the Board approved risk management strategy. She is responsible for ensuring that the Trust's risk management framework is complied with, and together with her team, ensuring that a culture of risk awareness and management runs throughout the Trust.

The Director of Finance is responsible for the management of risk in

relation to finance and contracting issues, whilst the Senior Information Risk Owner (SIRO) is responsible for leading the area of information governance and management of information processes within the Trust.

The Board has a formal schedule of Matters Reserved for its decision, and delegates certain matters to Board Committees, as set out below.

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 corporate induction programme that all colleagues, contractors and volunteers undertake ensures that everyone is provided with details of the Trust's risk management systems and processes, and this is also covered 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 in more generic areas, such as fire safety, health and safety, manual handling, resuscitation, infection control and safeguarding.

The Trust recognises that it is important to learn when things do not go as planned - this applies in all areas of the organisation. Learning is considered through local governance processes in both clinical and corporate environments.

Internal audit and clinical audit programmes are also used to provide assurance against internal controls, and recommendations are made where improvements may be appropriate. We recognise that our clinical governance framework could be more robust to further strengthen the assurance framework and work has already begun to reinforce our processes and structure in this area.

The risk and control framework

Risk appetite is outlined in the Trust's risk management strategy and was determined taking into account best practice from both within and outside of the health sector. Following considerable discussion with board members at informal seminar sessions and formal board meetings, risk appetites were agreed and are reflected therein.

The strategy identifies the Trust's risk management vision to be, ".... a risk intelligent organisation such that the safety and effectiveness of our services are enhanced".

The Trust's organisational risk management structure, the roles and responsibilities of committees and groups which have responsibility for risk, and the duties and authority of key individuals and managers, are outlined in the strategy. It describes the process to provide assurance for the Trust Board to review the strategic organisational risks, and the local structures to manage risk in support of the policy.

Management of risk extends across the organisation, from ward to Board, to promote the importance of managing and reducing clinical and non-clinical risks associated with healthcare. This also supports the underlying financial, operational and clinical sustainability of the Trust.

The Trust's quality priorities are set out in the Quality Report and reference the three domains of quality, and also reflect the CQC's five quality domains.

Key performance indicators are presented, on a monthly basis, to the Trust Board. These include progress against external targets (such as how we keep our hospital clean), internal safety measures (such as the effectiveness of actions to reduce infection), process measures (such as waiting list data) and other clinical quality measures, including Commissioning for Quality and Innovation.

The Board regularly receives reports on quality information (such as complaints, incidents and reports from specific quality functions). Further steps are being taken to improve triangulation of information, which will further strengthen existing processes.

Each clinical division has an internal monitoring structure so that teams can regularly review their progress and identify areas where improvements may be required. Each division's performance is reviewed at monthly performance meetings. However, further work is being undertaken to strengthen the organisation's clinical governance framework, which will help ensure continuous improvement in services for patients.

Patient feedback is received through the Patient Friends and Family Tests, local patient forums, Governor Surgeries, Healthwatch, open days, and from complaints and compliments received by the Trust. This feedback was also used to inform the decision making process which led to development of the quality improvement priorities.

The Trust Board committees, through the Board Assurance Framework (BAF) seek assurance on the management and assurance of significant risks.

There is a structure for following up and investigating incidents and complaints and disseminating learning from the results of investigations.

The Trust has well developed child protection policies in place and has identified and progressed in accordance with feedback on safeguarding issues highlighted in its CQC inspections carried out in February 2015 when the regulator inspected both the Trust's services and Health Services for Children Looked After and Safeguarding (CLAS) in Rotherham. Whilst significant progress has been made, there is still a need to further embed practice in a number of areas.

All Trust colleagues are governed by 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.

Role appropriate information governance training is mandatory for all contracted staff, volunteers and new starters in accordance with the requirements of the Health and Social Care Information Centre's (HSCIC) Information Governance Toolkit.

Information governance risks are managed in line with the Trust's risk management framework, and where appropriate, are recorded on the Trust's risk register.

The Trust has implemented the Department of Health Guidance, 'Checklist for Reporting, Managing and Investigating Information

Governance Serious Untoward Incidents'. Information security forms part of the Trust's risk management strategy and the management of Information Governance Serious Incidents (SIRIs) is documented in local IG policies.

Risks and issues involving information security are monitored by the Information Governance Committee and Corporate Informatics Committee, both of which report to the Trust Management Committee.

The Trust has in place a standard operating procedure for the reporting of appropriate IG incidents to the Information Commissioner. This procedure outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach.

The major risks for the Trust in-year and in the immediate future are:

1. Finances (Underlying deficit, increasing and ongoing cost pressures, significant capital investment required to address backlog maintenance and support transformation of services, liquidity, and the requirement to deliver above sector average.)

Reflecting the situation throughout the health sector, the financial position of the Trust remains challenging and there still was an underlying deficit at the start of 2016/17. Whilst this has reduced over the previous two financial years and the Trust will continue to set challenging CIP targets - striving to improve effective, efficient and economic use of resources – the Trust's 2016/17 plan aims to reduce the deficit further, but an underlying deficit will remain in place throughout 2016/17.

The 2015/16 financial plan was not achieved in full. The Trust ended the financial year with a deficit of £8.8million, £6.9million adverse to the plan of £1.9M deficit.

The overspend was largely driven by an increase in the agency / locum spending of circa £5M on that of the previous financial year, reflecting a total agency / locum spend for 2015/16 of £16M. Agency and locum spend significantly increased during the year due to medical workforce challenges, particularly in the ED, gastro and dermatology. The Trust reduced the percentage of nursing agency spend in 2015/16 compared with previous year. However, further work is required during 2016/17 to significantly impact and reduce agency and locum spend overall for the Trust and to meet agency cap requirements.

The Trust was set a target by its regulator to reduce agency expenditure for nursing staff to 8% for the last six months of the 2015/16 financial year. Outturn was at 6.5% (cumulatively 6.88% for the year but still ahead of target).

During 2015/16 the Trust identified a long standing issue, regarding failure to code activity in a timely way which led to an inability to secure income for associated activity undertaken. The Trust has been successful with the action taken address this risk going forward. However, £1.5M income was lost between April and October 2015.

The Trust secured a £15M loan from the Department of Health in October 2015, specifically to support the capital investment programme which amounted to £13.5M during 2015/16, and represented 95% of the planned position. However, the Trust continues to face significant

pressures for capital investment in terms of estate, equipment replacement and maintenance. This is recognised through the capital investment plan of £11.6M for 2016/17 which also reflects funding from Rotherham CCG to support the further development of the new Emergency Centre which is due to open in spring 2017.

The Trust achieved its 2015/16 £12.9M recurrent CIP target, with £12.6M savings in year, a shortfall of £300K compared with plan. Achievement of £12.9M recurrent CIP represents a 5.5% saving of controllable costs compared to a sector average of 3.1%.

The 2016/17 financial plan requires the Trust to deliver a surplus of £6.6M. This is dependent on receiving £6.5M Sustainability and Transformation Funding, and the achievement of associated performance trajectories.

Plans have been put in place to manage delivery of budgets, CIPs, CQUINS, and activity plans. All CIP plans are subject to quality impact assessments and monitoring to ensure no detrimental impact on services and/or patient care.

The Trust continues to be committed to ensuring that it moves to a position of financial sustainability and the Board of Directors remains focussed on this through the Board Assurance Framework.

2. Quality of care (Failure to deliver high quality patient care, leading to poor patient experience and avoidable harm, failure to deliver clinical sustainability, leading to financial penalties and regulatory action.)

Plans are in place to strengthen the clinical governance framework throughout the organisation with the establishment of a new Clinical Governance Committee, led by the Medical Director and Chief Nurse from May 2016.

As part of this new process, a review of organisational clinical governance structures throughout the organisation is underway; some subgroups were found to have been unproductive during the year.

A review of the complaints process and Serious Incident investigation procedures was undertaken during 2015/16 and improved systems put in place. Regular audits are being carried out to ensure that WHO Surgical checklists are being complied with whilst measures are being taken to strengthen a compliance culture throughout the Trust.

The Trust continues to review its clinical services to ensure clinical, operational and financial stability and is exploring collaborative opportunities for those services which would benefit from additional resources.

The CQC undertook an announced visit in February 2015 and as a result, implemented an extensive action plan to address areas where improvements were required (more details can be found within the Quality Report).

3. Workforce (Leadership capacity and capability, failure to recruit to significant posts, sickness absence, productivity, long term effects of industrial action.)

The Trust has an over-reliance on premium agency / locum staffing to fill vacancy and other workforce gaps (e.g. sickness absence) in order to maintain safe staffing levels. National workforce shortages are reflected in the local region with a number of hospitals and healthcare organisations competing to fill similar roles. This has been particularly reflected in a number of specialties where the Trust has experienced medical workforce shortages and absence resulting in a high reliance on locums. This coupled with workforce challenge in a number of other areas, such as clinical coding, has led to further reliance on temporary workforce and premium spend during 15/16. The Trust has been successful in recruiting a number of consultants during 15/16 and also is progressing actions to mitigate ongoing risks through potential collaboration with other acute providers

Acute care collaboration is being progressed through the wider strategic vision through the development of the South Yorkshire and Bassetlaw STP, the Working Together Partnership and Emergency and Acute Care Vanguard. The Trust is committed to significantly reducing its agency / locum cost during 2016/17 and future years, and actions are predicated on improved recruitment and retention, and further collaborative working and service redesign, whilst ensuring the provision of safe, high quality care for the population we serve. In addition, as one of only a small number of providers without e-rostering, the implementation of e-rostering in April 2016 is expected to bring further efficiencies and support effective management of effective workforce planning and productivity.

The Trust's new substantive Director of Workforce, commenced in post in April 2016 and will be immediately addressing some areas of ongoing workforce concern for the Trust, including management of sickness absence rates, recruitment and retention processes, some low levels of mandatory and statutory training compliance, and provision of structured leadership development.

4. Regulatory Risk (Breach of NHS Improvement, CQC and ICO requirements.)

Following, the CQC inspection in February 2015, the Trust developed an extensive action plan to address concerns that had been raised by the regulator. This has been reviewed by internal auditors and further recommendations made to strengthen quality improvement. The Trust awaits the CQC re-inspection which is expected during 2016/17.

The Trust ended the financial year in breach of its Provider Licence due to financial planning breaches, enforcement for which was originally put in place in April 2013.

The enforcement actions covered a wide range of financial requirements including aspects relating to the financial risk ratings. The Trust has made good progress in a number of areas, since 2013. However the risk rating – the calculation of which was changed by the regulator after Q1 from a 'Continuity of Service Rating' to a 'Financial Sustainability Risk Rating' - remains at 1 (against a 2015/16 plan of 2) representing the significant ongoing financial challenge facing the Trust in terms of underlying deficit and requirement to return to a surplus position supporting long term sustainability. The enforcement conditions required the Trust to return to a financial risk rating of 2 in the first two years of the recovery plan and a financial risk rating of 3 in the third year of the plan (2015/16).

The Trust did not achieve compliance with Level 2 of the Information Governance Toolkit at the end of the financial year. However, the Trust achieved 86.63% IG training figure, against a target of 95%, a 13.63% improvement compared with the previous year – although failure of this Key Requirement meant that the Trust was unable to achieve the required Toolkit assurance. However, the Trust achieved at least Level 2 in all applicable other Key Requirements. Plans are in place to progress awareness and increase training across the organisation to improve compliance further in 2016/17.

5. Operational delivery (Failure to achieve quality and operational targets, increased financial penalties, failure to deliver transformation at a reasonable pace.)

Whilst achieving the 4 hour access target in Q1, the Trust struggled throughout the remainder of the year and did not achieve the final three quarters. Overall, the Trust maintained a reasonable performance relative to other Trusts during a number of months throughout the year. However, during March 2016, the Trust's performance dipped to its lowest level to date, achieving only 77.14%. Despite significant improvement in reduced length of stay for long stay patients, winter pressures and the relocation of emergency department to a temporary ward environment and medical workforce pressures continued to create significant challenges for the Trust. Overall the Trust achieved 90.59% for the financial year. However, the target remains challenging and the Trust therefore continues to focus on delivery of actions in the improvement plan and embedding the required changes.

All cancer targets were achieved for each quarter of the financial year. However, performance for the 62-day cancer target during February 2016 was below target, despite achievement for the quarter overall. Support has been provided by ECIST and improvement plans are in place to support improved service performance for patients.

In February 2015, the Trust Board was first made aware of 52-week RTT breaches. After validation of circa 13,500 pathways, the Trust confirmed ten reportable 52-week breaches. No harm to patients occurred as a result of the delay in treatment.

At the request of the Trust, the NHS Intensive Support Team undertook a review of the Referral To Treatment pathway, resulting in an action plan which continued to be progressed.

As a result of improvements in waiting list management and oversight, in January 2016, further breaches were identified relating to management of the active treatment pathway.

This led to a plan being developed by the Trust for the validation of a further 13,500 pathways. To date, five patients have been found to have breached, with no harm resulting from the delay. Validation in this area continues into 2016/17 with the aim of completing this validation exercise by end of June 2016.

6. External environment (Changing regulatory regime and new collaborative working arrangements, increased reliance on partners through new working relationships.)

The period 1 April 2015 – 31 March 2016 saw significant changes in the regulatory regime in the NHS in England.

Recognising the significant challenges facing the Trust in terms of the ongoing provision of resilience and sustainability of services for the local population we serve, the Trust Board took the strategic decision in December 2013 to be a standalone Trust, with collaboration with partners. Strategically this decision remains central to our strategy and approach and fully aligned with the national context in which we operate.

Over the last two years, the Trust has made progress in terms of clinical sustainability and transformation of services. The national context, strategies and development of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan, provide the context in which the Trust continues to develop and progress its vision and clinical strategy.

The Trust plays a lead role with local stakeholders in developing the Rotherham Vision with members of the Rotherham Together Partnership, and on local health and social care needs through the local Health and Wellbeing Board, Chief Officer Group and RTP. The Trust has been identified within the South Yorkshire and Bassetlaw STP footprint, covering a planning population base of 1.6M. The intention is that each STP footprint will be convened by a local system leader and recognising that footprints are not statutory boundaries but rather vehicles for collaboration. The intention though is that planning should be on the basis of populations, not institutions or organisational form and steps are underway in consultation with partners and the public to develop these arrangements in line with planning guidance.

In parallel, the Five Year Forward View (5YFV) guidance for Acute Providers (Implementing the Forward View: Supporting providers to deliver) makes clear the challenge for Acute Providers and provides a roadmap. Providers need to deliver high quality patient care, NHS constitutional access standards and financial balance, eliminating unwarranted variation across all these areas, while also making the transformation that is needed to ensure long-term sustainability and in doing so reduce the three gaps – health and wellbeing, quality and finance.

The guidance sets out the vision and roadmap against five key domains:

- Quality: Success will represent a CQC rating of 'good' or better.
- Finance/use of resources: Success will represent delivering the 2016/17 control totals, reducing use of agency staffing, delivering required efficiency savings and productivity gains by responding to Carter review, maximising use of estate and realising value from surplus estate.
- Operational performance: Success will include delivering performance targets - A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, access to mental health services and progress on implementation of seven-day services.
- Workforce and Leadership: build on existing governance tools like the well-led framework to set out a single, shared system view on what good leadership looks like. Developing workforce strategies.
- Strategic change: assess how well Trusts are delivering the strategic changes set out in the 5YFV based on STPs.

Based on the guidance contained within the 5YFV for Acute Providers, in 2016/17 the Trust will continue to review its current performance against each of the domains in order to identify the gap to delivery and further actions needed.

The focus of the Acute Care Collaboration continues to be on delivering sustainable models of acute care for both smaller hospitals and multi-site Trusts through a wider perspective on problems that cannot be solved or services optimised at a single organisational level. This will be supported by greater standardisation of processes, use of technology and shared information to reduce unacceptable variation in care. Based on a three tiered approach to identify the best supporting organisational form and system governance this will require:

- Working more closely with local partners, including primary care, social care and community services, on local core services and vertical integration that will help to maintain the clinical and financial viability of smaller hospitals.
- Developing integrated service models that span organisational boundaries on smaller specialties, in particular for services with low volumes of patients where volume negatively impacts on costs or outcomes, or where there are national or local service pressures. Such an approach will support the delivery or management of services across different geographical sites.
- Provision of services through horizontal networks with other acute hospitals that risk-tier patients with the most acute needs and redirect to more specialist sites within the WTP patch and beyond. This may require the redesign of clinical models.

For the Trust this means: leveraging the opportunities provided through the programme to continue to work with partners to fix mutual service issues; building on the transformation and integration of services that has already been undertaken; based on the outcome of the clinical specialty reviews and subsequent knowledge and developments, develop service models with partners for those services that continue to have sustainability issues and where it is in mutual interests to do so and ensuring that our plans are completely aligned with the planning intentions of commissioners and local authorities where we provide services.

The Trust reviews its compliance with the NHS Foundation Trust licence condition 4 (FT governance) on an ongoing basis. A monthly governance report, prepared by the Company Secretary, is provided to the Trust Board, and highlights internal governance issues and external matters which may affect the Trust's compliance with those principles, systems and standards of good corporate governance which would be regarded as appropriate for a supplier of health care services to the NHS.

The Trust's board and committee structure is reviewed on a regular basis for its effectiveness, and to ensure clarity of reporting lines and accountabilities.

The Board Assurance Framework and Risk Management

The BAF evidences that The Rotherham NHS Foundation Trust's Board has a system of control relating to the delivery of its strategic objectives. Each strategic risk on the BAF has been allocated for oversight by one of the Executive Directors, and Board assurance committees review related mitigation controls and seek assurance that the controls are appropriate to manage the risk.

The BAF will continue to be reviewed and improved; a recent internal audit report suggests that the number of risks should be reduced to ensure that the document is sufficiently focussed.

In addition, the Trust 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.

Risk is assessed at every level in the organisation, from individual wards and divisions to the Trust Board. This ensures that both strategic and operational risks are identified and addressed.

Each division and CSU is required to identify, manage and control local risks whether clinical or non-clinical (such as finance, workforce, health and safety issues), in order to provide a safe environment for patients and colleagues and to reduce risk. These registers hold details of risks identified through day-to-day business activities, as well as risks from wider sources such as risk assessments, incidents (including serious incidents), inquests, complaints, claims, clinical audit, CAS alerts, and from review of external third party reports and recommendations. This ensures the early identification of risks and the devolution of responsibility for management of risks to colleagues at all levels of the organisation.

The Trust's Corporate Risk Register (Datix Risk Management System), collates the risks identified within the directorates, which are managed at local corporate and local directorate level.

Risks scoring 16 (out of 25) and above from the Corporate Risk Register, are reviewed monthly by the Trust Management Committee and quarterly by Board Committees, to provide assurance that operational requirements to mitigate and control risks, are being kept current.

The Corporate Risk Register also informs the Trust's annual plan with the aim of capturing all significant risks that may impact on the Trust's activities and achievement of its strategic objectives.

The risk management strategy sets out the organisation's approach to risk, the Executive and Non-Executive Director roles and responsibilities, and the framework in place for the management of risk throughout the organisation. It contains a definition of risk, and the management of risk is supported by the Quality and Standards team.

Risk management training has been provided to a number of colleagues and there are policies in place to describe their roles and responsibilities in relation to the identification and management of risk. Plans are in place, as part of the 2016/17 priorities, that the risk management framework and processes throughout the organisation will be strengthened; this will be supported by increased training and events aimed to raise awareness and to embed risk management processes.

The Trust learns from the outcomes of external inquiries and has paid significant attention to reviewing current practice in light of the findings of the national reports and implementing the recommendations where appropriate. It is supported in this work by the 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 Trust 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. Each priority has an implementation plan that indicates required milestones, KPIs and outcomes. The Trust Board committees also seek more detailed assurance that milestones are being achieved, KPIs are being met and that outcomes are as anticipated. The Trust 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.

A new data assurance metric is currently being developed with the majority of IPR KPIs having already been assessed against the metric. A designated data quality assurance standard is being used to provide a consistent measurement of data quality across all standards and to drive improvement in data quality

Whilst I am satisfied that Board reporting structures are robust, there is a commitment to increase the use of benchmarking and triangulation.

Operational committees report through the monthly Trust Management Committee (TMC) attended by the Trust's senior leadership team which includes Executive Directors. The TMC provides a conduit between organisational and board level governance processes.

The key ways in which public stakeholders are involved in managing risks which impact on them, include:

- Council of Governors' meetings which provide an opportunity to hold the Board of Directors to account on its performance, including quality and risk.
- The Trust's engagement with commissioners, Joint Health Scrutiny Committee and HealthWatch
- Consultation on the Quality Account involves key stakeholders and is evidenced through inclusion of their feedback.
- Annual NHS staff survey
- Patient surveys
- Consultation on transformational change with key stakeholders.

The foundation trust is **fully** compliant with the registration requirements of the Care Quality Commission and its current registration status is 'Registered without conditions'. A full copy of the Trust's registration certificate can be viewed at <http://www.cqc.org.uk/provider/RFR/registration-info>

However, following a routine, announced CQC inspection at the Trust in February 2015, CQC inspectors reviewed services across the eight acute and four community 'core services'. The overall rating from the inspection was 'requires improvement' with the ratings against the domains ratings being:

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

In response to the findings, the Trust developed an extensive action plan to address inadequacies found by the regulator. More details can be found within the Quality Report.

The Trust seeks continuous improvement in its services for the benefit of its patients and their carers and families. As a result, the organisation is now transitioning from its original CQC action plans (2015) to a Trust quality improvement plan (2016) to strengthen our approach to quality improvement and ensure that the Trust's journey towards more efficient and effective care continues.

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 Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's 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 organisation's annual financial plan is approved by the Board and submitted to the regulator. The plan, including forward projections, is monitored by Trust Board. In addition, the Finance and Performance Committee and the Trust Management Committee oversee assurance on a monthly basis, with key performance indicators and metrics reviewed by the Trust Board.

The Trust's resources are managed within the framework set by the Standing Financial Instructions, Matters Reserved for the Board and Standing Orders.

Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

Clinical and corporate divisions are responsible for the delivery of financial and other performance targets which are monitored through the performance management framework incorporating monthly reviews with members of the Executive team.

Information governance

On the basis of the reporting requirements, two Serious Incidents Requiring Investigation (SIRI) reports were made during the year where confidential information had been disclosed in error (May 2015, and January 2016). Both reports were filed on the basis of having been similar to previous breaches occurring during the previous 12 months. High risk confidential information was not disclosed, and the number of individuals concerned was less than 11 (first baseline on the scoring system).

In each case, the Trust was advised of the breaches via a third party agency to whom the data had been provided. Incidents were logged onto the Trust's Datix system when the Trust was notified, and internal investigations began.

The Information Commissioners Office, which is automatically advised when the reports are filed through the IG Toolkit, began investigations with the Trust regarding the incidents.

The regulator was satisfied that the Trust had taken the correct actions subsequent to the breaches, and that appropriate policies were in place. As a result, the regulator confirmed that no further action was needed, and no financial penalties or undertakings were required on these occasions. The Trust continues to progress through education and compliance with IT toolkit.

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 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 2015/16 has been developed in line with relevant national guidance and is supported internally through the Board Assurance Framework. The Chief Nurse and Medical Director provide leadership for quality improvements in the organisation and are the Executive lead for the Board's Quality Assurance Committee which seeks assurance as to the progress against the organisation's quality improvement indicators.

The report is prepared using national guidance, stakeholders receive a draft copy for comment and feedback is responded to within the final draft.

The Quality Assurance Committee has a key role in providing assurance on the implementation of the quality priorities. The data included is based on the national descriptors in the guidance and is subject to data quality checks. The completed Quality Report, including two mandated indicators and comments from Trust stakeholders, is subject to certain procedures by the Trust's external auditors.

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 auditors, 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 auditors 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 and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust reviews the effectiveness of the system of internal control through Executive Directors and managers in the organisation who have responsibility for the development and maintenance of the system of internal control and the Board Assurance Framework.

The Board is responsible for approving and monitoring the systems in place to ensure that there are proper and independent assurances given on the soundness and effectiveness of internal control.

The Audit Committee is responsible for independently overseeing the effectiveness of the Trust's systems for internal control and for reviewing the structures and processes for identifying and managing key risks. It also reviews the establishment and maintenance of effective systems of internal control.

In discharging its responsibilities, the Audit Committee also takes independent advice from the Trust's internal auditors (TIAA) and external auditors (KPMG).

In some instances, the audit work found that there was insufficient evidence that the controls are working effectively. The examples found during the year, were:

Data Quality – Mortality Reporting:

- Death Summary Documents had not been completed in some cases.
- Clinical Coding Validation forms were not complete within a week for a number of wards and specialties.
- The review of all deaths across the Trust lacked a standardised approach.
- Monitoring of the review of all deaths lacked internal KPI's to contextualise the results.

Human Resources – Agency Staffing:

- Testing identified that six out of 15 (40%) agency staff were being used without confirmation from the agency that the necessary evidence of pre-employment checks (qualifications, entitlement to work or appropriate personnel checks) had been undertaken.
- Six agency staff had been paid above the agreed target rate.
- A duplicate booking for the same date, time and agency staff member was recorded on the Talent system. Both bookings and timesheets had been approved

Recommendations were made by the internal auditors in each instance,

and action plans, were agreed. Progress against the recommendations is followed in the audit action tracker which is presented to each Audit Committee meeting.

The Board has a comprehensive internal audit work programme which includes matters which the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information which enables it to scrutinise the effectiveness of the Trust's operations and deliver focused strategic leadership through its decision making process.

Internal Audit has carried out specific reviews of the Trust's Board Assurance Framework and overall governance framework. The outcomes of reviews by internal audit have been considered throughout the year through regular reports to the Audit Committee and the Trust Management Committee.

On the basis of the work carried out by Internal Audit, reasonable assurance has been given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls, puts the achievement of particular objectives at risk.

The Trust's Board Committee structure delivers assurance on, and provides challenge to the organisation's risk management framework. Supported by a number of underlying committees and groups, the majority of the Trust's Board Committees meet on a monthly basis, and are all chaired by independent Non-Executive Directors - which provides additional scrutiny and challenge. Any risks or issues identified by the Committees are escalated to the Trust Board.

The Audit Committee ensures that the organisation operates effectively and meets its statutory and strategic objectives, and provides assurance on its adequacy with regard to all aspects of governance, risk management and internal control.

The Finance and Performance Committee provides the Board with an objective review of the in-year financial position of the Trust and provides assurance on the delivery of strategic objectives relating to financial performance.

The Quality Assurance Committee is responsible for providing assurance to the Board that there is an effective system of quality governance, risk management and internal control for clinical governance. In addition, it provides assurance for the three broad areas of patient experience, clinical effectiveness and patient safety.

The Strategic Workforce Committee provides the Board with assurance that the Trust's workforce related strategic objectives are delivered.

Conclusion

Whilst it is recognised that some areas of improvement exist within the Trust, as covered above, there have been no significant control issues during 2015/16 which have not been stated in this statement.

Action has been taken, or action plans are in place, to address the areas for improvement, and where appropriate, those plans will be tested via relevant scrutiny and review processes.

Annual Governance Statement signed by the Chief Executive:



Louise Barnett
24 May 2016

Accountability Report signed by the Chief Executive, as Accounting Officer:



Louise Barnett
24 May 2016

Sustainability Report

The Rotherham NHS Foundation Trust (TRFT) is committed to ensuring that all environmental impacts associated with its business activities are minimised as much as possible.

The Trust has a well-established management of energy, waste and water developed and despite site growth carbon emissions arising from energy use have continued to fall year on year.

An annual energy/environmental report is produced which shows how the Trust is performing against targets. Monthly dashboard reports are submitted to the Environmental Management Group (EMG) with graphs depicting the position both against the previous year and against a set of agreed KPIs (Key Performance Indicators).

Summary of Performance

The Trust has invested heavily in energy saving equipment and building controls with clear reductions in energy and carbon being achieved. Awareness training is delivered to as many full time staff and new starters as possible.

The Trust fully embraces the aims and requirements of the NHS Carbon Reduction Strategy which seeks to ensure that NHS organisations integrate sustainability and carbon reduction into their strategy, systems and procedure. The Trust recognises that a range of measures are necessary to deliver this effectively. As a result a Sustainable Development Management Plan (SDMP) is being formulated which highlights key areas of focus including responsibility and accountability, environmental legislation, energy management, procurement, transport and travel, water and waste management.

As a result, updated energy, water and carbon reduction have been set as follows:

- 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 **[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]**

Some of the schemes undertaken and completed by the Trust were:

Project	Capital Cost (£)	Annual Saving (£)	Annual Saving (tonnes Co2)	Payback (years)
Replacement of main heating valves on A & B Level (Phase 2)	7,000	3,000	6	2.3
Conversion of pneumatic controls on AHUs	37,000	6,800	25	5.4
Update BMS controls from MP100 system to Continuum	10,000	4,000	8	2.5
Replace modular lighting with LED panels	35,000	19,450	67	3.8
Replace T12 fluorescent with T5 fluorescent and LED panels	45,000	9,180	44	4.9

Sustainability Data

Category	Element	Non-financial Data 2014/15	Non-financial Data 2015/16	Financial Data 2014/15	Financial Data 2015/16
Waste Minimisation and Management	Clinical Waste				
	High Temp Disposal	68	66	£15717	£15197
	Non-Burn Treatment	160	148	£49200	£45510
	General Waste				
	Landfill	0	0	0	0
	District Heating Scheme	572	573	£803004	£77573.38
	Recycling				
	Glass	0.72	2.03	£30.60	£61.80
	Plastic	11.80	15.96	£962.26	£1435.70
	Paper	52.68	58.70	£2964.00	£3980.50
Energy	Cardboard	80.86	75.77	-£5660.20 - Rebate	-£3613.10 - Rebate
	Metal	14.40	23.98	-£635.50 Rebate	-£1079.10 Rebate
	WEEE	4.76	8.62	FOC	FOC
	Water	10,4971 m³	97,450 m³	£134,200	£72,376
	Sewage	89,225 m³	82,832 m³	£140,296	£133,373
	Electricity	3,483,766 kWh	1,460,710 kWh	£394,931	£179,194
	Gas	36,553,450 kWh	40,575,468 kWh	£1,042,991	£936,163
	Oil	40,000 litres	0 litres	£24,786	£0

Energy

During the past year the Trust has undertaken a host of Invest to Save projects where areas such as lighting and heating have been targeted. Obsolete T12 fluorescent light fittings have been replaced along with a significant number of modular fluorescent light fittings.

Major upgrade works have been carried out to the site heating and building controls and aging air handling equipment has been replaced.

The CHP (Combined Heat & Power) engine has to date had more run hours than the previous year resulting in producing 7,175,756 kWh of electricity and 5,856 MWh of heat up to the end of December 2015.

Water

Water saving devices, including sensor taps and "low flow" fittings have been fitted extensively throughout the site. Such devices reduce the time for which the water flows and reduce the available flow at the tap, substantially reducing water consumption and thereby the greenhouse gas emission associated with water supply and the effluent treatment process.

A programme of leak detection surveys has identified several underground leaks which have now been repaired reducing unnecessary water wastage.

Waste

The Trust continues to undertake additional clinical activity within the hospital which has the net effect of increasing the amount of clinical and general waste produced. During 2015 the Waste Management Policy has undergone its triennial review and was ratified in September 2015.

The Trust continues to comply fully with the HTM 07.01 Safe Management of Healthcare Waste ensuring that as a Trust waste is consigned correctly as set out in the Environmental Protection Act 1999 and also the Hazardous Waste Regulations 2005 and HTM 07.01.

All staff received the updated Waste Management Leaflet in October 2015 and 503 staff received face to face training with a further 50 hours of training carried out through the year. Waste audits for each ward and department have been carried out and a report produced with pictorial evidence and an action plan.

A number of recycling initiatives have been put in place which have resulted in increased recycling tonnages and rebates for the Trust. The domestic black bag waste has reduced by 9 tonnes, which is as a result of improved segregation initiated with the introduction of BART (Be A Recycler Today) and GRACE (Go Recycle A Can Every day) bins. BART was a character created by children from the Children's Ward.

Bart and Grace

In March 2015 a baler for plastic sheeting was installed and to date 9 bales of plastic wrap for recycling have been produced. Continuing with increasing the plastic recycling within the Trust, a trial commenced in December 2015 where bins were introduced in Theatre Recovery and in Day Surgery for the recycling of anaesthetic masks. This scheme is to be rolled out across the hospital during 2016.

A Waste Awareness Day was held in July 2015. At the event a competition to guess how many cans had been crushed into a small bale was run and GRACE was unveiled. The day was well attended and assisted greatly in spreading the message of recycling.

Both paper and cardboard recycling has increased and continued to support the Trust's environmental strategy in the period. A slight reduction in paper recycling has been noticed since the introduction of the new non-confidential recycling bins. The non-confidential paper is baled together with the cardboard and a rebate is achieved from this.

14.40 tonnes of metal waste, 4.76 tonnes of Waste Electronic and Electrical Equipment, 11.80 tonnes of plastic waste and 8.07 tonnes of furniture have been sent for recycling, these are all a reduction on 2013/2014 figures but this is due in the main to reduction in waste, with the Trust recycling furniture wherever possible and correctly segregating waste.

The above activity has assisted the Trust to reduce its costs by approximately £4,600 per annum.

There has been a large increase in the waste sent for District Heating due to a change in practice; all offensive waste from the hospital is sent to the nearby Energy Recovery site which provides district heating for Sheffield.

Improvements in the sluice rooms continue with the introduction of 770 litre bins or small trolleys to ensure that all waste is correctly stored and segregated in compliance with the Hazardous Waste Regulations 2005.

The Trust has also undertaken a Dangerous Goods Safety audit to comply with the Carriage of Dangerous Goods and Portable Pressures Equipment Regulations 2015, a report and action plan has been provided to areas where improvement and compliance with the regulations is required, and this is now being monitored by the Trust's Health and Safety Committee.

In June 2015 the Trust was a finalist in The Healthcare Recycler of the Year Award.



Transport

The Trust is currently revising its Green Travel Plan that will set out a range of strategies and objectives to enable staff, patients and visitors to take a healthier and environmentally friendly option when travelling to and from the hospital. Current initiatives include:

- Bus Boost scheme offering discounted bus tickets for staff;
- Reduced car parking charges for staff who car share;
- Road shows with local transport providers to offer staff, patients and visitors assistance in setting up personalised travel plans;
- Cycle to work scheme offering staff the opportunity to purchase cycles through a discounted salary sacrifice payment scheme;
- Doctor Bike scheme offering staff free MoTs for their cycles including minor repairs and servicing.

Procurement Initiatives

Local vs. National Spend

The Procurement Team continues to encourage local suppliers to engage with the Trust. This year 13% of our expenditure was with suppliers in the region. The Procurement web pages have been developed to advertise the Trust's contracts and procurement projects and provide links to the e-portal for all suppliers to participate.

In addition to this, the Procurement department is leading 2 further initiatives which are detailed below:

How to supply to the NHS (aimed at SME's):

This is currently being planned for April 2016 and will show potential suppliers how to access the Trust's contracts and how to apply and become a supplier for any opportunities which match their services or goods offered. This initiative is supported as part of the Local Enterprise Partnership (LEP)

Creation of a supplier marketplace:

This will create approximately 175 opportunities per month for registered suppliers to supply ad-hoc requirements to the Trust. This is to be piloted during the first quarter of 2016 and if the pilot is successful this will be implemented fully. This gives smaller suppliers the opportunity to supply goods in a timely manner to the Trust using the electronic portal and a rapid turnaround, therefore matching demand with local supply.

Transparency of data and opportunities:

The Procurement team have changed the entire content of the published pages of the Trust's procurement information and guidance. Each month the suppliers' spend is shown and the values are shown. There is also a link to the electronic portal which is free to register for and shows all of the procurement opportunities. In accordance with the newly updated Public Contract Regulations 2015, the Trust also publishes all contracts over £25,000 on the contracts finder website in addition to any OJEU stipulations (as appropriate depending on value).

Terms and Conditions

During 2016/17 the terms and conditions for sub-contractors will be developed to encourage sub-contractors to employ from the local community.

Transportation

We are continuing to work with local storage and distribution companies to reduce the amount of traffic around the estate which will reduce the carbon emissions from delivery vans and provide a healthier atmosphere for our patients, colleagues and visitors.

Future Priorities and Target

The Trust will further reduce costs by implementing the following in the next twelve months:

- Adhering to the Trusts Environmental Policy
- Working towards a Trust Environmental Management System in conjunction with BS8555:2003 Acorn Standard
- Introducing Environmental Contingency Plans in the event of Environmental Emergencies that may affect atmosphere, flora and fauna
- Invest in replacing worn out building controls systems
- Continue to invest in LED lighting replacement programmes
- Development of a revised Estates Strategy
- Development of a Sustainable Development Management Plan (SDMP)
- Review Trust Green Travel Plan

The Trust continues to progress its initiatives to reach its challenging CO₂ and energy reduction targets, and will continue to embed within the organisation both energy and environmental awareness that will provide further savings through the introduction of the above and other cost/carbon reduction measures, including site rationalisation and better space utilisation.

All these issues will be underpinned by the development and implementation of two strategic Board approved documents: an Estates Strategy and a Sustainable Development Management Plan both of which are mandatory requirements for NHS Trusts.

These key documents will be developed, approved and implemented over the coming year and will set the scene in terms of how the Trust's estate will be shaped to meet the needs of the clinical services it wishes to deliver and how it will manage the impact of its business activities on the environment over the next five years and beyond.

A photograph of a female healthcare professional with blonde hair, wearing blue scrubs and a stethoscope, examining a baby. She is holding the baby's arm and using a stethoscope to listen to the baby's chest. The baby is looking towards the right.

Quality Report
2015 16

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Welcome to The Rotherham NHS Foundation Trust's Quality Report for 2015/16 describing the Trust's performance across a range of national and local quality priorities. Quality priorities are agreed each year with local organisations representing patients and the public we serve, our commissioners (NHS Rotherham Clinical Commissioning Group), our Governors and Trust colleagues.

The Quality Report reflects the performance and achievements of colleagues and volunteers who deliver care to our patients. It provides a description of our performance over the last year and sets out our priorities for quality improvement in 2016/17. The quality priorities will help us achieve our newly adopted ambition: To be an outstanding trust, delivering excellent care at home, in our community and in hospital.

In the two years since I joined the Trust I have seen a new executive team put in place, providing consistent leadership and improved engagement with our colleagues, patients and communities. This has been a challenging year in which the Trust has had to respond to a CQC Inspector's report, the Children Looked-After and Safeguarding (CLAS) report, high demand for emergency care and continuing financial pressures.

The Report demonstrates the progress we have made in responding to these challenges, improvements to the safety and quality of patient care and presents our plans for building on our successes. In 2015/16 we have:

- Continued to improve the delivery of harm free care, lowering the incidence of pressure ulcers and falls.
- Implemented a robust system for improving mortality rates by reviewing and learning from all unexpected deaths.
- Reduced the number of patients staying in hospital when ready for discharge.
- Built on the 'Sign Up to Safety campaign' in our desire to significantly reduce missed and delayed diagnosis and respond to patients whose condition is deteriorating.
- Achieved the target for Clostridium Difficile infection
- Learned from our patients and their families by improving the response rate for the Friends and Family Test.
- Significantly increased the number of colleagues with training in dementia care, with many areas now having dementia champions to support improved standards of care.
- Invested in complaints management to improve responsiveness to, and support for, people with concerns about the care they receive.
- Expanded the use of the Listening into Action approach to support quality improvement across the Trust

Achieving our ambitions requires continued close collaboration with partner agencies and the effective integration of our own community and acute hospital services. The Working Together Partnership between the Trust and other hospitals in south Yorkshire, Mid Yorkshire and North Derbyshire was selected as a NHS England Vanguard project in September 2015. But the most visible sign of change is the new Emergency Centre that will act as a bridge between community and hospital. The build is now more than half way to completion.

It is also important to recognise areas where the Trust did not deliver the highest standards. During the year two Never Events were recorded, one identified through a claim relating to an incident from a previous accounting period, the other relating to wrong site treatment. There were also two breaches of information governance reported to the Information Commissioner's Office. The Trust was also unable to meet the four hour emergency care target with 90.59% of patients admitted, treated or discharged against a target of 95%. As an organisation we talk openly and honestly about these occurrences and their root causes; we take action to prevent reoccurrence through effective learning.

The personal impact of these events cannot be overestimated and we continue to strive to eliminate such incidents and deliver harm free care for every patient.

During 2015/16 the Trust has been taking action in response to the Care Quality Commission (CQC) inspection report and the Children Looked After and Safeguarding report (both published in July 2015). Overall the CQC believes the Trust 'Requires Improvement' whilst recognising areas of good practice.

There have been 17 Listening into Action 'big conversations' and pulse checks of more than 2,500 colleagues over a two-year period. The monthly Team Brief has been reviewed and enhanced, allowing for greater feedback from colleagues at the briefings or via email. The NHS continues to face new challenges meeting the healthcare needs of an aging and growing population in difficult economic times. The Trust plays a lead role with local stakeholders in developing the Rotherham Vision with members of the Rotherham Together Partnership (RTP), and on local health and social care needs through the local Health and Wellbeing Board. The Trust is also part of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP), covering a planning population of 1.6m.

If we listen to and learn from our patients and transform how we work to provide care that meets their needs we will deliver our quality priorities and help improve the health of our people.



Martin Havenhand
Chairman
May 2016



Once again it is my privilege to work with Trust colleagues, Governors, health and social care partners and the local community to achieve the ambitions described in this Quality Report for our patients and the population of Rotherham.

The Quality Report reflects the Trust's ethos: to celebrate achievements, learn from experience and improve care wherever possible. I am proud that colleagues are committed to delivering high quality care, listening to and learning from our patients. Our five Clinical Divisions now have prime responsibility for leading quality improvement, each contributing to delivering our quality priorities.

In 2015/16 we made steady progress in making improvements and we anticipate continuing this progress in the next twelve months. Although we fell just short of our overall target for harm-free care the STOP campaign to end avoidable pressure ulcers, the reduction in the incidence of falls causing harm, the 'Sign-up to Safety' campaign and the improvements to dementia care all demonstrate what can be achieved to enhance patient experience.

However, the CQC report received in July 2015 was a reminder of how far we still have to go. We have responded positively, taking action to:

- Eliminate mixed-sex sleeping accommodation from the Medical Assessment Unit and Surgical Assessment Unit.
- Re-focus hospital based children's services including a pilot for a 24 hour assessment unit.
- Develop an individualised end-of-life care pathway with implementation beginning in 2016.
- Monitor staffing levels in Nursing and Medicine with better controls on the use of bank, agency and locum staff and a review of safe staffing levels in Paediatrics, Maternity and emergency Care.
- Update and enhance skills in Dementia, Safeguarding Children and Vulnerable Adults, Resuscitation, the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Improve access to sexual health services for children and young people and for sharing information with school nurses.
- Improve the standards of medicines management.
- Improve the arrangements for prevention of healthcare acquired infections in the Community Short-Stay Children's and Young People's Service.
- Invest in additional Nurse leadership within the Division of Family Health.
- Implement a new risk management strategy.

At the same time we received the report into Safeguarding and services for Looked-After Children (CLAS) in Rotherham. We have since worked closely with partner agencies through the Children and Young People's Improvement Board to make our contribution to strengthening services and keeping children safe. The need has been underlined by the continuing investigations into Child Sexual Exploitation. The Trust will continue to commit the necessary resources to ensure that we fully contribute to making Rotherham a safe place for children and young people. We recognise the need to continue transforming our Children and Young People's service, a programme that we will develop over the next 12 months.

We have also begun the transformation of our community services, creating seven multi-disciplinary teams delivering local services. We want these services to be increasingly informed by the health needs of each locality, working closely with all our partner agencies and sharing resources effectively.

Engaging and developing all colleagues remains a key ambition. We are doing more to celebrate achievement and improve the visibility of and access to senior managers. Direct feedback is also encouraged via my 'Dear Louise' email address and my weekly message. Monthly Team Briefings help provide information for all colleagues on our performance. Colleagues are also able use email to share what they are proud of and their ideas for improvement. I want the Trust to be a great place to work, somewhere that colleagues recommend to others although I recognise we still have much work to do.

I am very pleased to have the continuing support of our Governors, Healthwatch Rotherham, the NHS Rotherham Clinical Commissioning Group and the Rotherham Health Select Commission for endorsing the quality priorities contained within this Quality Report. Achieving our programme of quality improvement for 2016/17 will mark a significant step forward for the Trust, our patients and our colleagues.

I declare that, to the best of my knowledge, the information in this Quality Report is accurate.



Louise Barnett
Chief Executive
May 2016

The Board of Directors



Martin Havenhand
Chairman



Louise Barnett
Chief Executive



Gabrielle Atmarow
Non-Executive Director



Alison Legg
Non-Executive Director



Barry Mellor
Non-Executive Director



Joe Barnes
Non-Executive Director



Mark Edgell
Non-Executive Director



Lynn Hagger
Non-Executive Director



Simon Sheppard
Director of Finance



Tracey McErlain-Burns
Chief Nurse



Lynne Waters
Executive Director of HR



Christopher Holt
Chief Operating Officer



Conrad Wareham
Medical Director



Priorities for improvement and statements of assurance from the board

2.1 Quality Narrative

Trust services are delivered through five Clinical Divisions, each accountable to Trust Executive Officers and the Board. Each Division is led by a General Manager with support from a Divisional Director (a senior clinician), a Head of Nursing, Finance and Human Resources.

The Divisions also maintain clinical governance structures that keep an overview of patient safety, clinical effectiveness and quality of services.

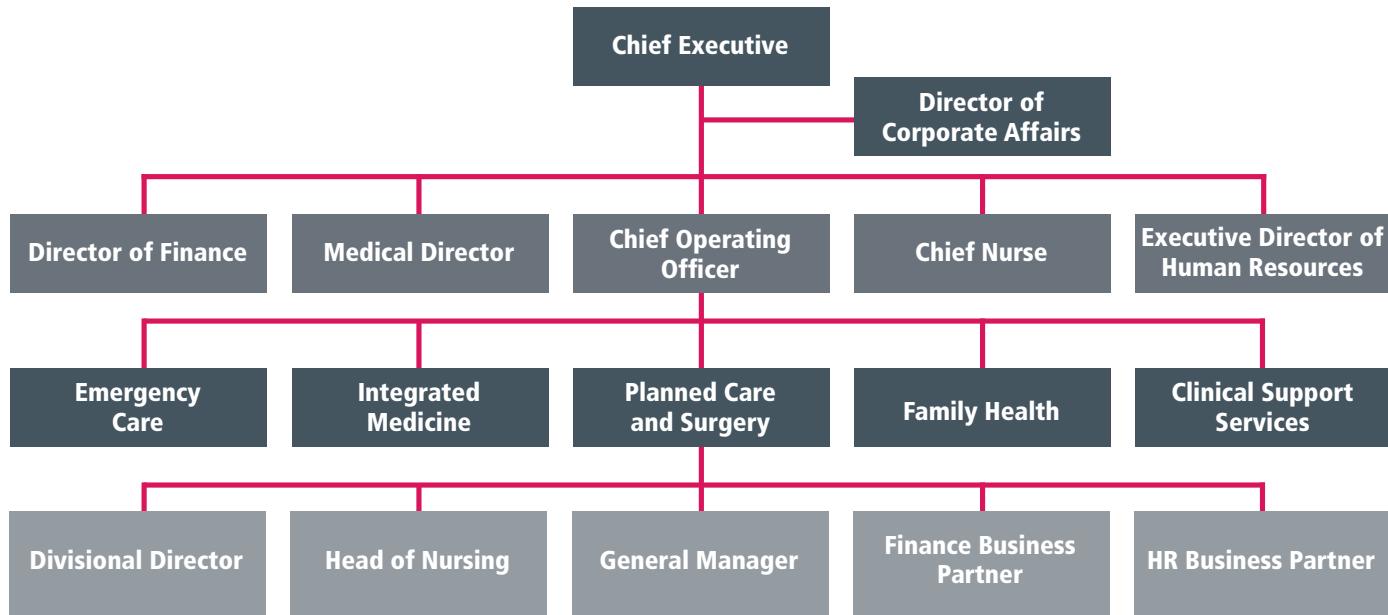


Chart 1: Clinical Divisions in The Rotherham NHS Foundation Trust

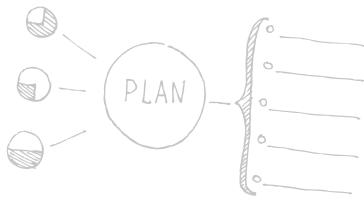
Since April 2010 all NHS Foundation Trusts have been required to publish an annual Quality Report as part of the move to ensure an open and transparent approach in making public information about the quality of the services they provide. This report therefore forms the Quality Report for 2015/16, on the quality of healthcare provided by The Rotherham NHS Foundation Trust and patients, members of the public and Trust colleagues are invited to use this report to evaluate the quality of care provided.

As in previous years the focus of this report is on how we take assurance that the services provided are safe, effective that enable patients, their relatives and carers to have a positive experience of care. This section of the report outlines some of the process and the results. The Board of Directors has ultimate accountability for quality, including the safety of services provided. The Quality Assurance Committee (QAC) is one of four Board committees and it has responsibility for seeking assurance that the Trust is providing the highest possible quality of care. The role of this committee is to seek assurance that the Trust is managing risk to quality, has the capability to ensure delivery of high quality services, is promoting a culture of openness, transparency and learning and has the right structures in place to ensure that these objectives can be achieved.

The committee holds managers and clinicians to account for performance across a range of quality and safety indicators, monitoring and tracking progress through measurement, identifying and challenging early warning signs that may emerge.

This year two of the Board committees had specific responsibilities for seeking assurance on the delivery of the Care Quality Commission (CQC) improvement action plan. Later on in section 2.4 of the Quality Report the detailed findings of the February 2015 CQC inspections will be presented together with the Trust improvement story. Throughout the year the QAC and the Strategic Workforce Committee (SWC), both led by Non-Executive Directors have sought assurances that the actions described in the improvement plans, and approved by the Board of Directors have been delivered and led to the improved outcomes required.

The Quality Assurance Committee is led by Mr Mark Edgell, a Non-Executive Director of the Board supported by Ms Tracey McErlain-Burns, Chief Nurse who is the executive lead for quality and safety. The Strategic Workforce Committee is led by Mrs Lynn Hagger, also a Non-Executive Director of the Board supported throughout the year by Mrs Lynne Waters, Director of Human Resources until December 2015, and more latterly by Mr Ken Hutchinson, Interim Director of Human Resources.

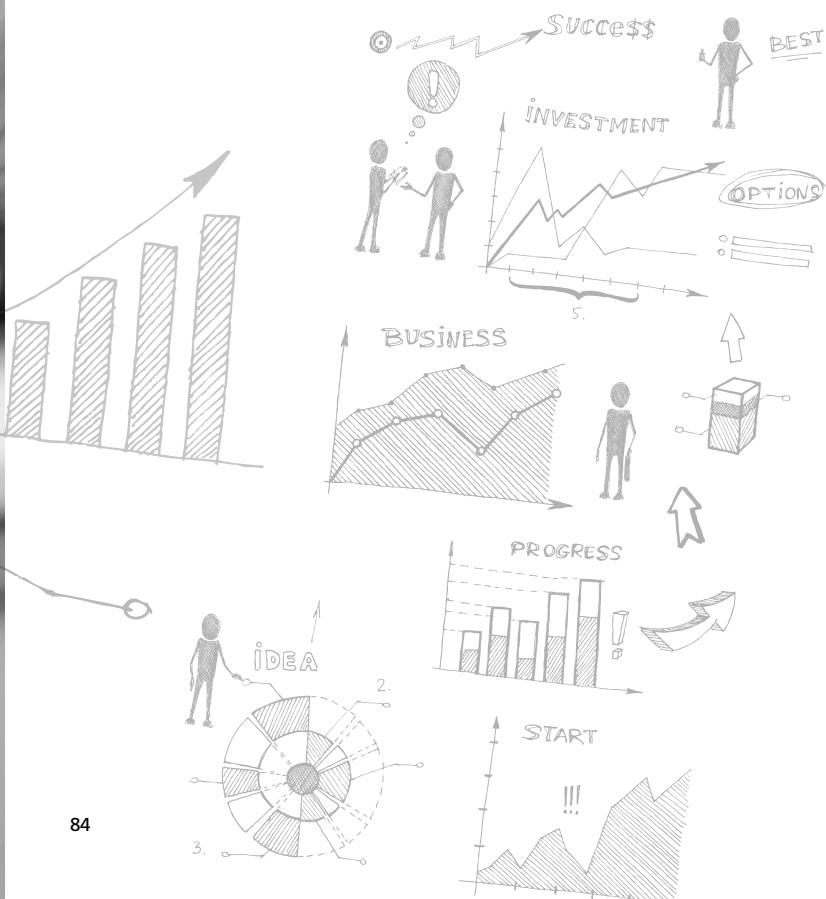


Since the publication of last year's Quality Report, the Trust has been focussed on three quality priorities; the achievement of the CQC improvement action plans; the achievement of the four-hour emergency care target and delivery of the financial plan including achieving the cost improvement and efficiency programme. Together these three priorities have driven innovation, integration of services and improvement.

At times the three priorities have created competing tensions which have been managed by the Chief Executive led Trust Management Committee. Specifically, through that Committee the executive team has led a series of weekly task groups the details of which are covered in later sections of this report, and created 30-day and 90-day plans with tangible deliverables.

Each year following a consultation process, the Trust selects priorities for quality improvement and progress against these targets has been reviewed monthly by the Quality Assurance Committee. A report on progress made over the last year is provided in Part 2.2 of the Quality Report. The outcome of this year's consultation is also included, which resulted in the identification of quality improvement priorities for the coming year. A more detailed picture of this improvement story is included in Part Three (Innovation and Improvement: Quality across the Trust).

Readers are asked to note that the figures reported in the Quality Report are correct at the time of reporting, and the report will be updated as year-end data becomes available, and added as appendices prior to publication at the end of June 2016.





Review of 2015/16 priorities

This section of the report presents in brief the Trust's progress since the publication of the 2014/15 Quality Report against the priorities for 2015/16.

For the past two years the Trust has produced a 'one-year quality plan on a page'. This dashboard is used by every part of the Trust's clinical governance structure and is reviewed monthly by the QAC. Consultation on the 2016/17 quality priorities has confirmed that it remains an ambition to achieve these goals and therefore they will continue to be the focus of improvement work for the coming year. The priorities for 2015/16 and outcomes are summarised in table 1 below².

Priority	Description	Did we achieve this goal?
1	100% of unpredicted deaths of patients in hospital will be reviewed in line with the Mortality Review Process.	Yes
2	Over 2015/16, the numbers of patients with a length of stay equal to, or greater than 14 days will be reduced.	Yes
3	Achieve minimum 96% Harm Free Care with the following percentage reduction on the 2014/15 baseline: <ul style="list-style-type: none"> ● 70% reduction in avoidable pressure ulcers grade 2-4 ● 50% reduction in avoidable falls with significant harm 	No. Trending at 94.85%; a 0.5% improvement on the previous year. Yes – 74% achieved. Yes – 57% achieved.
4.1	Significantly reduce the incidence of avoidable harm caused by missed or delayed diagnosis.	See narrative (p20)
4.2	Significantly reduce the incidence of avoidable harm caused by failure to recognise and manage the adult deteriorating patient.	See narrative (p20)
5.1	Increase the percentage of in-patients who are not disturbed at night during their admission	Yes – I/P survey scores improved from 7.5 – 8.1 (from staff) and 5.4 – 5.5 (from patients)
5.2.1	Achieve and maintain a minimum 95% positive Friends and Family Test (FFT) score – in-patients	Yes – 97% achieved
5.2.2	Achieve and maintain a minimum 86% positive Friends and Family Test (FFT) score – A&E	Yes – 88% achieved
5.2.3	Achieve a 40% FFT response rate – in-patient areas.	Yes – 41% achieved.
6.1	Increase the number of colleagues who have undertaken training in dementia awareness by 30%	Yes - >70% of colleagues now trained
6.2	A reduction in the number of complaints about our care of frail and elderly patients, including those with dementia, by at least 30%	Baseline data collected; 9 complaints related to dementia care in 2015/16
6.3	Achieve minimum 90% positive result from the dementia carers survey	90% achieved
7.1	Achieve 90% of complaint response times on the date agreed with the patient	No, but up from 20% to 41% by February 2016
7.2	Achieve 20% improvement in the complaints management satisfaction rate over the Q1 baseline position.	Response rate too low to be meaningful

Table 1: summary of the Trust's Quality Account priorities for 2015/16

¹ Further detail on the Trust's quality priorities are included in Part 3

Priority 1 Clinical Effectiveness	100% of unpredicted deaths of patients in hospital will be reviewed in line with the Mortality Review Process	Yes
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Our aim was to undertake reviews of all unexpected deaths as required by the Trust's Mortality Review Process.

Did we achieve this goal? Yes

Under the leadership of Dr Conrad Wareham, the Trust Medical Director, the Trust has achieved a number of improvements relating to mortality. The Mortality and Quality Alerts Group meets monthly bringing together clinicians, representatives of the Clinical Coding Department and Dr Foster³. The Group enables the Trust to analyse and understand trust-wide hospital standardised mortality ratios (HSMR); summary hospital-level mortality indices (SHMI); compare performance with other providers; examine variations in performance and undertake specific pieces of work such as a review of deaths at the weekend, deaths by source of admission and a review of all unexpected deaths.

The HSMR can be briefly described as the actual number of deaths occurring in a hospital compared to the number of those deaths that could be expected to happen. The SHMI can be briefly described as a ratio of the actual number of patients who die following hospitalisation and 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.

At the time of reporting the HSMR has fallen to 101.8 for January – December 2015 whilst the SHMI (1.084 for October 2014 – September 2015) remains significantly raised. The figures demonstrate the difference between the two measures and underline the importance of considering the whole range of available evidence in evaluating the Trust's performance.

Much of the focus during 2015/16 has been on embedding the processes of mortality reviews within the Division of Integrated Medicine. Following the introduction of a process to ensure that all deaths are summarily reviewed each week by the Divisional Director (doctor) and the Governance Lead (nurse) the Trust has achieved this Quality Report priority. The purpose of the summary review is to ensure that there is no delay in referring a death to Her Majesty's Coroner if concerns are identified; to make sure that any such referral is communicated speedily to the patient's family and to ensure that any immediate learning is not delayed whilst awaiting a full review.

Other Divisions including Family Health and Planned Care and Surgery already had established processes for undertaking mortality and morbidity reviews.

Responsibility for overseeing the systematic review of all deaths is led by the Associate Medical Director – Quality and Standards, Dr Carrie Kelly. The process ensures that all deaths receive both an early, summary, review and an in-depth review by a doctor within the specialty who is not the Consultant responsible for the patient's care. Learning from these peer reviews is captured and shared through the Mortality and Quality Groups.

Analysis undertaken by the Mortality and Quality Alerts Group has supported the Trust's commitment to:

- Implement the SAFER Care Bundle which ensures that all patients have consultant led review;
- Invest in a Practice Development Team which will focus on recognising and managing the acutely unwell and potentially deteriorating patient and
- Underpin the introduction of a 'ward round pro-forma'. This standardises how patient reviews and clinical management plans are recorded. This will be audited later in 2016.



Priority 2
Clinical Effectiveness

Over 2015/16, the numbers of patients with a length of stay equal to, or greater than 14 days will be reduced.

Yes

Our aim was to reduce the numbers of patients with a length of stay equal to, or greater than 14 days to fewer than 80 at any time, averaged over Q3 and Q4.

Did we achieve this goal? Yes

Under the leadership of Mr Chris Holt the Trust Chief Operating Officer the Trust has led a programme of health and social care transformation in order to achieve sustainable improvements in the numbers of patients with a long length of stay.

LOS > 14 Days - Snapshot as at last day of each month

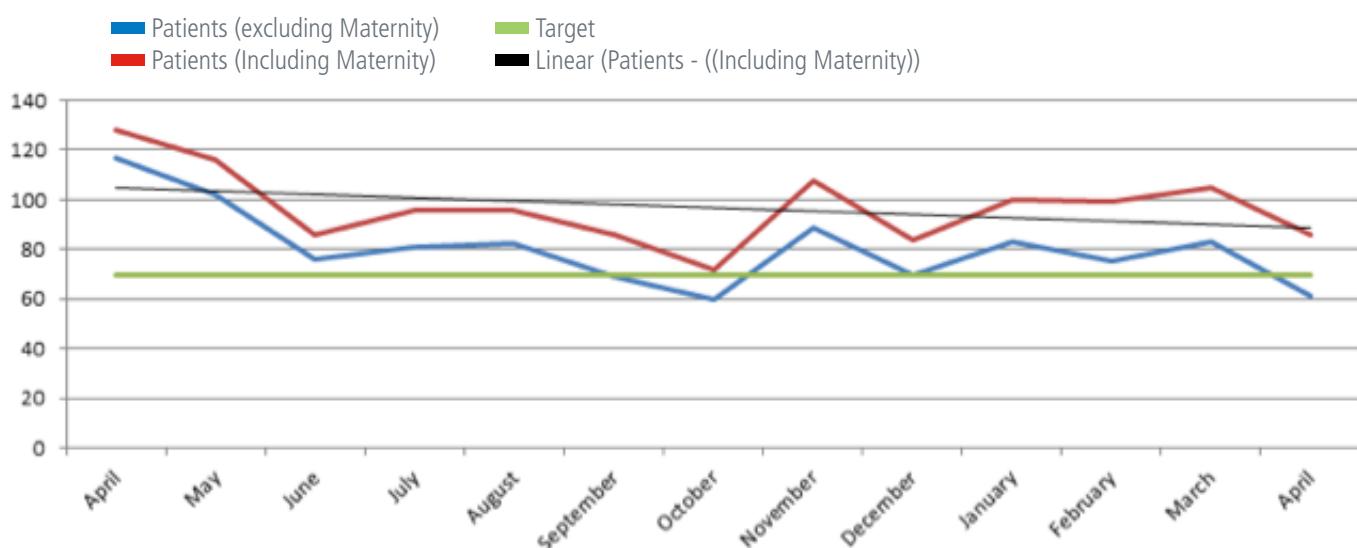


Table 2: Number of patients staying in hospital for more than 14 days 2015/16

The baseline in June 2015 was 116. Weekly dated was collected from August with the average number of patients in hospital for more than 14 days was reduced to 81 during Q3. In Q4 this increased to 88 (reflecting winter pressure) but remains below the baseline. Improvements have been achieved because the strategic intent was clearly described as part of the 2015/16 plans for acute and community integration / transformation. As a result health, social care and the voluntary sector have worked together to provide care for patients in the right location when acute care was no longer needed. In addition, on a weekly basis since the start of Q3 a partnership, multi-disciplinary ward round has taken place to create and manage individualised discharge plans for patients with a length of stay greater than 14 days; specifically this ward round has included GP leaders from the Rotherham Clinical Commissioning Group. A process for monitoring long admissions (14 days or more) is now being introduced where clinicians review after 14 days, with escalation to Division at 35 days and to Executive Officers at 50 days.

“Everybody working on this ward was very helpful and jolly. They couldn't do enough for you. Thanks to all the staff on CCU ward.”

**Friends and Family patient feedback
Coronary Care Unit**

2 Data in this section of the report is based on Q3 performance reports unless otherwise indicated. Given the deadlines for production of the Quality Report Q4 data will not be available. Where possible updates will be provided as footnotes or appendices before final publication in June 2016.

3 Dr Foster Intelligence in Healthcare – the system used by the Trust to analyse and understand mortality statistics.

Sometimes patients cannot be found a bed on the most appropriate ward. These cases are known as 'clinical outliers'. These patients tend to stay longer in hospital and be transferred between wards more often. The ward environment may be inappropriate as may the skills and knowledge of the ward team. Outliers present a challenge to good communications and patient safety. 4 For those reasons, therefore, the Trust closely monitors these patients and ensures they have a daily ward review. At all times the Trust is seeking to avoid patients outlying to the wrong speciality bed.

Priority 3 Patient Safety	Achieve minimum 96% Harm Free Care with the following percentage reduction on the 2014/15 baseline:	No. Trending at 94.85%; a 0.5% improvement on the previous year.
	<ul style="list-style-type: none"> ● 70% reduction in avoidable pressure ulcers grade 2-4 ● 50% reduction in avoidable falls with significant harm 	Yes – 74% achieved.
		Yes – 57% achieved.

Our aim was to achieve a minimum 96% harm free care, with a 70% reduction in the incidence of avoidable pressure ulcers grade 2-4 and a 50% reduction in avoidable falls with significant harm.

Did we achieve this goal? Partially

Under the leadership of Ms Tracey McErlain-Burns, the Chief Nurse, The trust has achieved targeted reduction in avoidable pressure ulcers grade 2 to 4 and falls with significant harm. However the Trust has not quite achieved the desired 96% harm free care as measured by the NHS Safety Thermometer.

Avoidable Grade 2 to 4 Pressure Ulcers

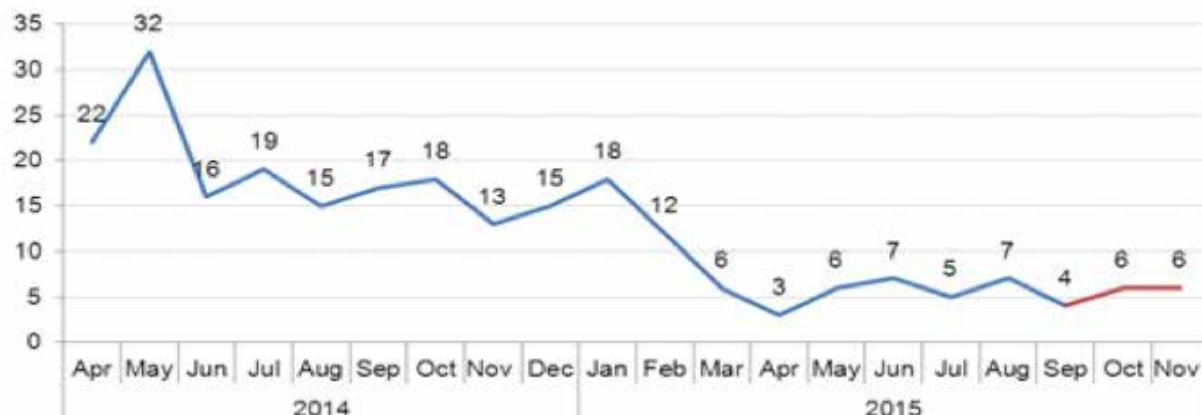


Table 3: Trend for avoidable pressure ulcers, grades 2 to 4

At the time of reporting the national average score for Harm Free Care is 94.17% and the Trust rate is 94.85%. Of note, The Rotherham NHS Foundation Trust is an integrated acute hospital and community Trust, one of a small but growing number of such Trusts in England. This is relevant when comparing ourselves against the national NHS Safety Thermometer results because of the prevalence of pressure ulcers in the community, not least in a Borough with high social deprivation indices.

When the acute hospital and community harm free care data is disaggregated the hospital achieves a 95.66% harm free care rate and the community achieves 94.15%. Key to the improvement has been the sustained commitment to the STOP Pressure Campaign which has led to the introduction of revised SSKIN bundles; training and education, especially for nursing colleagues, and celebrations

of achievement. All key areas have a Tissue Viability champion and every episode is subject to investigation using Root Cause Analysis. Each month at the Trust Team Brief led by the Chief Executive, teams are recognised for each 50 days that they avoid grade 2 to 4 pressure ulcers. Nine areas have achieved over a year free of pressure ulcers.

During 2015 the Trust committed to improving the identification of patients at high risk of falls, including those over the age of 65 years and those living with dementia, and/or managing with a sensory loss such as vision or hearing.

4: The quality and safety of healthcare provided to hospital in-patients who are placed on clinically inappropriate wards
Lucy Goulding http://etheses.whiterose.ac.uk/2400/1/Lucy_Goulding_Ph.D._thesis.pdf

Number of Falls with 'Significant Harm' (Moderate, Severe and Death)

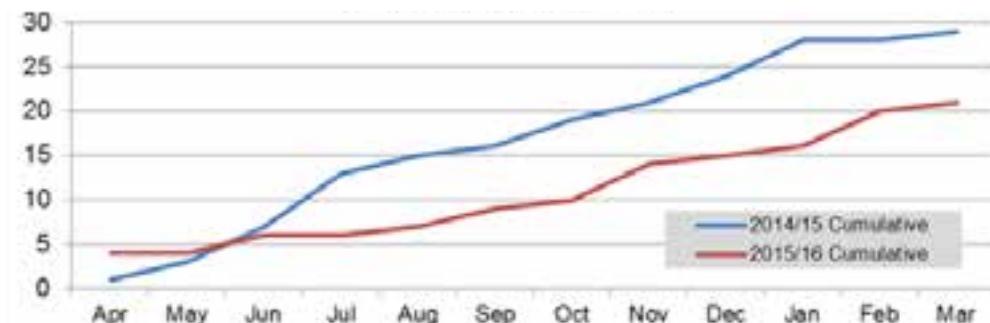


Table 4: Comparison of falls leading to significant harm 2014/15 with 2015/16

The Trust has identified and educated Falls Champions in each clinical area; purchased additional falls prevention equipment and implemented a Safe and Supportive Observation Framework which guides nurses in charge of a ward when allocating their nursing resources.

This year the Trust has worked closely with the Trusts Dementia Lead Nurse to improve assessment and appropriate management of dementia patients to help provide the appropriate level of support and care. Bespoke training has also been provided to clinical areas dependant on the needs of the speciality.

'Harm Free' Care

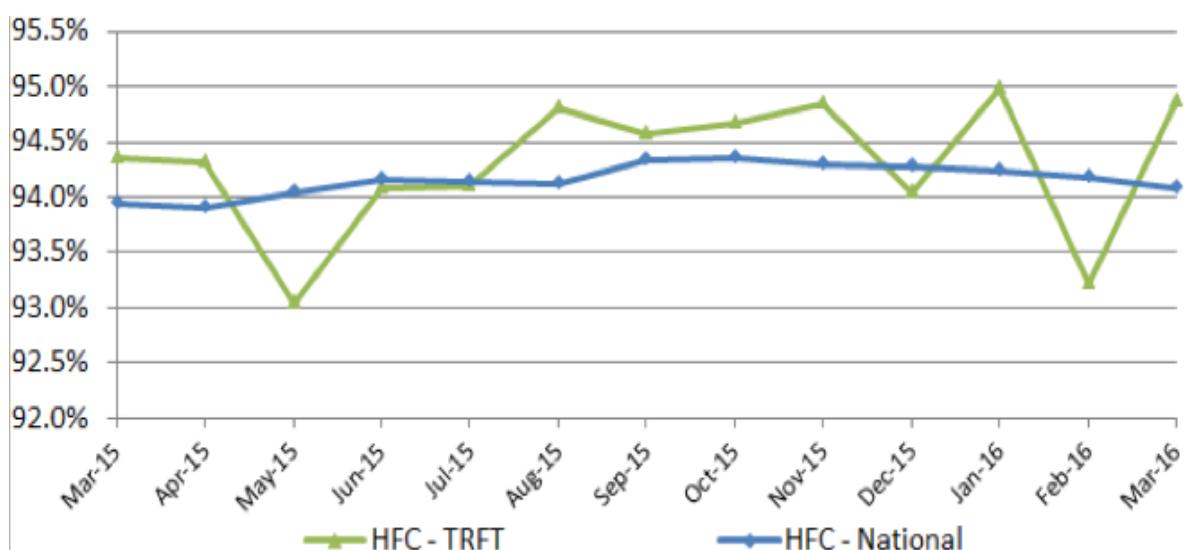


Table 5: Trust scores for 'harm-free' care 2015/16

In addition to falls and pressure ulcers the NHS Safety Thermometer also measures harms caused by infections secondary to urinary catheters and venous thromboembolism. These harms are relatively rare at The Rotherham NHS Foundation Trust. However towards the end of 2015/16 concerns were raised within the Trust regarding a number of medication errors and in particular those associated with critical medicines including Low Molecular Weight Heparins administered to prevent venous thromboembolism. As described in Section 2.3 actions have been taken to improve medication safety and efficiency and it has been agreed that this will continue to be a priority in 2016/17.

“Despite being busy staff and doctors checked and gave treatment and were very friendly with my mother”

**Friends and Family patient feedback
A&E**

The Rotherham NHS Foundation Trust	Acute - 'Harm Free' Care 2014/15	Acute - 'Harm Free' Care 2015/16	Community - 'Harm Free' Care 2014/15	Community - 'Harm Free' Care 2015/16	Trust 'Harm Free' Care 2014/15	National - 'Harm Free' Care 2014/15	Trust 'Harm Free' Care 2015/16	National - 'Harm Free' Care 2015/16
Apr	96.24%	95.81%	91.40%	93.00%	93.30%	93.57%	94.32%	93.89%
May	93.52%	95.77%	92.78%	90.89%	93.07%	93.61%	93.03%	94.03%
June	91.08%	95.17%	93.56%	93.14%	92.60%	93.62%	94.07%	94.15%
July	93.23%	96.38%	92.22%	92.49%	92.62%	93.80%	94.10%	94.14%
Aug	93.97%	95.83%	91.86%	93.96%	92.73%	93.68%	94.80%	94.12%
Sept	96.46%	94.66%	91.39%	94.51%	93.52%	93.78%	94.57%	94.33%
Oct	96.73%	94.89%	93.97%	94.48%	95.11%	93.98%	94.67%	94.36%
Nov	95.51%	95.66%	92.57%	94.15%	93.79%	93.92%	94.85%	94.30%
Dec	98.18%	95.63%	89.57%	92.83%	93.93%	94.13%	94.05%	94.28%
Jan	96.14%	96.15%	91.48%	94.02%	93.48%	93.88%	94.99%	94.23%
Feb	93.90%	94.10%	92.91%	92.56%	93.36%	93.77%	93.21%	94.18%
Mar	95.55%	95.48%	93.28%	94.39%	94.35%	93.95%	94.87%	94.08%

Table 6: NHS Safety Thermometer summary data for The Trust 2015/16 (target 96%; national target 95%)



“I now have a bit more confidence when going out”

**Friends and Family patient feedback
Integrated Falls and Fracture Service**

The first **National Audit of Inpatient Falls** is a national clinical audit run by the Falls and Fragility Fracture Programme at the Royal College of Physicians. National Audit measures compliance against national standards of best practice in reducing the risk of falls within acute care. The Trust will again participate in the National Audit of Inpatient Falls and Fragility Audit Programme (FFFAP) from the Royal College of Physicians and hope to see an improvement in 2016 compared with the 2015 results. Since the audit was undertaken the Trust has adopted a Delirium Policy with appropriate assessment tools and staff trained in using the tool.

FFFAP Organisational results			
Area	Audit questions	National	Trust
Falls prevention policy	2.01 Do you have a falls prevention policy?	100% (136)	Yes
	2.01b Does your falls prevention policy or policies require GPs to be informed of inpatient falls and/or identified falls risk?	32.6% (43)	Yes
Falls risk screening tool	2.02 Does your trust use a falls risk screening tool?	73.1% (98)	Yes
Multifactorial risk assessment (MFRA) and intervention Does your inpatient MFRA have:	2.03a A formal assessment of cognition?	76.5% (104)	Yes
	2.03 Does your inpatient MFRA documentation include:		
	A formal assessment for delirium using confusion assessment method (CAM), or other tool?	44.4% (60)	Yes
	Assessment of continence and toileting?	95.6% (130)	Yes
	Assessment of a history of falls?	98.5% (134)	Yes
	Assessment for fear of falling?	69.9% (95)	Yes
	Assessment of a history of blackouts or syncope?	55.9% (76)	Yes
	Assessment of footwear?	89.7% (122)	Yes
	Review of all medications that increase falls risk?	88.2% (120)	Yes
	Any assessment of gait, balance and mobility?	93.4% (127)	Yes
	A requirement to check lying and standing BP?	82.4% (112)	Yes
	An evaluation of vision?	66.9% (91)	Yes
	2.04 Does your inpatient multifactorial falls intervention include:		
	A care plan to support the patient with cognitive impairment e.g. 'This is me' (tailored to the patient, not generic)?	86.0% (117)	No
	A delirium management plan?	52.9% (72)	No ⁵
	Suggested actions when problems with continence are identified?	83.7% (113)	Yes
	Access to safe footwear?	86.8% (118)	Yes
	Modification of medications that increase falls risk?	89.0% (121)	Yes
	Avoidance of unnecessary sleeping tablets/sedative medication	72.6% (98)	Yes
	Provision of appropriate walking aids 7-days a week?	69.6% (94)	Yes
	Ensuring that patients have access to their own spectacles?	94.1% (128)	Yes
	A review of room/bed space most appropriate for the patient?	89.7% (122)	Yes

5 Since the audit was undertaken, the Trust has developed policy and implemented the use of an electronic dementia and delirium screening tool

FFFAP Organisational results

Area	Audit questions	National	Trust
	An assessment of and provision for enhanced observation?	94.9% (129)	Yes
	Provision of written information on falls for the patient?	80.9% (110)	Yes
	Provision of written information on falls for family/informal carers?	76.5% (104)	Yes
	Provision of written information on falls in any non-English language?	27.9% (38)	Yes
Bedrails	2.05 Has your trust carried out an audit of the clinical appropriateness of bedrail use for individual patients within the past 24 months?		
	Yes we have carried out an audit.	50.7% (68)	
	We use bedrails but haven't carried out an audit	49.3% (66)	We use bedrails but have not carried out an audit.
	We never use bedrails.	0	
Post-falls protocol	2.07 Does your trust have a post-falls protocol?	100% (136)	Yes
Leadership and service provision	3.01 Does your trust have an executive director who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?		
	Yes	84.4% (114)	Yes
	No	9.6% (13)	
	Not known		
	3.02 Does your trust have a non-executive director (or other board member) who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?		
	Yes	40.0% (54)	
	No	39.3% (53)	No
	Not known		
	3.03 Does your trust have a standing multidisciplinary working group or steering group or subgroup specifically for falls prevention, which has met at least four times a year over the last 2 years? As a minimum, this group must contain a nurse, doctor, AHP and manager as part of its membership.		
		85.3% (116)	Yes
	3.03a Is information on rates of falls (expressed as falls per OBD) routinely presented and discussed at most or all meetings of the central falls prevention group?	79.2% (103)	Yes
	3.04 Is information on falls rates and trends routinely provided to individual directorates, wards, units or departments at least quarterly?	86.0% (117)	Yes

FFFAP Organisational results			
Area	Audit questions	National	Trust
Walking aids	3.05 Is it policy that all inpatient wards/units have access to walking aids for newly admitted patients (or patients whose mobility needs have changed) 7 days per week?	64.7% (88)	No

Table 7: FFFAP 2015 audit results for the Trust

A further element of the programme is the National Hip Fracture Database. This provides comparative data enabling the Trust to benchmark against best practice and identify priorities for improvement. The summary results for 2015 are shown in Table 8, below:

NHFD Dashboard 2015: Rotherham General Hospital
Figures are average hospital percentages for 2013 and 2014. Data is taken from the National Hip Fracture Database.
Lead Clinician: Stephen Blair

Table 8: National Hip Fracture Database summary data for the Trust

	2013	2014	Rating	Progress
Ward Management				
Admitted to Orthopaedic Ward within 4 hours	77.2	74.9	✓	No change
Mental test score recorded on admission	95.5	96.3	●	No change
Perioperative medical assessment	92.6	92.2	●	No change
Mobilised out of bed on the day after surgery	No data	51.1	✗	No change
Received falls assessment	100.0	100.0	N/A	No change
Received bone health assessment	98.9	98.6	N/A	No change
Best practice tariff achievement	68.5	69.9	●	No change

Surgery

Surgery on day of, or day after, admission	80.3	78.7	●	No change
Proportion of general anaesthetic with nerve blocks	66.7	63.9	●	▼
Proportion of spinal anaesthetic with nerve blocks	6.5	12.6	●	▲
Proportion of arthroplasties that are cemented	84.1	85.0	●	No change
Eligible displaced intracapsular fractures treated with THR	47.4	34.0	●	▼
Intertrochanteric fractures treated with SHS	71.7	63.2	✗	▼
Subtrochanteric fractures treated with an IM nail	100.0	100.0	✓	No change

Outcomes

Case ascertainment	No data	88.1	●	
Overall hospital length of stay (days)	18.2	20.4	●	No change
Return to original residence within 30 days	50.8	47.9	●	No change
Developed a pressure ulcer after presenting with hip fracture	3.6	1.4	N/A	▲
Pressure ulcer status not recorded	0.0	0.0	✓	No change
Hip fractures which were sustained as an inpatient	No data	2.7	N/A	

✓ Top quartile

● 2nd/3rd quartile

✗ Lowest quartile

▲ Performance improving

▼ Performance declining

In response, the Trust plans to

- Review and update the falls policy to reflect changes made to the assessment forms and the inclusion of a post-fall checklist.
- Improve GP awareness of inpatient falls or falls risk.
- Review the cognition and delirium assessments on the falls form to ensure accurate assessment/diagnosis is carried out.
- Review the falls assessment form to ensure it includes assessment of whether the patient is experiencing blackouts or syncope, vision checks and review of medication.
- Assess the provision of walking aids to patients.
- Provide appropriate facilities for patients to improve observation and reduce the risk of falls.
- Provide written information booklets including information for non-English speaking patients/relatives carers to be available across the Trust.
- Audit the clinical appropriateness of bedrails used for individual patients.
- Review the composition of the Trust's multi-disciplinary falls group to ensure effective MDT involvement.
- Ensure all clinical areas to be made aware of appropriate falls information.
- Ensure appropriate education and training is provided to all clinical colleagues - Nursing, Medical and Allied Health Professionals.
- Escalate concerns over access to Orthogeriatricians for Hip Fracture patients to the Operational, Quality and Safety Experience Group.
- Work with the Anaesthetics Department to increase the number of nerve blocks performed.

Priority 4 Patient Safety	Significantly reduce the incidence of avoidable harm caused by missed or delayed diagnosis Significantly reduce the incidence of avoidable harm caused by failure to recognise and manage the adult deteriorating patient	For delivery in 2016 and 2017
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Our aim is to significantly reduce the incidence of harm caused by missed or delayed diagnosis, and the failure to recognise and manage the adult deteriorating patient as part of the National Sign up to Safety Campaign.

Did we achieve this goal? Partially

Leadership of the two elements of the Sign up to Safety Campaign has been provided by the Medical Directors Office under the leadership of Mrs Susan Douglas, Associate Medical Director – Patient Safety and Governance.

Two 'task and finish' groups have been analysing data and auditing practices in order to put mechanisms in place to alert clinicians to the presence of abnormal test or diagnostic results and improve the recognition and escalation of the deteriorating adult in-patient.

Following an audit of clinical administration systems the missed and delayed diagnosis task and finish group will move during Q4 and the start of 2016/17 to document standardised procedures for all diagnostic tests with agreed timescales for result reporting. The same group will move during 2016/17 to eradicate the use of fax machines and mandate the electronic requesting of all diagnostic investigations.

The Trust uses the Datix incident reporting system. The task and finish group leading a reduction in the incidence of missed and delayed diagnosis has reviewed the number of incidents captured on the Datix system since 2013. A total of 670 incidents reference a delay in diagnosis and in the case of twenty patients some form of harm occurred. The group has identified the causes of harm to be delayed access to diagnostics including referral to hospital, failure to monitor the patient, getting the diagnosis wrong and a delay in requesting clinical assistance linked to not recognising and managing the deterioration in a patient.

The group leading the reduction in incidence of the deteriorating patient have audited Patient at Risk (PAR) management charts and the application of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders after a cardiac arrest. This group have used Listening into Action (LiA) as a methodology to engage with doctors and nurses to understand where there might be gaps in handover communication, understanding how to calculate an accurate PAR score and / or escalate and manage a patient recognised to be at risk of deterioration. Learning is supported by the Practice Development Team that provides learning and support to front-line staff.

As a result of this work and through partnership with Barnsley NHS Foundation Trust (because of a shared pathology service) and GPs, the Trust has implemented a care pathway (algorithm) for the prevention of acute kidney injury based on NICE guidance.

The Medical Director and Chief Nurse now jointly issue and monitor Patient Safety Alerts. These clarify colleague responsibilities for identifying patients at risk of deteriorating and the steps required to provide an appropriate level of medical response. The Trust has also invested in a Practice Development Team.

The Practice Development Team commenced in post in February 2016 and have a work programme directly aligned to the Sign up to Safety campaign that aims to reduce the incidence of adult inpatients who deteriorate whilst in hospital and missed or delayed diagnoses. In addition they are working with the Deputy Chief Nurse to support the standards of nursing practice as measured by nursing metrics such as the incidence of falls, the incidence of pressure ulcers and the incidence of complaints.

Priority 5 Patient Experience	Increase the percentage of in-patients who are not disturbed at night during their admission	Yes: IP survey results
	Achieve and maintain a minimum 95% positive Friends and Family Test (FFT) score – in-patients	Yes – 97% achieved
	Achieve and maintain a minimum 86% positive Friends and Family Test (FFT) score – A&E	Yes – 88% achieved
	Achieve a 40% FFT response rate – in-patient areas.	Yes – 41% achieved.

Our aim is to improve the rate of feedback regarding services, patients and families experience and improve the FFT positive score.

Did we achieve this goal? Yes

The Trust has exceeded its targets in all areas. The latest CQC in-patient survey (2014) demonstrates that the Trust has made progress in relation to night-time disturbance. The position of patients saying they had been disturbed by staff has improved from a score of 7.5/10 for 2013 to 8.1/10 for 2014. There has also been a marginal improvement from 5.4 to 5.5/10 for patients disturbed by other patients. The 2015 survey is due for release in late May/early June 2016.

In order to improve the percentage of patients not disturbed by other patients at night, the Trust has upgraded the ward environment on wards A2, A5 and the Acute Medical Unit (AMU). Specifically in wards A2 and A5 the Trust has invested in developing dementia-friendly environments and on A2 has removed a bed from each bay to create en-suite bathroom facilities.

Furthermore the Trust has invested in a Clinical Site Management Team with the aim of achieving all inpatient medical transfers from the AMU to speciality wards before 9 o'clock at night such that the amount of disturbance caused by patient moves is minimised. As reported in last year's Quality Report, the Chief Nurse leads on a number of night time hospital and community visits. The levels of disturbance at night are monitored during these visits as is the extent to which nursing colleagues are positioned outside each bay in order to provide a quick response to patient need.

Priority 6 Patient Experience	Increase the number of colleagues who have undertaken training in dementia awareness by 30%	Yes: IP survey results
	A reduction in the number of complaints about our care of frail and elderly patients, including those with dementia, by at least 30% in 2015/16	Unable to collate data; new KPIs for complaints and dementia care adopted 2015/16
	Achieve minimum 90% positive result from carers' survey	89.4 by Q3

Our aim was to increase the number of colleagues who have undertaken training in dementia awareness, such that patients living with dementia and their families have a better experience of care and are therefore less likely to use the complaints mechanism to provide feedback.

Did we achieve this goal? Partially

In 2015/16 the Trust continued to develop its approach to improving care for those living with dementia. The appointment of a specialist nurse has improved access to Dementia Awareness Training (provided to ALL colleagues) and led to the identification of Dementia Champions in the majority of clinical areas. Dementia champions have completed gold level dementia awareness training provided by the Alzheimer's Society and are now leading dementia workshops in their own clinical areas. Bespoke training sessions focusing on purposeful walking and nutritional dementia care are available to clinical areas. Sessions

specifically written for Security guards, Porters, Switch board and Kitchen Colleagues have been delivered.

In August 2015 the 'Forget Me Not' carer passport was launched in response to John's Campaign: a Dementia Action Alliance Call to Action. In response to John's Campaign for the right to stay with people with dementia in hospital the Trust has actively supported a range of initiatives to improve the experience of hospital admission for people with dementia and their carers. The Passport includes:

- Greater carer involvement in continuing to deliver care in hospital and the opportunity for open visiting
- Parking concessions
- Access to Purple Butterfly rooms and comfortable chairs for carers wishing to stay with relatives

Under the leadership of the Specialist Dementia Care Nurse, the Trust has achieved the CQUIN associated with FAIR (Find, Assess, Investigate, Refer) and is also helping colleagues to understand more about patients living with dementia by using the This is me booklet, completed with family support and involvement.

The Trust has also invested in a range of games and activities for people with dementia (and for people with learning disabilities).

The Trust continues to measure the quality of dementia care through the digital dementia survey. The survey has been redesigned and relaunched. The earlier version was often confused with the Friends and Family Test, but now relates specifically to carers' needs and concerns related to dementia. The Trust is trialling different methods of administering the survey – handing forms directly to relatives and also offering stamped addressed envelopes to increase the response rate. Finally, the Trust is working in partnership with the Police to achieve a response should a person with dementia go missing.

“A very pleasant atmosphere and friendly staff. As far as operations go it was a good experience. I was very nervous on arrival but was soon put at ease by the nurses and other staff. Very professional.”

Friends and Family patient feedback Breast Surgery Day Case

Priority 7 Patient Experience	Achieve 80% of complaints response times on the date agreed with the patient by July 2015	No
	Achieve 90% of complaints response times on the date agreed with the patient by March 2016	No: up from 20% to 41% by February 2016
	Achieve 20% patient satisfaction rate improvement with Trust complaint and concerns management processes above the 46% baseline	Response rate too low for meaningful measurement

Our aim was to achieve a high level of compliance with the complaint response time agreed with complainants.

Did we achieve this goal? No

The Trust acknowledges that there are two key measures of success in relation to effective complaints management. Firstly, the ability to demonstrate that the Trust has listened to the concerns of patients and their families and have provided a good quality response that not only answers their questions in full but also describes the actions the Trust has taken in order to demonstrate learning.

Secondly, an effective complaints process would also ensure that the response is provided in a timely manner and as a minimum, received by the complainant on or before the date agreed.

In 2014/15 the complaints management process was reviewed and as a consequence, towards the end of that year, there was investment in leadership capability in the Divisional Teams and the Complaints Management Team.

The Trust failed to achieve the level of improvement required to meet the standard of 90% of people making a complaint would receive their response on time. In the course of 2015/16 the Trust has provided Complaints Management training, appointed a new Patient Experience Manager, revitalised the improvement plan following a series of Task and finish Groups that utilise the Listening into Action methodology and clarified with all Divisions the key performance indicators against which they will be measured. The indicators are:

- All complaints will be acknowledged within 3 working days.
- At least 95% of complainants will be offered a face to face meeting.
- 100% of all complaints will have an action plan.
- 95% responses within the timescale agreed with the complainant
- 95% of meeting notes or digital recordings issued within 14 working days of meeting
- Encourage more individual contact with complainants, encouraging the use of face to face meetings where appropriate.

Between April and December 2015, 25 complainants have taken their complaints to the Parliamentary and Health Service Ombudsman (PHSO). Of these, 7 were accepted for investigation by advisors appointed by the PHSO. In 2015/16 the PHSO completed three investigations of which one was partially upheld and two were not upheld.

Where complaints are upheld fully or partially the PHSO makes recommendations with which the Trust complies. These may be for financial compensation for loss or damage to property or the sharing of information such as audits and improvement plans.



2.3 Priorities for Improvement 2016/17

Following consultation with Rotherham CCG, the Rotherham Health Select Commission, governors and colleagues, and consideration of patient feedback, concerns and complaints the Trust has agreed quality improvement priorities for 2016/17. These are:

Patient Experience:

1. The management of discharge from hospital
2. Complaints Management

Patient Safety:

1. Medication safety and efficiency.
2. Avoiding missed or delayed diagnosis (Sign up to Safety Campaign)
3. Preventing the deteriorating patient. (Sign up to Safety Campaign)
4. Harm Free Care
5. Extending the scope of the NHS Safety Thermometer

Clinical Effectiveness:

1. Mortality

Patient Experience 1:

The management of discharge from hospital

Executive Lead: Chief Operating Officer

Operational Lead: Interim Deputy Chief Nurse – Operation

CQC domain: Effective

Current Position and why is this important?

A well organised discharge not only helps the patient have the best possible experience of hospital admission but also shows that the Trust is using its resources effectively. The Trust knows from patient feedback that delays in leaving hospital whilst waiting for a prescription or transport can be upsetting and inconvenient. If discharge is not well managed it can lead to early readmission. The Trust expects to discharge patients from hospital in a timely manner, with all the necessary medication and relevant information to support safe, effective medicines use and arrangements for any follow-up care in place.

What is our aim?

The Trust wants to:

- Follow best practice by ensuring all patients are given an expected date of discharge (EDD) at the earliest appropriate moment and are informed of any changes to the EDD that may occur
- Reduce the time taken from decision-to-discharge to actual discharge
- Ensure discharge Medication is available in a timely way.
- Improve patient experience of discharge
- Improve liaison with community services and social care to ensure post-discharge follow-up is in place.

What will we do to achieve this?

The Trust plans to use the SAFER Care Bundle to reduce the length of hospital stays whilst improving quality of care and patient safety. SAFER means

- **S** – All patients will have a senior review (preferably by a Consultant) before midday, every day.
- **A** – All patients will be given an Expected Discharge Date based on the 'medically suitable for discharge' status as agreed by clinical teams.
- **F** – Flow of patients will commence at the earliest opportunity (by 10am) from assessment units to inpatient wards. Wards are expected identify appropriate patients in assessment and 'pull' the first patient to their ward before 10am.
- **E** – Early discharge: 33% of patients due for discharge will leave their ward before midday. Discharge medication should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible
- **R** – Every patient with an admission exceeding 14 days will have their care reviewed by a senior clinician. Operational management support is provided to ensure that any issues delaying discharge can be addressed.

In addition, the Trust will continue to use daily Board Rounds to identify patients medically ready for discharge and audit the 'Ward round proforma' to ensure consistent attention is paid to discharge planning.

Our objectives for 2016/17

- Compliance with the SAFER care bundle will be audited and reported to the Clinical Governance Committee each month
- 90% of patients will have an EDD recorded in their notes.
- Case note audit will clearly show changes to EDD are discussed with patient
- 40% of TTOs will be ordered by 3pm on the day before discharge.
- Reduce complaints about discharge, first establishing a baseline and then reducing over following six months by 30%
- Reduce readmission rates by at least 10% in year.

How will progress be monitored and reported?

Data on discharge will be collated and reported through the clinical governance structures of the Trust. Progress will be monitored at monthly performance meetings held with each Division. The Ward Round Proforma will also be audited in 2016.

“My care was first class. Everybody was in a friendly mood and willing to help.”

**Friends and Family patient feedback
Community Hospital**

Patient Experience 2: Complaints Management

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse
CQC domains: Responsive

Current Position and why is this important?

There continues to be an increasing focus on listening to, acting upon and learning from feedback from users of Trust services to ensure the patient voice is heard. The Trust needs to use the complaints process to ensure that comments, concerns and complaints are acted upon in a timely and effective manner. As a Trust on an improvement journey it means seeking out and acting on the feedback from patients, relatives and carers.

The Trust wants to use the complaints process as a way of developing services, cultures and practice to enhance overall patient experience. But there is still some work to improve people's experience of making a complaint to ensure that:

- People know how to access the complaints service
- People know how to make a complaint or raise a concern
- People are offered support to help them through the process
- The complaints system is easy to use
- There is openness and transparency about how complaints are heard, reviewed and answered; all complainants get a copy of the complaint action plan.
- Action is taken as a result of a complaint that enhances the service and that lessons are shared with others.
- Learning from complaints, incidents and claims is brought together.
- Young People can access the service

What is our aim?

Encourage more individual contact with complainants, encouraging the use of face to face meetings where appropriate.

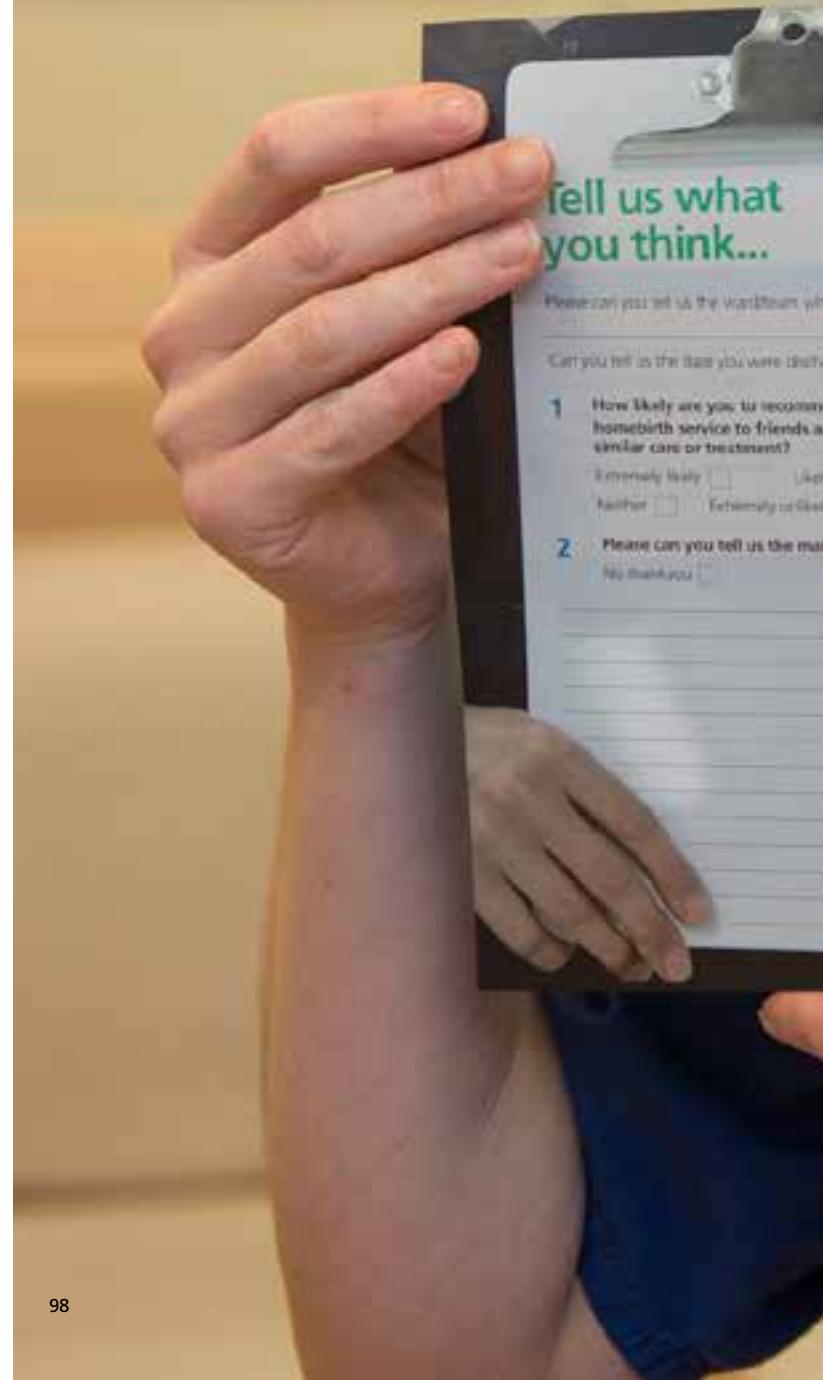
All complaints will have an action plan to ensure changes within practice or lessons are shared with staff and to encourage active feedback as a learning tool across individuals, teams and organisations. Triangulate complaints and concerns data with incidents, claims, FFT and ward based metrics.

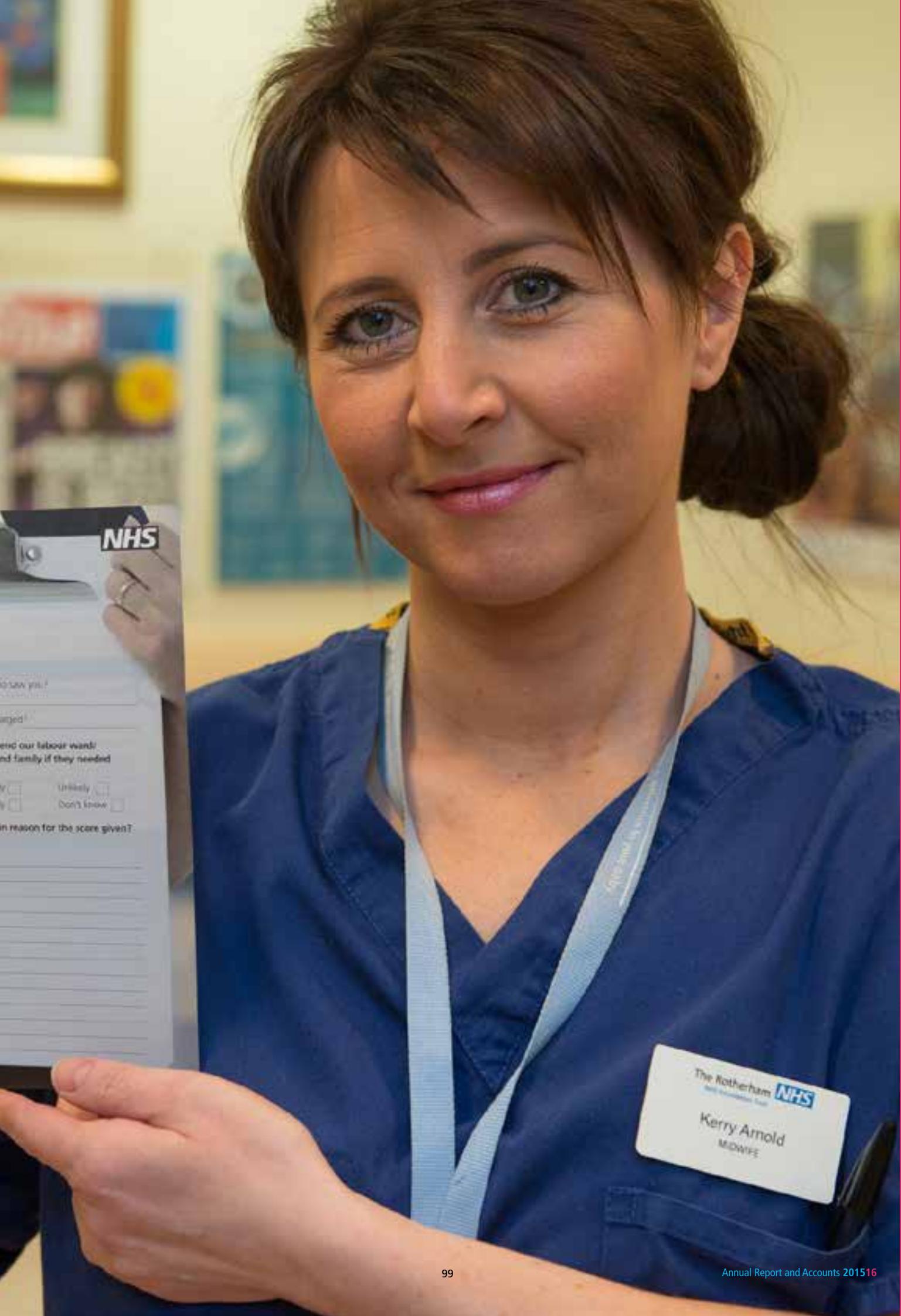
Review the visibility of the complaints process within the trust, including looking at materials and methods used in relation to patient information and information for vulnerable groups including children. Respond to complaints within timescale agreed with patient in at least 95% of occasions.

Engage directly with young people to ensure they know how to access the service.

“If I need anything then the staff get it for me. The care is good. Very friendly and compassionate. **”**

**Friends and Family patient feedback
Ward A6 (PIU)**





What will we do to achieve this?

The trust complaints process is being reviewed to enhance the individual's experience of raising a concern or complaint; the process will be more focused on the individual's requirements and outcomes as a result of the complaint. The Trust will also learn from good practice from other organisations, NHS England and PHSO publications.

- Review good practice from other organisations and national publications/organisations
- Continue to develop the knowledge of those undertaking investigations in how to conduct a good investigation and write a response
- Ensure changes to practice are embedded within the organisational structure as a result of a complaint using the organisational divisional governance structures
- Encourage the investigating lead to contact the complainant and negotiate a way of working together to resolve their concerns and work through the issues.

Our objectives for 2016/17

- All complaints will be acknowledged within 3 working days.
- At least 95% of complainants will be offered a face-to-face meeting.
- Every clinical area will have at least two members of staff trained in complaints investigation and management by year end.
- 95% of complaints responded to within the timescale agreed with complainant.
- Achieve an 'about the same' rating for access to complaints information in the 2016 in-patient survey.

How will progress be monitored and reported?

The Trust currently has a Complaints Improvement Plan which is monitored by the Clinical Governance Committee and Quality Assurance Committee.

Patient Safety 1: Medication safety and efficiency.

Executive Lead: Medical Director
Operational Lead: Chief Pharmacist
CQC domain: Safe

Current Position and why this is important

Medicines play a critical role, not only in cure of disease but also in maintaining health, preventing illness, diagnosing, treating and managing chronic health conditions. Medicines are the most common healthcare intervention made and at a time of financial, demographic, technological, and regulatory challenge it is vital that patients get the best possible outcomes from medicines. There is, however, evidence that shows an urgent need for us to get the fundamentals of medicines use right for patients. Incident reporting shows a need to address a number of medication concerns including prescribing, administering and dispensing.

What is our aim?

- Reduce the rate of medication error.
- Eliminate failure to sign an administration chart or record the reason for non-administration
- Ensure all errors are reviewed and learned from.
- Improve the rate of medication reconciliation on admission
- Ensure effective monitoring systems are in place consistent with national guidelines.

The Trust must ensure patients receive quality care in line with best practice. This means patients should expect to get the right medicines, at the right dose, at the right time, by the right route of administration, with the right information and all necessary documentation completed. Colleagues will have the training necessary to keep abreast of changes to legislation, policies or procedures

What will we do to achieve this?

Having established a baseline position in March 2016, the Trust will

- Identify key areas of concern
- Engage and educate prescribers, nurses and pharmacy staff on issues identified
- Share learning from errors

The trust plans to review and update all medicines procedures and review the tools used to manage medication errors and benchmark Trust performance against national standards.

Education, training, collaboration, multi-professional working and process change will be deployed to transform practice. Processes that need to change in order to deliver a quality patient experience and enhance patient safety will be prioritised.

The newly formed Rotherham Medicines Optimisation Group (RMOG) brings together the Drugs and Therapeutics Committee and the Primary Care Area Prescribing Committee to provide effective leadership in medicines management.

Our objectives for 2016/17

- Reduce the rate and range of medication omission errors by 50% by year end
- In medicine administration charts 100% of entries will be signed and completed with rationale for non-administration where appropriate
- By September 2016 at least 90% of admissions will have medication reconciliation before leaving ED
- Undertake re-audit of medicine administration systems in by 31 December 2016
- Identify a process for benchmarking Trust performance against that of other Trusts by September 2016

How will progress be monitored and reported?

Progress on all issues will be monitored through the Operational, Quality, Safety and Experience Group and reported quarterly to the Quality Assurance Committee.



Patient safety and the National 'Sign up to Safety' Campaign

The Trust continues to support NHS England's Sign up to Safety campaign and its ambition to reduce avoidable harm by 50%, saving 6,000 lives across England over a three year period to September 2017. This national campaign requires NHS staff to put safety first, to continually learn, to be open and honest, to work collaboratively, to share learning and to support staff to enable personal and professional reflection, promote learning and reduce stress. This is an important goal for the Trust which is fully committed to delivering consistently safe care and taking action to reduce harm. This year there are two specific priorities related to the campaign: avoiding missed or delayed diagnosis and preventing the deteriorating patient.

Patient Safety 2: Avoiding missed or delayed diagnosis (Sign up to Safety Campaign)

Executive Lead: Medical Director

Operational Lead: Associate Medical Director

CQC domain: Responsive

Current Position and why is this important?

Following an audit of clinical administration systems the missed and delayed diagnosis task and finish group will move during Q4 and the start of 2016/17 to document standardised procedures for all diagnostic tests with agreed timescales for result reporting.

The Trust uses the Datix incident reporting system. The task and finish group has reviewed the number of incidents captured on the Datix system since 2013. A total of 670 incidents reference a delay in diagnosis and in the case of twenty patients some form of harm occurred. The group has identified the causes of harm to be delayed access to diagnostics including referral to hospital, failure to monitor the patient, getting the diagnosis wrong and a delay in requesting clinical assistance linked to not recognising and managing the deterioration in a patient (see PS3 below).

What is our aim?

- Approve standardised procedures for all diagnostic tests including agreed timescales for result reporting.
- Move to electronic requesting and reporting of diagnostic tests and imaging.

What will we do to achieve this?

During 2016/17 the Trust will move to eradicate the use of fax machines and mandate the electronic requesting of all diagnostic investigations. New clinical pathways between community and hospital services will also contribute to the early requesting of diagnostic tests. Continued training and development of colleagues using LiA methodology will improve identification and monitoring of patients at risk.

Our objectives for 2016/17

- 95% of diagnostic tests and imaging will be requested via an electronic system
- 90% of diagnostic tests used by the Trust will have a standardised procedure including agreed timescales for result reporting.

How will progress be monitored and reported?

Progress will be monitored by the Operational Quality, Safety and Experience Group and reported quarterly to the Quality Assurance Committee

Patient Safety 3: Preventing the deteriorating patient (Sign up to Safety Campaign)

Executive Lead: Medical Director

Operational Lead: Associate Medical Director

CQC domain: Safe

Current Position and why is this important?

Avoidable deaths and poor clinical outcomes are strongly correlated with failures to identify and act upon deterioration in patients. The Trust uses the Patient At Risk (PAR) tool to assess whether patients are deteriorating.

A Task and Finish group have audited PAR management charts and used Listening into Action (LiA) as a methodology to engage with doctors and nurses to understand where there might be gaps in handover communication. They have addressed how to calculate an accurate PAR score and how to escalate and manage a patient recognised to be at risk of deterioration. Learning is supported by the Practice Development Team that provides learning and support to front-line staff. The Medical Director and Chief Nurse have jointly issued two Safety Alerts related to use of the PAR and clarifying responsibility for escalating concerns about a deteriorating patient appropriately.

What is our aim?

- All deteriorating patients are identified and the appropriate medical team informed
- Colleagues understand the clinical management of the deteriorating patient and provide appropriate care
- Unplanned admissions to critical care are avoided

What will we do to achieve this?

- Use LiA methodology to meet learning needs of colleagues
- Use the Safety Alert system where necessary to clarify best practice
- Use the Practice development team to support learning
- Developing a 'Hospital at Night' Team

Our objectives for 2016/17

- Documentation audit will demonstrate that 100% of deteriorating patients are medically escalated as per policy.
- At least 1 Registered Nurse per shift on in-patient wards to have completed training relating to the deteriorating patient by 31 December 2016.

How will progress be monitored and reported?

Performance data and information from incident reviews will be shared at Divisional Clinical Governance Meetings. Progress will be monitored by the Operational Quality, Safety and Experience Group and reported quarterly to the Quality Assurance Committee

Patient Safety 4: Harm Free Care

Executive Lead: Chief Nurse

Operational Lead: Assistant Director of Patient Safety and Risk

CQC domain: Effective, Responsive

Current Position and why is this important?

Harm free care as defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE. Through much of 2015 the Trust made steady progress towards improving its score for Harm-Free Care. This score is derived by reporting a number of events where patients have incurred harm, including falls. An improving score reflects safer care and a better experience for patients. The aspiration is to achieve and maintain a score of 96% which is above the 95% level expected by NHS England.

What is our aim?

Achieving and sustaining 96% level of harm-free care.

What will we do to achieve this?

- Continue to review of all current assessments and documentation to ensure compliance with national and local guidelines to ensure these meet the needs of patients.
- Repeat the National Audit of Inpatient Falls and Fragility Audit Programme (FFFAP) from the Royal College of Physicians and ensure appropriate actions and monitoring is undertaken as identified in the final report
- Improved awareness and training for all clinical staff on falls assessment and prevention for patients.
- Continue the STOP Pressure campaign and the React to Red campaign designed to raise awareness of early signs of tissue viability concerns.
- Improved support for patients identified for patient at high risk of falls by continuing to provide 1:1 observation or grouping patients where appropriate to maintain patient safety.
- Continue to improve the knowledge of staff in undertaking robust RCAs following incidents to ensure that learning is embedded locally.
- Continue to review the equipment available to reduce the risk of falls and to provide safe and effective care of patients.

Our objectives for 2016/17

- Take-up of relevant mandatory training will exceed 90% in 2016/17.
- All incidents relating to falls and tissue viability will have an RCA completed within 3 weeks of event.
- Overall, the patient thermometer score for harm free care will be improved to and sustained at 96% and above.

How will progress be monitored and reported?

Progress will be reported each month to the Clinical Governance Committee and the Quality Assurance Committee.



Patient Safety 5:

Extending the scope of the NHS Safety Thermometer:

Executive Lead: Chief Nurse

Operational Lead: Assistant Director of Patient Safety and Risk

CQC domain: Effective, Responsive

Current Position and why is this important?

The Trust plans to participate in data collection for the Children's and Maternity Safety Thermometer during 2016/17.

The Children's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that use children and young people's services. The Safety Thermometer collects data on Deterioration, Extravasation, Pain and Skin Integrity.

The Maternity Safety Thermometer measures harm from Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety.

What is our aim?

The Trust will collect and submit data for the Children's' and Maternity Safety Thermometers, providing evidence of current performance and identifying priorities for improvement.

What will we do to achieve this?

Identify those babies with an APGAR of less than seven at Five Minutes after parturition and/or those who are admitted to a Neonatal Unit through a point of care survey that is carried out on one day per month in each maternity service on all postnatal mothers and babies. Data is collected from postnatal wards, mother's homes and community postnatal clinics.

Our objectives for 2016/17

- Establish a process for collecting and submitting data by July 2016
- Establish a performance baseline from data by August 2016
- Identify improvement priorities from benchmarking by end-September 2016

How will progress be monitored and reported?

Progress will be reported each month to the Clinical Governance Committee and quarterly to the Quality Assurance Committee.

Clinical Effectiveness 1: Mortality

Executive Lead: Medical Director

Operational Lead: Associate Medical Director

CQC domain: Effective

Current Position and why is this important?

Mortality has been a priority for the Trust over the last year. New procedures now ensure that every death is reviewed within a week. The Trust uses data from HSMR and SHMI to monitor mortality rates. The Mortality and Quality Alerts Group has enabled the Trust to analyse and understand trust-wide hospital standardised mortality ratios (HSMR) and summary hospital-level mortality indices (SHMI). Performance is compared with other providers, and the reasons for variations are explored. The Trust undertakes specific pieces of work such as a review of deaths at the weekend, deaths by source of admission and a review of all unexpected deaths. However latest available data for HSMR and SHMI show that the Trust is not consistently achieving the target so this remains a priority for 2016/17. At the time of reporting the HSMR has

fallen to 101.8 for January – December 2015 whilst the SHMI (1.084 for October 2014 – September 2015) remains significantly raised. The figures demonstrate the difference between the two measures and underline the importance of considering the whole range of available evidence in evaluating the Trust's performance.

What is our aim?

All deaths in hospital will be subject to review. The outcome of these reviews will be shared through the clinical governance system, appropriate support and training provided to improve mortality rates.

What will we do to achieve this?

- Continue to use the mortality review process to identify and share learning points
- Implement the SAFER Care Bundle which ensures that all patients have consultant led review;
- Invest in a Practice Development Team which will focus on recognising and managing the acutely unwell and potentially deteriorating patient
- Audit use of the new 'ward round pro-forma'. This standardises how patient reviews and clinical management plans are recorded.

Our objectives for 2016/17

- 100% of unpredicted deaths of patients in hospital will be reviewed in line with the Mortality Review Process.
- HSMR score will be at or below 100 by year end; SHMI score will be at or below 1.00 by year end

How will progress be monitored and reported?

Progress will be reported monthly to the Quality Assurance Committee

2.3.1 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.

“Friendly and helpful team and always treated with the dignity and respect I deserve”

**Friends and Family patient feedback
Health Village, District Nursing**



Statements of Assurance from the Board

During 2015/16 The Rotherham NHS Foundation Trust provided and/or subcontracted 65 services, both community and acute services.

The Rotherham NHS Trust has reviewed all the data available to them on the quality of care in all 65 of those relevant health services. The income generated by the relevant health services reviewed in 2015/16 represents 85% of the total income generated from the provision of the relevant health services by The Rotherham NHS Foundation Trust for 2015/16

“All staff were extremely helpful and explained everything thoroughly through & were on hand whenever i needed them for advice”

**Friends and Family patient feedback
Children's Assessment Unit**

Clinical Audit: summary

During 2015/16, 36 national clinical audits and 8 national confidential enquiries covered NHS services that The Rotherham NHS Foundation Trust provides. During that period the Trust participated in 92% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries the Trust was eligible to participate in during April 2015 to March 2016 are as follows in Table 9 below:

	Number of audits relevant to services provided by the Trust	Percentage of audits participated in
National Clinical Audits	36	92% (33/36)
National Confidential Enquiries		
National Confidential Enquiries into Patient Outcome and Death (NCEPOD)	5	100%
Confidential Enquiries into Maternal and Child Health	3	100%
National Confidential Enquiry into Suicide and Homicide by People with a Mental Illness (NCI/ NCISH)	0	Not applicable

Table 9: Number of Clinical Audits and National confidential Enquiries that the trust participated in 2015/16

The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2015/16, are listed in table 10 alongside the number of registered 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.

The reports of 19 National Clinical Audits were reviewed by the provider in 2015-16 and the Trust intends to take the following actions to improve the quality of the healthcare provided, as listed in Table 10. The table also provides an explanation for non-participation where appropriate.

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	Data collection ongoing	No	n/a	Not applicable.
Adult Asthma	Yes	Did not take place during 2015-16	n/a	n/a	n/a	Trust will participate in 2016/17
Adult Cardiac Surgery	No	n/a	n/a	n/a	n/a	n/a
Bowel Cancer (NBOCAP)	Yes	Yes	85%	Yes	Yes	Work to take place with colorectal multidisciplinary team to ensure all patients are made aware that approximately half of rectal cancer patients have a stoma 18 months after surgery. Collaboration with healthcare of the elderly services is required to avoid potential delays to discharge and ensure provision of community services, if required.
Cardiac Rhythm Management (CRM)	Yes	Yes	100%	No	n/a	n/a
Case Mix Programme (CMP)	Yes	Yes	100%	Yes	Yes	No actions required.

Child Health Clinical Outcome Review Programme (NCEPOD):

Chronic Neurodisability	Yes	Did not take place during 2015-16	n/a	No	n/a	Data collection will take place in 2016/17
Young People's Mental Health	Yes	Yes	Data collection ongoing	No	n/a	n/a
Chronic Kidney Disease in primary care	No	n/a	n/a	n/a	n/a	n/a
Congenital Heart Disease (CHD) - Paediatric - Adult	No	n/a	n/a	n/a	n/a	n/a
Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI)	No	n/a	n/a	n/a	n/a	n/a

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	Yes	Yes	Send requests for Albuminuria screening to patients before appointment and check that test is done; review method for albuminuria testing; ensure updated clinical guidelines on Trust website; deliver teaching to trainee doctors; evaluate the purchase of 'safe use of insulin' e-learning package; approach Charitable funding resources to support patient education; discuss formalising structured education for each patient contact, and increased emphasis on exercise advice; propose purchase of blood ketone meters for children's wards and provide meters to all Diabetes patients; increase patients on insulin pump therapy and CGM by targeting specific groups plan purchase of Diasend (Diabetes record downloading software); encourage team to adopt best practice treatment as used by to improve HbA1c results; consider extra Health Care Assistant support for diabetes clinics; consider how to improve access to Psychological services.
Elective Surgery (National PROMs Programme)	Yes	Yes	90.3% (April-Sept 2015)	Yes	Yes	Identify executive lead for the Elective Surgery Patient Related Outcome Measures (PROMS) programme and review reporting arrangements.
Emergency Use of Oxygen	Yes	Yes	100%	No	n/a	n/a
Falls and Fragility Fractures Audit programme (FFFAP):						
1 Fracture Liaison Service Database	Yes	Did not take place during 2015-16	n/a	No	n/a	Data collection will take place in 2016/17
2 Inpatient Falls	Yes	Yes	100%	Yes	Yes	Ensure appropriate education and training is provided to all clinical colleagues - Nursing, Medical and Allied Health Professionals. Escalate concerns over access to Orthogeriatricians for Hip Fracture patients to the Operational, Quality and Safety Experience Group. Work with the Anaesthetics Department to increase the number of nerve blocks performed.
3 National Hip Fracture Database	Yes	Yes	100%	Yes	Yes	Escalate concerns over access to Orthogeriatricians for Hip Fracture patients to the clinical Governance Committee. Work with the Anaesthetist department to increase the number of nerve blocks performed has been completed.
Inflammatory Bowel Disease (IBD) programme	Yes	Yes	100%	Yes	Yes	Ensure that the relevant disease activity index is available in clinical areas and that IBD clinical teams are made aware of its availability and importance. To introduce the patient reported outcome measures (PROMs).

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
Major Trauma Audit	Yes	Yes	77.4%	Yes	Yes	Consider having a Consultant Anaesthetist available for all operations on shocked patients. Improve the percentage of cases submitted to the audit by reviewing the workload within the Clinical Effectiveness department. Ensure data quality by continuing clinician input into every case submitted. Increase the number of patients seen promptly by an A&E doctor; ensure all open fracture cases are discussed with the Major Trauma Centre; ensure accurate documentation of Gustilo and Anderson grades, size of wound, and type of fracture; ensure cases are accurately coded as open or closed fractures.

Maternal, New-born and Infant Clinical Outcome Review Programme (NCEPOD):

1 Perinatal Mortality Surveillance Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	100%	Yes	Yes	Establish protocol for communication of mental health concerns with primary care, and ensure patients are aware of limits to confidentiality. Ensure early involvement of the police in management of cases involving DNA, risk of morbidity, or mortality to women and baby. Remind A&E consultants about documenting attendance of pregnant or postnatal women at labour ward. Advise staff to consider other causes when treating weight loss and persistent hyperemesis. Discuss prescribing full 6 weeks course of thromboprophylaxis . Discuss communications between primary care, secondary care, perinatal psychiatrist, independent and voluntary sectors at Mental Health Rotherham network.
2 Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity)						
3 early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)						
4 Maternal mortality surveillance						
2 Physical and mental health care of mental health patients in acute hospitals	Yes	Yes	100%	No	n/a	n/a
3 Non-invasive ventilation						

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
Mental Health Clinical Outcome Review Programme 1 Suicide in children and young people (CYP) 2 Suicide, Homicide & Sudden Unexplained Death 3 The management and risk of patients with personality disorder prior to suicide and homicide	No	n/a	n/a	n/a	n/a	n/a
National Audit of Intermediate Care	Yes	Yes	100%	Yes	Yes	Establish protocol for communication of mental health concerns with primary care, and ensure patients are aware of limits to confidentiality. Ensure early involvement of the police in management of cases involving DNA, risk of morbidity, or mortality to women and baby. Remind A&E consultants about documenting attendance of pregnant or postnatal women at labour ward. Advise staff to consider other causes when treating weight loss and persistent hyperemesis. Discuss prescribing full 6 weeks course of thromboprophylaxis . Discuss communications between primary care, secondary care, perinatal psychiatrist, independent and voluntary sectors at Mental Health Rotherham network.
National Audit of Pulmonary Hypertension	No	Yes	100%	No	n/a	n/a
National Cardiac Arrest Audit (NCAA)	Yes	Yes	99%	Yes	Yes	Increase awareness of the deteriorating patient and the need to make 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions through discussion at the Operational, Quality, Safety and Experience Group and liaising with the Chief Nurse to discuss training competencies.

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
		Did not take place during 2015-16				
3 Primary Care (Data collection limited to Wales)	No	n/a	n/a	n/a	n/a	n/a
National Comparative Audit of Blood Transfusion programme						
1 Use of blood in Haematology	Yes	Yes	100%	No	n/a	n/a
2 Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	100%	No	n/a	n/a
National Complicated Diverticulitis Audit (CAD)	No	n/a	n/a	n/a	n/a	Trusts must have participated in year one to be eligible
National Diabetes Audit - Adults						
1 National Footcare Audit	Yes	Yes	45%	No	n/a	n/a
2 National Inpatient Audit	Yes	Yes	100%	No	n/a	n/a
3 National Pregnancy in Diabetes Audit	Yes	Yes	100%	No	n/a	n/a
4 National Diabetes Transition	No	n/a	n/a	n/a	n/a	n/a
5 National Core	Yes	No	n/a	n/a	n/a	Divisional Service Manager reviewing participation for 2016/17
National Emergency Laparotomy Audit (NELA)	Yes	Yes	35%	Yes	Yes	Develop and implement a dedicated pathway for emergency laparotomy patients and establish a formal mortality and morbidity meeting between General Surgery and Anaesthetics. Review data collection processes to ensure all eligible patients are submitted to the audit.

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
National Joint Registry - Knee replacement - Hip replacement	Yes Yes	Yes Yes	100% 100%	No No	n/a n/a	No actions required No actions required
National Lung Cancer Audit (NLCA)	Yes	Yes	100%	Yes	Yes	No actions required
National Ophthalmology Audit	Yes	Yes	National data collection not yet started	No	n/a	n/a
National Prostate Cancer Audit	Yes	Yes	86%	Yes	Yes	Recruit a dedicated Clinical Nurse Specialist to ensure all patients with prostate cancer have access to specialist support. Review data collection processes to ensure all eligible patients are submitted to the audit
National Vascular Registry	No	n/a	n/a	n/a	n/a	n/a
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%	Yes	Yes	Establish BadgerNet data service training programme to be provided twice a year on junior doctors' induction programme. Provide Baby Friendly Initiative breastfeeding training for all staff. Reinstate admissions and discharge checklist on SCBU. Re-audit of quality of documentation on BadgerNet.
Non-Invasive Ventilation - Adults	Yes	No data collection during 2015-16	n/a	No	n/a	n/a
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100%	Yes	Yes	Determine a lead for this audit in view of the new service provision and joint working with Doncaster.
Paediatric Asthma	Yes	Yes	100%	No	n/a	n/a
Paediatric Intensive Care (PICANet)	No	n/a	n/a	n/a	n/a	n/a
Paediatric Pneumonia	No	No data collection during 2015-16	n/a	No	n/a	n/a

“Everyone so helpful a godsend, treatment has been wonderful and so kind.”

**Friends and Family patient feedback
Matrons Central**

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
Prescribing Observatory for Mental Health (POMH-UK) 1 Prescribing for substance misuse - alcohol detoxification 2 Prescribing for bipolar disorder (use of sodium valproate) 3 Prescribing for ADHD in children, adults and adolescents	No	n/a	n/a	n/a	n/a	n/a
Procedural Sedation in Adults (care in emergency departments)	Yes	Yes	100%	No	n/a	n/a
Renal Replacement Therapy (Renal Registry)	Yes	Yes	100%	Yes	Yes	Determine a lead for this audit in view of the new service provision and joint working with Doncaster.
Rheumatoid and Early Inflammatory Arthritis 1 Clinician/Patient Follow-up 2 Clinician/Patient Baseline	Yes	Yes	100%	No	n/a	n/a
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Band A (90%+)	Yes	Yes	SSNAP actions have been agreed and improvements are monitored through the Stroke Business and Governance meetings.
UK Cystic Fibrosis Registry - Paediatric - Adult	No	n/a	n/a	n/a	n/a	n/a

“ I had Daniel and Julie. Both were fantastic explaining every procedure clearly and reassuring. I felt at ease. Daniel did a fantastic job with the injections. I didn’t feel a thing. The whole experience was quick, painless and done very professionally. ”

**Friends and Family patient feedback
Community Dental Services**

Title	Eligible	Participation	% Cases submitted	Report published 2015 (calendar year)	Report Reviewed	Action(s) to improve quality of care
UK Parkinson's Audit						
1 Occupational Therapy	Yes	Yes	40%			
2 Speech and Language Therapy	Yes	Yes	100%	No	n/a	Review data collection processes to ensure all eligible patients are submitted to the audit
3 Physiotherapy	Yes	Yes	40%			
4 Patient Management, elderly care and neurology	Yes	Yes	100%			
Vital signs in children (care in emergency departments)	Yes	Yes	100%	No	n/a	n/a
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	No.	n/a	n/a	n/a	A protocol to ensure compliance with NICE standards is currently in development. This will be implemented and audited locally in July 2016, with reference to the findings of the national audit carried out by the Royal College

Table 10: National audit participation and actions 2015-16



Review of Local Clinical Audits

The reports of 241 local clinical audits were reviewed by the Provider in 2015/16 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as listed in Appendix One.

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 262 compared to 403 in 2014/15.

Table 11 shows the number of studies actively recruiting participants during this period, Table 12 shows numbers of Rotherham participants recruited to studies where the Trust is hosting a study. Table 13 shows the number of studies currently undergoing local review to provide Trust approval for studies to commence.

Study Type	Number of studies
Commercial Portfolio	8
Non-commercial Portfolio (including Participant Identification Centres)	50
Non-portfolio The Rotherham NHSFT Sponsored	4
Other Non-portfolio	11

Table 11: Active studies (actively recruiting patients)

Study Type	Patient Recruits
Portfolio study (data cut 27 March 2016)	262
Non- Portfolio	Data not collected in 15/16

Table 12: Research Recruitment

Study Type	Number of studies
Commercial	5
Non- commercial Portfolio (including Participant Identification Centres)	27
Non-portfolio The Rotherham NHSFT Sponsored	3

Table 13: Studies currently undergoing Trust review

The Trust has experienced a reduction in recruitment to portfolio studies in the last year in common with a number of similar Trusts in the Yorkshire & Humber Clinical Research Network. This may be attributed in part to a Trust research portfolio which includes relatively complex studies with small target numbers, limited opportunities to participate in studies outside of the larger more research active Teaching Hospitals and limited resources to support the setup and delivery of research studies. In the next year the plan is to re-establish the Trust's R&D team to include experienced administration and delivery staff, set up robust systems to proactively manage research activity and work with the Yorkshire & Humber Clinical Research Network to identify opportunities to participate in a wider portfolio of research studies.

“Friendly staff, always make me feel at ease and offer advice when needed. Nothing is ever too much trouble.”

**Friends and Family patient feedback
Community Midwives**

Goals agreed with Commissioners: CQUIN framework

A proportion of The Rotherham NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the 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.

Further details of the agreed goals for 2015/16 and for the following 12 months are available electronically from Rotherham Clinical Commissioning Group. Progress in achieving CQUIN goals is reported to the Board and available via Board minutes.

In 2015/16 £4m of Trust income was conditional upon achieving the CQUIN goals compared with £4.4million in 2014/15.

“Friendly approachable specialists who are interested in us and all aspects of our lives not just lymphoedema.”

Friends and Family patient feedback Lymphoedema Clinic

Ref	National or local	Indicator	Sub-indicators	Description	RAG rating
1	N	Acute Kidney Injury (AKI)	n/a	The percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items: 1. Stage of AKI (a key aspect of AKI diagnosis); 2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment) 3. Type of blood tests required on discharge; for monitoring (a key aspect of post discharge care) 4. Frequency of blood tests required on discharge	Yellow
2	N	Sepsis	2a:Local Protocol and Screening	The total number of patients presenting to emergency departments and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis.	Yellow
			2b: Intravenous	The number of patients who present to emergency departments and other wards/units that directly admit emergencies with severe sepsis, Red Flag Sepsis or Septic Shock (as identified retrospectively via case note review of patients with clinical codes for sepsis) and who received intravenous antibiotics within 1 hour of presenting	Green
3	N	Dementia and Delirium	3a: Dementia Find, Assess, Investigate and Refer	i. The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services; ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed; iii. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP.	Green
			3b: Dementia Clinical Leadership	To ensure that appropriate dementia training is available to staff through a locally determined training programme.	Green
			3c: Dementia Supporting Carers of People with Dementia	To ensure that carers of people with dementia and delirium feel adequately supported.	Green

Ref	National or local	Indicator	Sub-indicators	Description	RAG rating
4	N	Improving Urgent and Emergency Care	5a: Mental Health Diagnosis	To decrease the proportion of avoidable emergency admissions to hospital; keep both indicators as proposed as they are important for the urgent care system. The Trust and RCCG have confirmed that a baseline and final indicator value will be agreed by no later than 30th April. The final indicator will be the reduction agreed on the number of avoidable admissions as a proportion of all emergency admissions. There are rules for partial achievement built into the national CQUIN and this will apply to the level of reduction that is achieved at year end.	Amber
5	N	Improving Urgent and Emergency Care	5a: Mental Health Diagnosis	To improve recording of diagnosis in A&E. There are rules for partial achievement built into the national CQUIN and this will apply to the level of reduction that is achieved at year end.	Green
6	L	Communications and Improving Waiting Times	6a: Improving Quality and Timeliness of Clinic Letters from Secondary Care to	Improving clinical communications between secondary care and primary care including: - Replying to the referring GP for all clinic letters. - Improving the timeliness of sending clinic letters. Auditing the quality and timeliness of clinic letters and the use of new datasets. RCCG does not wish to see a reduction in the specialties covered by audit. All specialties are to be included in the audits which will take place at St Ann's Practice and Dinnington Practice. The following thresholds are proposed: Specialties previously audited Q1 & Q2 80% and Q3 & Q4 90% across all three indicators. New specialties Q1 baseline assessment to be completed, Q3 - 50% and Q4 80% across all three indicators.	Replies to referring GP Timeless Adherence to agreed letter templates
				Improving clinical communications between secondary care and primary care including: Improving the timeliness of sending discharge letters including Handover Plans. Auditing the quality and timeliness of discharge letters and the use of new datasets. RCCG does not wish to see a reduction in the specialties covered by audit. All specialties are to be included in the audits which will take place at St Ann's Practice and Dinnington Practice. The following thresholds are proposed: Specialties previously audited Q1 & Q2 80% and Q3 & Q4 90% across all three indicators. New specialties Q1 baseline assessment to be completed, Q3 50% and Q4 80% across all three indicators.	Replies to referring GP Timeless Adherence to agreed letter templates
				Improving clinical communications between secondary care and primary care including: Auditing the use of the new data set for A&E discharge letter. RCCG does not wish to see a reduction in the specialties covered by audit. Audits will take place at St Ann's Practice and Dinnington Practice. The following thresholds are proposed: A&E new data set Q1 agree baseline, content of A&E letters and trajectory with RCCG/Trust clinicians, Q2 implement new data set, Q3 and Q4 thresholds to be agreed	Green

Ref	National or local	Indicator	Sub-indicators	Description	Outcome
7	L	Safeguarding	n/a	To review the current safeguarding plan and agree deliverables against the Safeguarding Standards Toolkit. To provide assurance to both Provider and Commissioner(s) that safeguarding standards across services provided by the Trust are achieved and improved upon. The Trust and RCCG will ensure that any DH published guidance will be considered if it conflicts with the requirements of the agreed CQUIN. RCCG have proposed further additions to the indicator particularly relating to active participation in the MASH. The full amended indicator will be shared with Trust colleagues for review/agreement	
8	L	Clinical Leadership to QIPP Programmes	Engagement in CRMC/UCMC including Audits	The completion of audit work in key strategic areas has been agreed with the Trust and is a priority for the CCG. Engagement of secondary care clinicians to primary care clinicians in the provision of education by a variety of methods is incorporated to ensure improvement in the quality and need for referrals. There will be no additional payment for clinicians' time across all requirements of this indicator. Confirmation of agreement from the Trust for a 50/50 split between the completion of audits and the completion of action plans has been received. List of audits to be agreed and formally approved through CRMC/SRG.	
9	L	Francis, Keogh, Berwick Recommendations	Nurse Leadership/Key Nurses incorporating Staffing Levels	Trust to submit a report to the Contract Quality Meeting to include data showing Ward Nurse Managers working in a supernumerary role, agency levels per ward qualified and unqualified, acute and community staffing levels staffing levels plan vs actual and A&E staffing levels plan vs actual and in line with recent guidance. In addition, the report will include achievement against set thresholds for agency levels and sickness levels as agreed. The Trust will produce an implementation plan in conjunction with RCCG clinicians to ensure all patients have a named doctor/nurse. RCCG and the Trust will work together to review the current national indicators relating to handovers and how the Trust benchmarks against other Trusts. An action plan will be developed to improve against these national targets. Thresholds for agency levels and sickness will be agreed by no later than 30th April 2015.	
10	L	SAFER Care Bundle	To implement the SAFER Care Bundle across all Inpatient Wards	1. Identified wards (as below) to hold twice daily multidisciplinary ward rounds at 8.45am and 12md. This will be audited monthly to demonstrate compliance. (Q1/2 60%, Q3 80%, Q4 100%). 2. Percentage of patients on identified wards (as below) that have a documented expected discharge date within 24 hours of admission. (Q1/2 60%, Q3 70%, Q4 80%). 3. Percentage of inpatients discharged that have left the identified ward (as below) by 12 noon. (Q1/2 20%, Q3 30%, Q4 40%). <ul style="list-style-type: none"> • A1 – Cardiology – General Medicine • A2 – Respiratory Medicine General Medicine • A3 – General Medicine • A4 – Gastroenterology General Medicine • A5 – Endocrinology General Medicine • Fitzwilliam – Geriatric Medicine General Medicine • Stroke Unit – General Medicine 	

Ref	National or local	Indicator	Sub-indicators	Description	Outcome
11	L	Clinical Administration Systems	n/a	<p>Q1 The Clinical Administration Systems Project will undertake a baseline audit of clinical administration systems across the Trust.</p> <p>Q2 The results of the audit will be benchmarked against an idealised set of standards and a gap analysis performed. The results of the audit will be fed back to the clinical workforce 1 September 2015.</p> <p>Q3 There will be a consultation process involving the whole clinical workforce with a view to adopting or adapting/localising the relevant standards.</p> <p>Q4 Clinical departments will agree and adopt departmental protocols using the model protocols contained;</p> <p>Equality impact assessment undertaken;</p> <p>Systems will be developed to ensure that there is both regular audit of the clinical administration systems and that there is continuous monitoring of key elements of these systems;</p> <p>Objectives will be agreed both with departments and individual Clinicians in respect of the implementation of agreed standards through 2016/17.</p>	
12	L	Clinical Quality	n/a	<p>The completion of audit work in key strategic areas has been agreed with the Trust and is a priority for the CCG.</p> <p>Engagement of secondary care clinicians to primary care clinicians in the provision of education by a variety of methods is incorporated to ensure improvement in the quality and need for referrals. There will be no additional payment for clinicians' time across all requirements of this indicator. Confirmation of agreement from the Trust for a 50/50 split between the completion of audits and the completion of action plans has been received. List of audits to be agreed and formally approved through CRMC/SRG.</p>	

Table 14: Outcomes for CQUINS agreed for 2015/16

“Very professional and quick without fuss! Excellent.”

**Friends and Family patient feedback
Cardiac Catheter Suite**

“I found the doctor and nurses so pleasant and cheerful that it was easy to relax and it seemed to go quite quickly.”

**Friends and Family patient feedback
Dermatology Day Case**

CQUIN	Goal	Rationale
Improving the health and wellbeing of NHS Staff	Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well	Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. Evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.
Identification and Early Treatment of Sepsis	Systematic screening for Sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review.	Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented.
Physical Health of People with Serious Mental illness (PSMI)	Service users with SMI have comprehensive cardio metabolic risk assessments, the necessary treatments and the results are recorded and shared with the patient and treating clinical teams.	There is an excess of over 40,000 deaths, which could be reduced if SMI patients received the same healthcare interventions as the general population. NHS England has committed to reduce the 15 to 20 year premature mortality in people with psychosis through improved assessment, treatment and communication between clinicians.
Antimicrobial resistance	Reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours.	Reducing consumption of antibiotics and optimising prescribing practice by reducing the indiscriminate or inappropriate use of antibiotics which is a key driver in the spread of antibiotic resistance.

Table 15a: National CQUINs for Acute Trusts 2016/17 (Source NHS England)

CQUIN	Goal	Rationale
Communications and Improving Waiting Times	Improving Quality and Timeliness of Clinic Letters from Secondary Care to Primary Care (Outpatients)	Improving clinical communications between secondary care and primary care:- - Improving the timeliness of sending clinic letters in preparation for electronic transfer from 2017/18 RCCG does not wish to see a reduction in the specialties covered by audit. All elements above will be checked during audits for compliance. All specialties are to be included in the audits which will take place at St Ann's Practice and Dinnington Practice
	Improving Quality and Timeliness of Discharge Letters from Secondary Care to Primary Care including Intermediate Care and Handover Plans (Inpatients)	
Clinical Leadership to QIPP Programmes	Engagement in CRMC/SRG including Audits	The completion of audit work in key strategic areas has been agreed with TRFT and is a priority for the CCG. Funding will be split 50/50 between the completion of the audits and the active monitoring and implementation of action plans.
	Clinician Engagement in Other CCG Priorities	Engagement of secondary care clinicians with primary care clinicians in the provision of education by a variety of methods is incorporated to ensure improvement in the quality and need for referrals. There will be no additional payment for clinician's time across all requirements of this indicator.
SAFER Care Plus	To embed the SAFER Care Bundle and support 7 day working across Inpatient Wards	To be agreed

Table 15b: Local CQUINs for 2016/17

CQC Registration and Periodic and Specialist Reviews

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Registered without Conditions'. The Care Quality Commission has not taken enforcement action against The Rotherham Foundation Trust during 2015/16.

During a routine, announced, comprehensive inspection between 23rd and 27th February 2015 sixty-five CQC inspectors reviewed services across the eight acute and four community 'core services' as follows:

Acute Core Services:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical Care
- Maternity & Gynaecology
- Services for children and young people
- End of life care
- Outpatients & diagnostic imaging

Community Core Services:

- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- Community end of life care.

The Trust's overall rating from this inspection was 'Requires Improvement'. For each of the CQC's five key questions the Trust's overall ratings were as follows:

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Tables 16 and 17 on the next page show the detailed ratings by key question and by core service.





“A very pleasant atmosphere and friendly staff. As far as operations go it was a good experience. I was very nervous on arrival but was soon put at ease by the nurses and other staff. Very professional.**”**

**Friends and Family patient feedback
Breast Surgery Day Case**

	Safe	Effective	Caring	Responsive	Well led	OVERALL RATING
Urgent and Emergency Services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical Care	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical Care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Maternity and Gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good

Table 16: Ratings for the Trust's acute services

	Safe	Effective	Caring	Responsive	Well led	OVERALL RATING
Community Dental	Good	Good	Good	Good	Good	Good
Community children	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community Inpatients	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community end of life	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Table 17: Ratings for the Trust's community services

All of the reports from the Trust's inspection are available on the CQC's website: www.cqc.org.uk and the Trust website: <http://www.therotherhamft.nhs.uk>

A comprehensive improvement action plan was created as a result of the inspection findings and approved by Board of Directors in July 2015. Progress updates against the improvement action plan are presented on a monthly basis to the public part of the Board of Directors meetings. These monthly updates and the improvement action plan itself are available on the Trust's internet site.

In addition to the announced inspection of the Trust's acute and community services, during the same week in February 2015 the CQC also undertook a review of services for Children Looked After and Safeguarding (CLAS) in Rotherham. This was a joint review involving the Trust; NHS England; Rotherham, Doncaster and South Humber NHS Foundation Trust and Rotherham Clinical Commissioning Group and Rotherham Metropolitan Borough Council.

The Care Quality Commission CLAS review lines of enquiry are centred on:

- 1) The experiences and views of children and their families.
- 2) The quality and effectiveness of safeguarding arrangements within health economies.
- 3) The quality of health services and outcomes for children who are looked after and care leavers.
- 4) Health leadership and assurance of local safeguarding and looked after children arrangements.

CLAS inspections and associated action plans are coordinated by Clinical Commissioning Groups (CCGs) and include a wide cross-section of the health economy.

Within the Rotherham inspection the providers of health care included:

- The Rotherham NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
- Walk in Centre and Out of Hours
- Independent GP Practices

Within the Rotherham inspection partner organisations included:

- Rotherham Metropolitan Borough Council (RMBC) Children and Young Peoples Services,
- Rotherham Local Safeguarding Children Board (RLSCB)

The CQC tracked 84 individual cases where there had been an identified safeguarding concern. Some cases were of children who had recently been referred to social care and some where children and families were not referred, but were assessed as needing early help from health services.

The outcome following the CQC CLAS Inspection is provided by way of a narrative report and no ratings are provided. In total 24 recommendations were made. A SMART Action Plan addressing all 24 recommendations was produced and is monitored via a monthly Challenge Meeting led by Rotherham CCG. To date the Trust's actions have progressed well and as per plan with no exceptions to report.

The Care Quality Commission has not taken enforcement action against The Rotherham NHS Foundation Trust during 2015/16.

The Rotherham NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period other than those already detailed in this section.

During the comprehensive inspection in February 2015 the Trust took the opportunity to provide evidence to the CQC of the actions it had taken regarding its remaining open outlier alerts. As a result the CQC confirmed in its inspection report that the Trust no longer had any outlier alerts. No further mortality outlier alerts have been notified to the Trust since the inspection in February 2015.

The Trust is also required to report any breaches of the Ionising Radiation Regulations to the CQC and in year three such breaches were reported (six the previous year).

April 2015	Unnecessary dental film (orthopantomogram) taken at community dental location
October 2015	Incorrect anatomical site x-rayed (knee instead of ankle)
February 2016	Duplicate mammography examination

Each of the three incidents have been investigated and all have been escalated through to the Diagnostics and Support divisional governance meeting and onto the Trust's Operational Quality, Safety & Experience Group in order to provide assurance as to the quality of the investigation and the robustness of the remedial actions taken.

Since the 2014/15 Quality Report was published the basis for reporting breaches of the Ionising Radiation Regulations has changed. Duplication of requests including CTs no longer need to be reported externally although they are still recorded internally. In the same way dentition and extremities errors are no longer reported to CQC but are recorded and acted upon within the Trust. Further information is available at <http://www.cqc.org.uk/content/ionising-radiation>⁶

The CQC published its final Intelligent Monitoring report for Foundation Trusts in May 2015. The Trust was not assigned to a band on this occasion due to the fact it had been recently inspected. However the report detailed the Trust's lowest risk score since the Intelligent Monitoring reports had begun, a score of five (with Band six being the lowest risk)

⁶ A Guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and Interventional radiology London, Royal College of Radiologists, 2015

The table below illustrates the Trust's position in all five of the CQC's Intelligent Monitoring reports:

Report date	Overall Risk Score	Priority Band for Inspection
October 2013	7	Band 4
March 2014	7	Band 4
July 2014	12	Band 2
December 2014	7	Band 4
May 2015	5	'Recently Inspected'

Table 18: CQC Intelligent Monitoring scores and Banding for the Trust

The May 2015 report identified 4 risks of which one was an elevated risk. This related to the Trust's Governance risk rating assigned by Monitor, the Foundation Trust regulator.

On 5 November 2015 the CQC announced that it would not publish any further Intelligent Monitoring reports for acute trusts. All of the Trust's Intelligent Monitoring reports are available on the CQC website.

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. No changes to the Trust's CQC registration have been required during 2015/16. A full 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 a sequence of service-level and Trust-level self-assessments and quarterly presentation to the Medical Director and Chief Nurse reporting ultimately to the Quality Assurance Committee and the Board of Directors.

The standard most often self-assessed as at risk was 'Are services Safe?' largely due to workforce constraints. The self-assessments are triangulated with learning from quality and safety walkrounds and monthly performance meetings and The Operational Quality, Safety and Experience Committee reviewed the reasons for these self-assessments in both Quarter 1 and Quarter 2 in order to ensure that the appropriate actions to improve this position were being taken.

“In a very busy environment my son was dealt with very efficiently and lots of kindness.”

**Friends and Family patient feedback
A&E**

“These nurses can't do enough for us. We would recommend them to friends and family.”

**Friends and Family patient feedback
Rother Valley North District Nurses**

Responding to the CQC Inspections: The Trust's Action Plan

Following the CQC inspections in February 2015 the Trust responded by developing the action plans mentioned above. In March 2015 the Trust took decisive action to eliminate all mixed-sex sleeping accommodation from the Medical Assessment Unit and Surgical Assessment Unit.

In addition the Trust began a review in March 2015 of its in-hospital children's services, reducing the inpatient bed base by four beds in order to improve the nurse-patient ratio. The review has also resulted in the Trust piloting a further reduction in inpatient beds to 12 and a 24 hour Children's Assessment Unit with 10 beds. This model is currently being evaluated with the support of the South Yorkshire Clinical Children's network.

In partnership with the Rotherham, Doncaster and South Humber Foundation Trust colleagues within the Paediatric services have received training on the management of children and young people who present with suicidal ideation and of children gender reassignment. Further training is planned to provide training in the care and management of young people with eating disorders.

The Trust has also reviewed its approach to end-of-life care for patients in the community. A partnership between community nurses and Rotherham Hospice has developed an individualised end-of-life care pathway with implementation beginning in 2016.

Nurse staffing levels remain closely monitored and reviewed with daily 'safe staffing huddles' led by the heads of nursing. Nurse staffing levels are reported monthly to the Board and the Quality Assurance Committee and the Trust will report on medical staffing in the same way from 2016/17. Vendors have been appointed for bank and agency nursing and medical locums and a medical workforce manager is now in post to support delivery of the Medical Workforce Strategy and lead on recruitment campaigns. Safe staffing levels have been reviewed in Maternity Services using the Birthrate+ tool, in Paediatrics using the Paediatric Acuity and Nurse Dependency Assessment tool (PANDA) and in Emergency Care using the Baseline Emergency Staffing Tool (BEST).

The Trust has also implemented a training programme to update and enhance skills in Dementia, Safeguarding Children, Safeguarding Vulnerable Adults, Resuscitation, the Mental Capacity Act and Deprivation of Liberty Safeguards. In the last 12 months DoLS applications have risen from 74 to over 200. Every colleague has been given a card explaining the five MCA principles and the key criteria to consider in assessing capacity.

The Trust also reviewed the pathways for children and young people using sexual health services and for sharing information with school nurses.

The Trust has improved the standards of medicines management by implementing new processes for the storage and recording of administration of medications. There have also been improvements in the arrangements for prevention of healthcare acquired infections in the Community Short-Stay Children's and Young People's Service. This has been achieved by implementing new guidance on care and decontamination of play equipment together with undertaking Essential Standards Audits.

Senior Nurse leadership within the Division of Family Health has been enhanced following the appointment of both a Deputy Head of Nursing for Children's Services together with a Matron for Acute and Complex Care. In addition, a Team Leader has been appointed to the Complex Needs Team and is due to commence in post in April 2016. The Trust also reviewed the pathways for children and young people using sexual health services and for sharing information with school nurses. The Trust has approved a new risk management strategy, ensuring that the risk register is reviewed each month at the Trust Management Committee.

In Q1 2016/17 the Trust will publish a Quality Improvement Plan, building on the work achieved in the last year.

Serious Incidents 2015/16

A 'Serious Incident' is defined as 'an adverse or near-miss event, act or omission which has produced (or has the potential to produce) serious injury, serious psychological injury or death, pose a serious risk to the objectives of the Trust and which has produced (or has the potential to produce) significant legal/media or other interest'.

For the period 1 April 2015 to 30 September 2015 the trust has reported 15 incidents (0.5% of the total) resulting in severe harm or death. This compares with an average of 19.55 (0.4%) for all non-specialist acute trusts.

The Trust reported 3,204 incidents for the period 1 April 2015 to 30 September 2015 at a rate of 42.14 per 1,000 bed days against a median reporting rate for this cluster of 38.25.

The Trust has logged two Never Events during 2015/16. One is retrospective, identified through a claim relating to an incident in 2013. The other relates to wrong site treatment. Never Events are reported to Monitor and the CQC and are subject to detailed investigation.

Table 19 shows the comparative Incident Reporting Rate summary, per 1000 bed days, for 136 acute non-specialist organisations for the period 1 April 2015 to 30 September 2015 (patient safety incidents). In general a higher incident reporting rate correlates with a better and more effective safety culture. The Trust reports 50% of incidents within 8 days, compared with an all-trust average of 27 days.

“Thank you for all the care you gave my dad. You went above and beyond over the weekend.”

**Friends and Family patient feedback
Rother Valley North District Nurses**

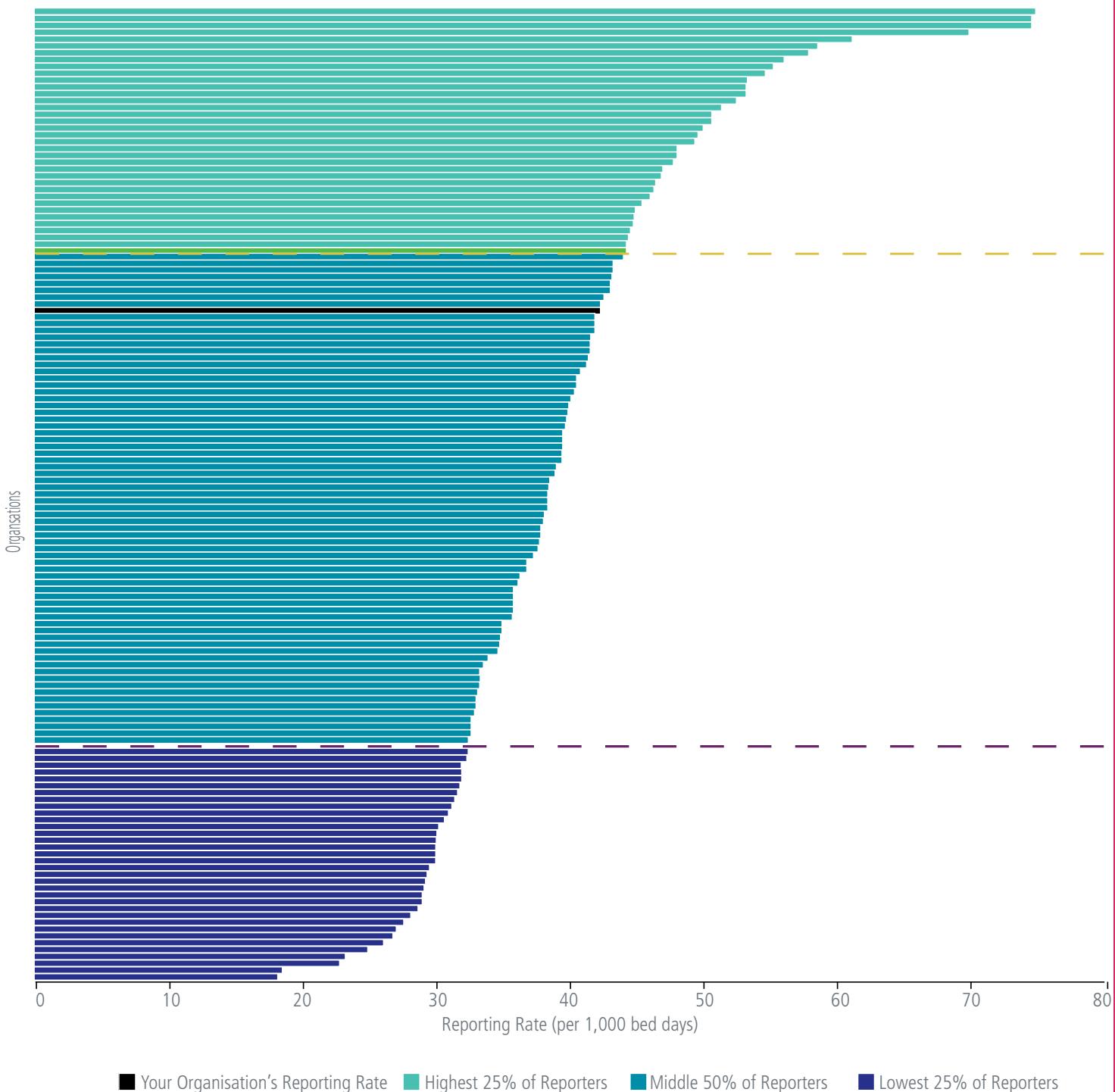


Table 19: The Rotherham NHS Foundation Trust (dark line) rate of incident reporting compared with other non-specialist acute trusts [source: NRLS]

“ I was treated with the upmost respect in my treatment and can say without reservation I was truely satisfied with the treatment and had the procedure explained throughout. ”

Friends and Family patient feedback
Rother Valley South District Nurses



Her Majesty's Coroner's Inquests 2015/16

The Trust continues to support HM Coroner and ensure inquests are investigated in a timely manner. The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. These are known as 'Reports to Prevent Future Deaths'; the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013. The Trust has had no such reports during 2015/16.

Data quality 2015/16

The Rotherham NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data April 15 – February 16. The percentage of records in the published data which included the patient's valid NHS number was 99.8% for admitted patient care, 99.9% for outpatient care and 88.1% for accident and emergency care. This compares with 99.6% having a valid NHS number for admitted care, 99.7% for out-patient care and 88.1% for accident and emergency April 2014 to March 2015.

The percentage of records which included the patient's valid General Medical Practice Code was 99.7% for admitted patient care, 99.9% for outpatient care and 99.2% for accident and emergency care. These percentages compare to 99.7% GP registration code for admitted care, 99.90% for out-patient care and 99.3% for accident and emergency care April 2014 to March 2015. On both the NHS Number, and GP code, we have maintained the level of data quality from the previous year, and aim to improve further in 2016/17 as more services are linked to the NHS Spine, which provides up to date data on NHS Number and demographic details.

Data Quality Index (HRG4 based)

CHKS continues to be the source of information for the Data Quality Index and at the time of reporting Q4 data is unavailable. Despite a marginal decrease from the previous year, the Trust continues to outperform peer averages with an index of 95.9 compared to a peer average of 95.1

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

The Trust has marginally missed its target of unaccepted diagnosis codes in the period up to February 2016, achieving 1.35% against a previous measurement of 0.76% for 2014/15. Further improvement has been delayed in part due to a significant period of restructuring within our clinical coding department during Q2 and Q3. The expected improvement is now happening and will be in place for Q1 2016/17. Our depth of coding (average number of diagnoses per coded episode) continues to increase from 4.1 in the first three quarters of 2014/15 to 4.9 in the first three quarters in 2015/16.

Clinical coding

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

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Score	95.5	94.4	94.4	94.2

These scores help us to achieve assurance Level 2 of the Information Governance Toolkit for coding accuracy, and are just short of achieving the highest level, Level 3.

In 2015/16 the Trust took the following actions to improve clinical coding data quality:

- Conducted regular internal audits across specialties using the devised new internal audit methodology
- 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 organised with the consultants
- Explored possibilities for letting clinicians validate their own data, extending from the mortality data validation to morbidity data section.

Improvements and actions to further improve clinical coding during 2016/17 include:

- Coding to within 2 weeks of month end ("flex" dates), rather than the current 6 weeks ("freeze").
- Implement a programme of more coders working towards and achieving ACC professional qualification.
- Reviewing coding processes across the organisation to benefit from coding at source and in near-real time wherever practicable.
- Implementing coding performance indicators
- Standardising work hours and practices
- Addressing gaps in management and supervisory capacity and capability



Areas selected for focussed improvement activity		Baseline period Full Year	Baseline Value	Target	Q 1 2015-16	Q 2 2015-16	Q3 2015-16	Q 4	YTD	Progress
Improving Data Quality	IDQ-1 Data Quality Index (CHKS Live)	2014-15	96.2	Increase	95.7	95.1	96.7	94.9	94.7	▼
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2014-15	0.76%	Decrease	1.58%	2.23%	0.66%	1.24%	1.35%	▼
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)	2014-15	9.29%	Decrease	9.12%	9.593%	8.96%	9.70%	9.12%	▼
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)	2014-15	14.36%	Decrease	10.69%	12.17%	12.73%	11.39%	11.13%	▼
	IDQ-5 Average Diagnoses per coded episode (CHKS Live)	2014-15	4.2	Increase	4.6	5.0	5.1	4.9	4.9	▼
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (HSCIC Dashboard)	2014-15	99.60%	Increase	99.80%	99.80%	99.70%	99.80%	99.80%	▼
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (HSCIC Dashboard)	2014-15	99.70%	Increase	99.80%	99.60%	99.70%	99.70	99.70%	▼
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (HSCIC Dashboard)	2014-15	99.70%	Increase	99.80%	99.90%	99.80%	99.9%	99.90%	▼
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (HSCIC Dashboard)	2014-15	99.90%	Increase	100.00%	99.90%	99.90%	99.90%	99.90%	▼
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (HSCIC Dashboard)	2014-15	88.20%	Increase	87.10%	87.30%	88.10%	86.90%	88.10%	▼
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (HSCIC Dashboard)	2014-15	99.30%	Increase	99.20%	99.20%	99.20%	99.20%	99.20%	▼

Table 20: Progress on Trust data quality to February 2016

Information Governance

The Rotherham NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 72%. This marks an improvement on last year's level of 62% but the Trust retains a 'not satisfactory' rating. Four areas saw significant improvement but the Trust failed to achieve the minimum 95% requirement for staff undertaking annual IG Training. The Trust therefore achieved a Level One compliance for Information Governance Management, with 81% of colleagues having completed the training by year-end. This is a significant step towards the target and the Trust will build on this in 2016/17.

The Trust has reported two information governance breaches, both of which involved person identifiable information being sent, one to a member of the public and one involving backing data sent in error to NHS England using an unsecured email address. These breaches have been reported and investigated as serious incidents and both have been drawn to the attention of Monitor and the Information Commissioner. The Information Commissioner's Office was satisfied on both occasions with the actions taken by the Trust in response to these incidents. The Information Governance Assessment Report overall score for 2015/16 was 72%.

	Overall score 2014/15	Overall score 2015/16	Grade
Information Governance Management	60%	86%	Not Satisfactory
Confidentiality and Data Protection Assurance	66%	75%	Satisfactory
Information Security Assurance	60%	71%	Satisfactory
Clinical Information Assurance	66%	66%	Satisfactory
Secondary Use Assurance	62%	66%	Satisfactory
Corporate Information Assurance	55%	77%	Satisfactory
Overall	62%	72%	Not Satisfactory

Table 21: Trust scores for Information Governance 2015/16

Department of Health Mandatory Core Indicators for Acute Trusts

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 the Health and Social Care Information Centre and in providing this information the most up to date data available to us has been used and is shown in Table 22, providing comparison with peer acute trusts. PROMS data is in Table 23.

The Rotherham NHS Foundation Trust considers that this data is as described for the following reasons: data is validated by submission to HSCIC and assurance provided by the Trust's external auditors.

Domain	HSCIC Ref	Indicator name	Trust previous value [Jul 13-Jun 14]	Trust value [Oct 14-sept 15]	Acute Trust highest	Acute Trust lowest	Acute Trust average
Domain 1: preventing people from dying prematurely	P01544	SHMI: value	1.059		1.06	0.89	1.01
				1.084	1.17	1.00	0.65
	P01544	SHMI: banding	2 [as expected]		2 [as ex- pected]	2 [as ex- pected]	2 [as ex- pected]
				2 [as expected]	2 [as ex- pected]	2 [as ex- pected]	2 [as ex- pected]
	P01544	SHMI: percentage of patient deaths with palliative care coding at diagnosis level	n/a		52.90%	0%	26.00%
				31.50%	53.50%	0.20%	26.50%

Table 22a: Department of Health Core Indicators

“Everyone is friendly and I enjoy peoples company. I feel I am benefitting from the exercise and feel that i am walking better.”

**Friends and Family patient feedback
Day Rehabilitation Service**

“I wish all the health service would spend time like the matron does, a worthwhile service to us elderly. GPs do not have the time for us anymore.”

**Friends and Family patient feedback
Matrons South**

Domain	HSCIC REF	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	P01551	Primary hip replacement surgery (EQ-5D Index) - health gain							
		1 April 2014 - 30 Sept 2014	7	0.25	0.864	0.614	7 (100%)	0 (0%)	0 (0%)
	P01551	1 April 2015 - 31 Oct 2015	20	0.28	0.765	0.485	17 (85%)	1 (5%)	2 (10%)
	P01551	Groin hernia surgery (EQ-5D Index) - health gain							
		1 April 2014 - 30 Sept 2014	16	0.625	0.898	0.273	13 (81.3%)	1 (6.3%)	2 (12.5%)
	P01551	1 April 2015 - 31 Oct 2015	30	0.757	0.889	0.132	19 (63.3%)	7 (23.3%)	4 (4.3%)
	P01551	Primary knee replacement surgery (EQ-5D Index) - health gain							
		1 April 2014 - 30 Sept 2014	16	0.448	0.786	0.338	14 (87.5%)	1 (6.3%)	1 (6.3%)
	P01551	1 April 2015 - 31 Oct 2015	16	0.385	0.663	0.278	12 (75%)	0 (0%)	4 (25%)
	P01551	Varicose vein surgery (EQ-5D Index) - health gain							
		1 April 2014 – 30 September 2014	*	*	*	*	*	*	*
	P01551	1 April 2015 – 31 Oct 2015	*	*	*	*	*	*	*
NB: * Reflects that adjusted health gain has been suppressed due to fewer than 30 modelled records being available									

Table 22b: Patient Reported Outcome Measures, Domain 3

Domain	HSCIC Ref	Indicator name	Trust previous value [Jul 13-Jun 14]	Trust value [Oct 14-sept 15]	Acute Trust highest	Acute Trust lowest	Acute Trust average
Domain 4: ensuring that people have a positive experience of care	P01533	CQUIN responsiveness to personal needs	76.2		88.2	68	76.9
				68.1	86.1	59.1	68.9
	P01533	Staff who would recommend the Trust to family and friends	53.00%		89.00%	38.00%	87.00%
				53.00%	85.00%	46.00%	72.00%

Table 22c: Department of Health Core Indicators

Domain	HSCIC Ref	Indicator name	Previous reporting periods	Latest reporting periods	Trust previous value	Trust latest value	Acute Trust highest	Acute Trust lowest	Acute Trust average
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	PO1556	Percentage of patients admitted to hospital and risk assessed for VTE	Oct 14 – Dec 14	Oct 15 - Dec 15	98%	95.90%	96.00%	61.50%	95.50%
	PO1557	Rate per 100,000 bed days of cases of C.diff amongst patients aged 2 or over	Apr 13 – Mar 14	Apr 14- Mar 15	14	17	17.4	0	14.5
	PO1394	Patient safety incidents: rate per 1000 bed days(acute non-specialist for comparison)	Apr 14 - Sept 14	Apr 15 – Sept 15	38.2	40.5	82.2	0.2	35.9
	PO1395	Patient safety Incidents: % resulting in severe harm or death (medium acute Trusts for comparison)	Oct 14 – Mar 15	Apr 15 – Sept 15	0.08%	0.05%	0.19%	0%	0.4%

Table 23: Department of Health Core Indicators

“ My first visit, have been treated very well. Feel very confident that I have received excellent care. Thank you. ”

**Friends and Family patient feedback
Musculoskeletal Service**



The Trust intends to take the following actions to improve outcomes 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 Table 24.

Core Indicator	The trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to maintain or improve this score and so the quality of its services by:
The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period	<p>Data validated and published by HSCIC.</p> <p>The Trust continues to make incremental improvements and has no current mortality outliers.</p> <p>The Trust is banded as 2 ('As expected')</p>	<p>The Trust has embedded its Mortality Review process in 2015/16 with regular meetings of the Review Group and reports to the Clinical effectiveness and Research Group.</p> <p>Data (SHMI and HSMR) is reviewed to help identify trends and areas of concern. A summary of the Trust's performance and any mitigating actions taken is shared in Board quality reports.</p>
<p>The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.</p> <p>*The palliative care indicator is a contextual indicator.</p>	<p>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</p>	<p>The Medical Division conduct an early review of all deaths (within one week)</p>
<p>Patient Reported Outcome Measures scores for—</p> <ul style="list-style-type: none"> (i) groin hernia surgery; (ii) varicose vein surgery; (iii) hip replacement surgery; and (iv) knee replacement surgery during the reporting period 	<p>The data is considered to be accurate based on the number of returns received and the data validated and published by HSCIC</p> <p>The Trust performs too few Varicose Vein procedures to reach the threshold for data analysis</p>	<p>PROMS are measures recorded pre- and post-operatively by patients. They measure changes in quality of life and health outcomes</p>
<p>Percentage of patients aged—</p> <ul style="list-style-type: none"> (i) 0 to 15; and (ii) 16 or over, <p>Readmitted to a hospital which forms part of the trust within 28 days of discharge.</p>	<p>This indicator is not presently being updated by HSCIC; next data release is planned for August 2016.</p> <p>Data shown for the period 2015/16 for elective and non-elective patients is drawn from internal sources.</p>	<p>The Indicator continues to be monitored through the Quality Report for the Quality Assurance Committee based on the Trust's own data.</p> <p>The Care Home Team identifies factors leading to admission and readmission and works with the sector to improve effectiveness.</p>
The trust's responsiveness to the personal needs of its patients during the reporting period.	<p>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 September 2014 and January 2015. Full results are available in Section 3.3 of this report.</p>	<p>CQC will publish 2015 patient survey results in May or June 2016</p>

“On time and lovely reception from all staff.”

**Friends and Family patient feedback
Orthotics**

Core Indicator	The trust considers that this data is as described for the following reasons	The Trust intends to take or has taken the following actions to maintain or improve this score and so the quality of its services by:
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	Figures validated and published by HSCIC	The Trust will continue to monitor VTE rates, and report through local clinical governance structures to the QAC
Rate per 100,000 bed days of cases of C-difficile infection	Figures validated and published by HSCIC. Trust data quality subject to external audit	The Trust will continue to monitor C-Difficile rates, and report through local clinical governance structures to the QAC; for further actions to reduce rate of c-diff see Part 3
Number and rate of patient safety incidents.	Data validated and published by NRLS; latest data is for the period April – September 2015	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures.
Number and percentage of patient safety incidents that resulted in severe harm or death.		
Friends and Family Test (Q12d): If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.	Department of Health conduct an annual independent survey of staff opinion	For staff survey data see Part 3.4 Trust's Listening in Action programme will continue in 2016/17 (See Part 3)

Table 24: Department of Health Mandatory Core Indicators for Acute Trusts: rationale for performance over 2015/16



3

Innovation and Improvement: Quality across the Trust

This part of the report presents information relating to the quality of services the Trust provides with detail about progress made against quality improvement priorities agreed locally last year. In addition it describes the Trust's performance against national priorities and core indicators.

Priorities for improving quality lie within three core domains:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

3.1 Patient Safety

Healthcare Associated Infections

The Director of Infection Prevention and Control (DIPC) published the annual infection prevention and control report in June 2015. The 2015/16 annual report will be completed in April 2016 with the aim to have final approval in June 2016. 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 Operational Quality Safety and Experience Group. The Chief Nurse is the Executive lead for Infection Prevention and Control and meets regularly with the DIPC.

In year there have been no cases of hospital acquired MRSA bacteraemia meeting the requirement that the Trust continues to avoid preventable cases. The Trust has been MRSA bacteraemia free for 34 months (at year end) and indeed the case reported 35 months ago was from a blood culture contaminated sample and not a clinical infection. The last genuine MRSA bacteraemia infection occurred more than 5 years ago.



There was one community acquired case of MRSA bacteraemia which was investigated using the national toolkit and reviewed at a post infection review meeting led by the CCG where it was agreed that this was not attributable to any Trust care provision.

Throughout the year the Infection Prevention and Control and Decontamination Committee has maintained a focus on blood culture contamination rates. The national average is 3%, i.e. 3% of samples taken are contaminated, usually with flora or bacteria on the skin. The Trust has exceeded the 3% month-on-month. Action plans to reduce contamination risk have continued with new focus in the Emergency Department (ED) where the highest percentage of blood culture sampling is undertaken. The whole of the ED team are working in a multi-professional and multi-disciplinary manner to reduce contaminated samples with the collaboration being led by an ED consultant.

Table 25 (data source: Trust Winpath system)

Rates of contaminated blood samples for 2015/16

	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
Blood culture contamination Target is to have less than 3% every month	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
Blood culture contamination actual %	4.27%	4.03%	4.47%	4.51%	5.07%	5.46%	4.42%	5.78%	5.08%	4.02%	3.79%	5.41%

The Rotherham NHS Foundation Trust

Rotherham NHS Foundation Trust

ENDS
N?

CARE
HAND
COST LINE



MRSA and C-difficile are both alert organisms subject to annual improvement targets. The MRSA target for 2015/16 was 'zero preventable cases' which has been achieved. The C-difficile trajectory was 26 cases to year-end and the Trust is better than trajectory, recording 19 cases.

Table 26 C-Difficile trajectory (data source: Trust Winpath system)

TRFT		Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
2015/16 Target = 26	Monthly Actual	0	4	1	4	0	4	0	1	1	2	1	1
	Monthly Plan	2	2	1	2	2	3	2	3	2	2	2	3
	YTD Actual	0	4	5	9	9	13	13	14	15	17	18	19
	YTD Plan	2	4	5	7	9	12	14	17	19	21	23	26

All cases of hospital acquired C-difficile are reviewed in depth by the IPC team. Shared ownership of completion of the RCA investigation with the clinical directorates 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 and prolonged length of stay, the antimicrobial subgroup regarding antimicrobial prescribing. Multi-disciplinary Team (MDT) meetings with the relevant Division take place in the following week where a full review of the RCA is undertaken.

A post-infection review (PIR) is carried out each month with the Health Protection Principal from Rotherham Public Health, The Antimicrobial Pharmacist at the CCG and with the Lead Nurse in Infection Prevention and Control for the 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 2015/16 twelve cases have been classed as unavoidable with no lapse in quality of care identified whilst 7 cases did have an identified lapse in quality of care. The lapses were:

- One delay in sample acquisition,
- One linked to insufficient records of bowel movements,
- Two classed as cross infection and
- Three cases linked to antibiotic usage.

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.

There were 22 samples Ribotyped during 2015/16, 19 of which were hospital acquired cases. Community acquired cases may be tested and reported via the Trust on admission or may be direct GP samples which are tested and reported via Barnsley Laboratory.

There were 13 different Ribotypes identified from the 22 samples tested. Whenever there is more than one sample of the same Ribotype they are further analysed to determine if there is any correlation between the cases.

For Infection Prevention and Control, the Quality Assurance Committee had prioritised two key improvement areas for 2015/16:

- 1 A deep clean rolling programme including the use of hydrogen peroxide vapour (HPV) decontamination to be implemented with the Medical in-patient areas as the primary sites for action.

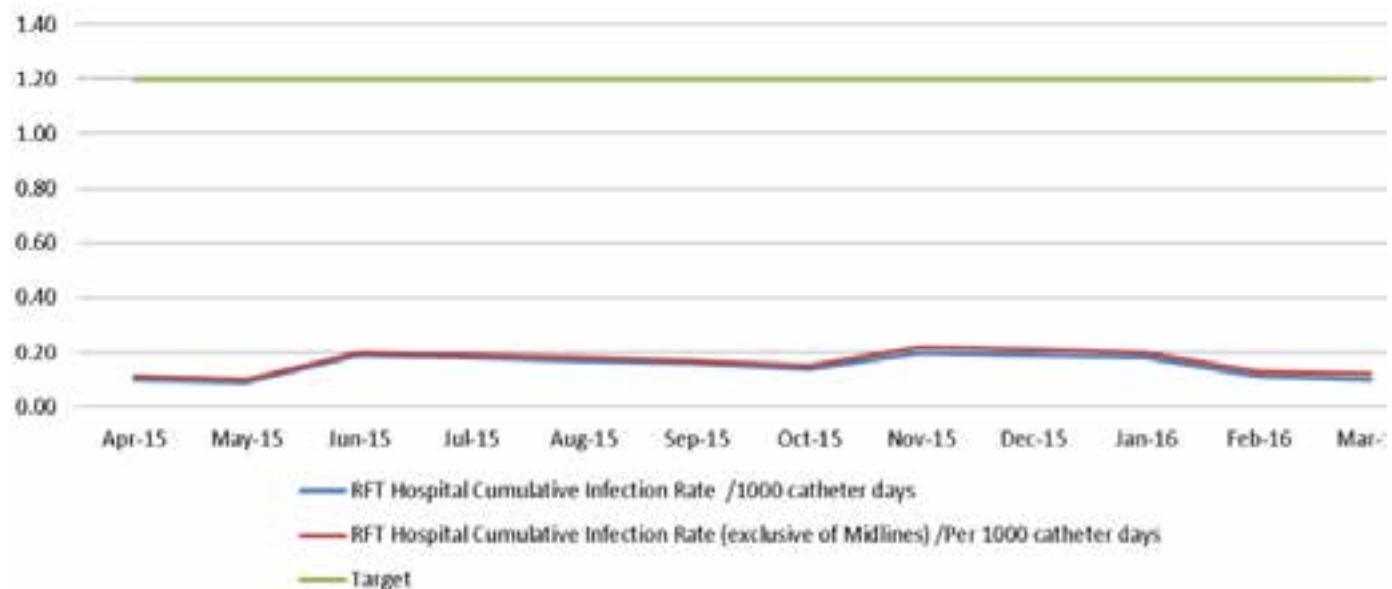
Outcome: Due to the new Emergency department building work a number of ward areas have been relocated. As each ward was moved a deep clean and Bioquell process for environmental disinfection was undertaken. This has led to a large proportion of wards being deep cleaned. A formal rolling programme is to be developed from April 2016 following the closure of the winter pressure ward which can then be utilised as a decant area whilst the process is undertaken. In addition a number of the wards have had additional toilet and hand wash basins installed (A2 and A5) and one ward (A2) has en-suite facilities included within each bay.

- 2 A sustained reduction in the incidence of C-difficile. As 40% of those patients who acquired infection had a length of stay greater than 30 days at the time of the infection, reducing length of stay and avoiding delayed discharge can make a significant contribution to reducing the incidence of C-difficile cases.

Outcome: Close examination of the c-diff cases shows that many of the patients have had an unusually short admission prior to onset of symptoms; this continues to be monitored. These infections are likely to have been contracted before admission. Almost all hospital acquired infections occur from 48 hours after admission onwards; in the case of C-diff it is 72 hours.

The Trust continues to have an outstanding, extremely low, rate of Central Line Associated Blood Stream Infections (CLABSI). The data for CLABSI is monitored by the Intra-venous Access Group via the Vascular Access team and is re-analysed for monthly presentation on a rolling 12 month basis. Each monthly report shows the cumulative line days and reported CLABSI incidents in the previous 12 months. This is intended to produce a more relevant and contemporaneous report of central line infections and a reflection of current practice. From March 2015 community patients have been included in the report; from December 2015 Paediatrics and SCBU inpatients were added to the data. In 2015/16 there were two CLABSI incidents recorded.

Table 27 Incidence of CLABSI 2015/16 (data source: Trust Winpath system)



The Trust currently includes midlines in the data as these lines are often used as an appropriate alternative to central lines. Surveillance therefore reflects catheter related bloodstream infection rates for both sites. Many Trusts do not insert midlines and therefore their data does not include them. To bring data into line with other Trusts the infection rate is calculated without the midline data (red line below), giving fewer catheter days and therefore a slightly different infection rate.

The intravenous (IV) access steering group was established to oversee IV access both in the hospital and community setting and an important initiative is to enhance IV antibiotic therapy in the community. The Access Team in collaboration with the District Nurses and other stakeholders have been instrumental in the delivery of this service. A performance dashboard has been created with good clinical outcomes and was shared with the commissioners in year.

Small numbers of cases of Norovirus and Influenza have been identified but these have been well managed to reduce further cases and to avoid outbreak situations. No wards have been closed due to either of the viruses which are usually challenging during the winter months.

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. They have demonstrated continually low rates of infection. The data has been confirmed by a further case review by the Head of Midwifery to provide assurance of the system.

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 been extended during 15/16 to include continual surveillance of all lower limb arthroplasty with the initial results due in early 16/17 which will be shared with the Orthopaedic Division.

The Consultant for Podiatric Surgery completes continual SSI surveillance via the speciality national data base and has had zero post-operative infection.

Whilst Ebola remained a very low threat to the UK the IPC team and the Health & Safety Lead led a multi-disciplinary preparedness group to ensure that the correct PPE is available in key areas, that a designated area of care has been identified and prepared with appropriate equipment and that the most up to date national and international information has been shared with clinical colleagues. Particular thanks must be given to a Consultant colleague who provided hands on care in West Africa and shared this experience and knowledge with the preparedness group on return to the Trust.

The Trust is very pleased with infection prevention in other areas such as central line associated blood stream infections, rates of MRSA bacteraemia (zero), rates of C diff against trajectory and the low SSI rates for Caesarean sections and Podiatric Surgery. Norovirus infections have been well managed; there has been no need to close wards. More patients are being treated in the community with I/V antimicrobials which means that patients are prevented from hospital admissions or discharged earlier. The IPC team has been instrumental in education and training at regional level. Finally, there has been no patient complaint or serious incidents to do with acquisition of healthcare associated infections at the Trust.

Duty of Candour: Trust Response to Francis, Keogh and Berwick Reports on patient safety and whistleblowing

The Trust has adopted and implemented the 'Being Open' Policy, providing guidance to all staff on how they are expected to respond if patient safety is at risk. The patient and/or family is spoken with directly by an appropriate clinician and a letter is then sent explaining the concern and what steps are being taken by the Trust in response. The Trust always provides information about the progress and outcome of investigations and inquiries in line with the request of the patient or their family.

The Trust recognises the importance of supporting everyone who raises an issue of safety or public concern so that it can be dealt with promptly and sensitively and has therefore revised its Raising Concerns (Whistleblowing) policy and procedures. The Trust now provides a range of options for colleagues who may wish to raise concerns. Implementing a key recommendation of the Francis Report, the Trust has trained and appointed Freedom to Speak Up guardians. Eight colleagues from across the Trust have volunteered to take on this role, offering support to all colleagues, at every level, so that they feel confident and safe in the knowledge that:

- They will be supported in disclosing concerns they may have,
- Their concerns will be listened to and
- All concerns disclosed will be fully investigated and, where appropriate, the necessary action taken.

In addition, the Trust now has a dedicated confidential hotline for colleagues who may wish to raise concerns. This hotline is available for all colleagues and has a voicemail facility. Contact is made within 24 hours of a message being left to discuss concerns in more detail and provide appropriate advice and support. The Freedom to Speak Up Guardians can also be emailed directly.

Another theme of the Reports was concern that Boards and senior managers needed to be properly informed about safety and quality issues. To support this process, two 'patient stories' are presented at each Board meeting, one a negative or challenging story for the Trust and the other a positive account; the Board hears how the Trust responded to and learned from each story. Additionally Board members participate in Safety Walkabouts whilst Governors and senior nurses undertake Quality walkabouts, providing verbal and written reports to Governor's meetings.

Reports on relevant incidents are reviewed at a meeting led by the Chief Nurse and Medical Director with a copy of every Datix report shared with all at the weekly executive meeting.

Mental Capacity Act/Deprivation of Liberty Safeguards

- The Trust has continued to provide training and support to enable colleagues to deliver care consistent with the requirements of the Mental Capacity Act (MCA) 2005. This has been provided in a variety of formats including workshops, e-learning, brief support sessions and face-to-face taught sessions. The Trust has commissioned part of its training from Rotherham, Doncaster & S Humber NHS Foundation Trust.
- All colleagues have been provided with cards describing the five MCA principles and the questions to consider in assessing capacity.

- Audit was completed which demonstrated that colleagues felt they had knowledge of the MCA. An action plan was developed from this, and will be progressed in the coming months.
- In the year 2015/16 requests submitted for Deprivation of Liberty (DoLS) authorisation have risen to 201. This represents a substantial increase on 2014/15 (74 requests made) which demonstrates increased staff awareness of the MCA within the Trust. A database collates all DoLS requests. This is serviced by the MCA Support Worker, employed through additional funding.
- A quarterly report is provided to the Contact Quality Group (Rotherham Clinical Commissioning Group) to provide assurance that the Trust continues to work towards improved implementation of the MCA and DoLS agenda.

In line with the National Quality Board Safer Staffing guidance issued in November 2013 and the NICE guidance on Safe staffing levels from July 2014 each trust is contractually obliged to inform the board of nursing establishments on a 6 monthly basis, have visible staffing levels in place on wards for people to see, and submit information on nursing shift fill rates for each in patient area.

The trust currently has in place a process for collecting and submitting data on a monthly basis to inform the 'unify submission', a national data base which identifies how many nursing hours were planned, and how many were covered.

This is reported by the internet and the Quality Assurance Committee, a subcommittee of the board on a monthly basis. This is also supported by a narrative paper that triangulates this data with nursing metrics, vacancies, recruitment and any Red flag events.

Although there is no current guideline to support community nursing, the Trust also reports on community staffing planned hours. Establishments are reviewed every 6 months using the NICE accredited Safer Nursing Care Tool to ensure establishments reflect the acuity on the wards.

Trust objectives for the coming year are

- To ensure the Trust is providing safe levels of nursing care
- To ensure staffing and skill mix is reviewed to reflect the acuity of patients
- To provide safe and compassionate care across inpatients and the community

To achieve this, the Trust will continue to submit Information to the Unify national database and submit a report with a narrative and triangulation to the Quality Assurance Committee each month. The acuity of patients and appropriateness of nursing establishments are reviewed on a 6 monthly basis and reported to the board. A robust process supports the nursing establishment review involving ward managers, matrons, heads of nursing, the CNO team, HR and finance.

Safe Staffing levels are monitored by the Quality Assurance Committee and reported to the Trust Board.



Patient Experience

Improving Patient Experience of Complaints

Since last year's Quality Report was published the Trust has invested in a new post of Patient Experience and Complaints manager. This has been a part of a change in approach to managing complaints. Responsibility for the initial response to concerns now rests with each of the five clinical divisions

- % acknowledged within 3 working days upon receipt – standard 100%
- % Divisions to be informed of the complaint and provided with the complaints management plan within 3 working days of receipt – standard 100%
- % all complaints to be risk graded – standard 95%
- % of PHSO requests responded to in time –standard 95%

National NHS In-Patient survey overview

The 2015/16 survey conducted between September 2015 and January 2016. CQC will not publish data until May 2016 at the earliest

NHS In-Patient Survey: 2014/15 results

(published 21 May 2015)

This survey looked at the experiences of over 59,000 people who were admitted to an NHS hospital in 2014. Between September 2014 and January 2015, a questionnaire was sent to 850 recent inpatients at each trust. Responses were received from 338 patients at The Rotherham NHS Foundation Trust.

The emergency/A&E department (answered by emergency patients only)	8.5/10 About the same	
Information: for being given enough information on their condition and treatment in A&E	8.2/10	About the same
Privacy: for being given enough privacy when being examined or treated in A&E	8.8/10	About the same
Waiting lists and planned admissions (answered by those referred to hospital)		9.0/10 About the same
Waiting to be admitted: for feeling that they waited the right amount of time on the waiting list to be admitted	9.0/10	About the same
Changes to admission dates: for not having their admission date changed by the hospital	8.9/10	About the same
Transitions between services: that the specialist they saw in hospital had been given all the necessary information about their condition or illness from the person who referred them	9.1/10	About the same
Waiting to get to a bed on a ward		7.6/10 About the same
Waiting to get to a bed on a ward: for feeling they did not have to wait a long time to get to a bed on a ward, following their arrival at the hospital	7.6/10	About the same
The hospital and ward	7.8/10 About the same	
Single sex accommodation: for not having to share a sleeping area, such as a room or bay, with patients of the opposite sex	8.8/10	About the same
Single sex bathrooms: for not having to share a bathroom or shower area with patients of the opposite sex	7.8/10	About the same
Noise from other patients: for not being bothered by noise at night from other patients	5.5/10	About the same
Noise from staff: for not being bothered by noise at night from hospital staff	8.1/10	About the same
Cleanliness of rooms or wards: for describing the hospital room or wards as clean	8.7/10	About the same
Cleanliness of toilets and bathrooms: for describing the toilets and bathrooms as clean	8.3/10	About the same
Safety: for not feeling threatened by other patients or visitors during their hospital stay	9.6/10	About the same
Availability of hand-wash gels: for hand-wash gels being available for patients and visitors to use	9.3/10	About the same
Quality of food: for describing the hospital food as good	5.0/10	About the same
Choice of food: for having been offered a choice of food	8.2/10	About the same
Help with eating: for being given enough help from staff to eat their meals, if they needed this	6.8/10	About the same

Doctors	8.3/10 About the same	
Answers to questions: for doctors answering questions in a way they could understand	7.8/10	About the same
Confidence and trust: for having confidence and trust in the doctors treating them	8.6/10	About the same
Acknowledging patients: for doctors not talking in front of them, as if they weren't there	8.4/10	About the same
Nurses	8.2/10 About the same	
Answers to questions: for nurses answering questions in a way they could understand	8.3/10	About the same
Confidence and trust: for having confidence and trust in the nurses treating them	8.8/10	About the same
Acknowledging patients: for nurses not talking in front of them, as if they weren't there	8.8/10	About the same
Enough nurses: for feeling that there were enough nurses on duty to care for them	7.0/10	About the same
Care and treatment	7.6/10 About the same	
Avoiding confusion: For not being told one thing by a member of staff and something quite different by another	7.9/10	About the same
Involvement in decisions: for being involved as much as they wanted to be in decisions about their care and treatment	7.3/10	About the same
Confidence in decisions: for having confidence in decisions made about their condition or treatment	8.1/10	About the same
Information: for being given enough information on their condition and treatment	7.8/10	About the same
Talking about worries and fears: for finding someone on the hospital staff to talk to about any worries and fears, if needed	5.3/10	About the same
Emotional Support: for receiving enough emotional support, from hospital staff, if needed	7.1/10	About the same
Privacy for discussions: for being given enough privacy when discussing their condition or treatment	8.5/10	About the same
Privacy for examinations: for being given enough privacy when being examined or treated	9.6/10	About the same
Pain control: that hospital staff did all they could to help control their pain, if they were ever in pain	7.9/10	About the same
Getting help: for the call button being responded to quickly, when used	6.1/10	About the same
Operations and procedures (answered by patients who had an operation or procedure)	8.1/10 About the same	
Explanation of risks and benefits: before the operation or procedure, being given an explanation that they could understand about the risks and benefits	8.8/10	About the same
Explanation of operation: before the operation or procedure, being given an explanation of what would happen	8.5/10	About the same
Answers to questions: before the operation or procedure, having any questions answered in a way they could understand	8.4/10	About the same
Expectation after the operation: for being told how they could expect to feel after the operation or procedure	6.9/10	About the same
Information: for receiving an explanation they could understand from the anaesthetist or another member of staff about how they would be put to sleep or their pain controlled	8.6/10	About the same
After the operation: for being told how the operation or procedure had gone in a way they could understand	7.6/10	About the same

Leaving hospital	7.0/10 About the same
Involvement in decisions: for being involved in decisions about their discharge from hospital, if they wanted to be	6.8/10 About the same
Notice of discharge: for being given enough notice about when they were going to be discharged	7.0/10 About the same
Delays to discharge: for not being delayed on the day they were discharged from hospital	5.8/10 About the same
Length of Delay to discharge: for not being delayed for a long time	7.0/10 About the same
Advice after discharge: for being given written or printed information about what they should or should not do after leaving hospital	5.9/10 Worse
Purpose of medicines: for having the purpose of medicines explained to them in a way they could understand (those given medicines to take home)	8.0/10 About the same
Medication side effects: for being told about medication side effects to watch out for (those given medicines to take home)	4.9/10 About the same
Taking medication: for being told how to take medication in a way they could understand (those given medicines to take home)	7.9/10 About the same
Information about medicines: for being given clear written or printed information about medicines (those given medicines to take home)	7.8/10 About the same
Danger signals: for being told about any danger signals to watch for after going home	5.4/10 About the same
Home and family situation: for feeling staff considered their family and home situation when planning their discharge	6.9/10 About the same
Information for family or friends: for information being given to family or friends, about how to help care for them if needed	5.9/10 About the same
Contact: for being told who to contact if worried about their condition or treatment after leaving hospital	8.1/10 About the same
Equipment and adaptions in the home: for hospital staff discussing if any equipment, or home adaptions were needed when leaving hospital, if this was necessary	8.0/10 About the same
Health and social care services: for hospital staff discussing if any further health or social care services were needed when leaving hospital, if this was necessary	8.9/10 About the same
Overall views of care and services	5.1/10 Worse
Respect and dignity: for being treated with respect and dignity	8.7/10 About the same
Care from staff: for feeling that they were well looked after by hospital staff	8.6/10 About the same
Patients' views: during their hospital stay, being asked to give their views about the quality of care	1.3/10 Worse
Information about complaints: for seeing, or being given, any information explaining how to complain to the hospital about care received	1.8/10 Worse
Overall experience	7.9/10 About the same
Overall view of inpatient services: for feeling that overall they had a good experience	7.9/10 About the same

Table 28 NHS In-patient survey scores for the Trust 2015/16

As part of the Trusts response to the CQC inspection, posters and leaflets about 'How to complain' are made available in several languages. The Trust hopes that this, and the continued efforts through Friends and Family Tests, will improve the Trust score in 2016.

About these scores:

The CQC survey asks people to answer questions about different aspects of their care and treatment. Based on their responses, they gave each NHS trust a score out of 10 for each question (the higher the score the better). Each trust also receives a rating of 'Better', 'About the same' or 'Worse'.

- Better: the trust is better for that particular question compared to most other trusts that took part in the survey.
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

CQC do not provide a single overall rating for each NHS Trust. They say it would be misleading as trust performance will vary between the different elements of the survey.

Eliminating mixed-sex sleeping accommodation

The Trust estate now complies with the rules on mixed-sex sleeping accommodation and monitors for breaches of these rules as part of the QAC dashboard. In 2015/16 there was one breach which was subject to review with learning shared through Divisional Governance processes.

Reduction in Noise at Night

The Trust has shown an improvement in both measures on the In-patient survey for 2015. Disturbance relating to other patients has improved from 5.4 to 5.5/10 whilst disturbance caused by staff has risen from 7.5 to 8.1/10. The Chief Nurse leads on regular night time hospital and community visits. The levels of disturbance at night are monitored during these visits as is the extent to which nursing colleagues are positioned outside each bay in order to provide a quick response to patient need. Patients are consistently asked about disturbance in quality assurance walkabouts.

Improving Hospital food choice

The new catering contract has now been embedded into the ward routines; patients on all wards are now asked via the ward hostess the choice of food they would like approx. 2 hours before the meal time. Breakfast is chosen at the point of service. Food wastage has reduced since the introduction of the new process, with patients getting what they ordered. Snacks are offered twice a day between meals for those who require a little extra. Patients are consistently asked about food in quality assurance walkabouts; most responses are positive.

The 2015 inpatient survey scores suggest the need to offer help with eating more consistently, whilst the new approach to catering may be reflected in a better score for food quality.

Improving pain control across all clinical areas

Pain relief is a key aspect of patient care. Ineffective pain management has negative effects on a patient's physical and psychological recovery; effective pain management is also central to enhanced recovery and early discharge.

In the 2014 National In-patient Survey only 66% of patients felt that the Trust did everything possible to help control their pain. This result was similar to the 2013 result and lower than the national average of 75%.

So what has been done to address this?

- 1.** 'Intentional rounding' now involves assessing patients' pain hourly or two hourly, according to need.
- 2.** Nurse essential training includes pain management. In 2015 the Trust introduced separate sessions for medical nurses and surgical nurses, but to further increase attendance training has been extended to a whole day to include all aspects essential training. The wards will have 2 years in which to ensure all nurses attend.

3. In the last 12 months the In-patient Pain Team has introduced an epidural and local anaesthetic service for patients having Orthopaedic and Gynaecology surgery. This was initially a short term project for patients undergoing revision hip or knee replacement surgery, or bilateral hip or knee replacement surgery. This short term project identified that epidural analgesia significantly improved pain relief for these patients; 92% of patients reported an overall pain experience on no pain or mild pain in the first 48 hours post-surgery, and length of stay was reduced by at least 2 days. The service was made permanent from April 2015. In 2015 for all surgical epidurals: General surgery, Urology, Gynaecology and Orthopaedics, 93% of patients reported an overall experience of no pain or mild pain.

4. Patients with fractured ribs have significant pain. Patients admitted with fractured ribs to this hospital are mostly elderly patients who have had a fall. Inadequate pain management in these patients can have devastating consequences including chest infection, pneumonia and death. Several years ago the in-patient pain team in Rotherham Hospital developed a very clear pathway of care for patients with fractured ribs; this includes an early epidural and respiratory physiotherapy, which has resulted in excellent outcomes for patients.

In 2015 the Lead Clinician and Lead Specialist Nurse were invited to present the pathway nationally and regionally on several occasions resulting in this pathway being adopted by several trauma centres around the country.

In 2016 the Trust is improving this pathway further by working more closely with the respiratory physicians; patients requiring an epidural will continue to be nursed on surgical wards under a shared care arrangement but they will be seen by the respiratory physicians on a regular basis.

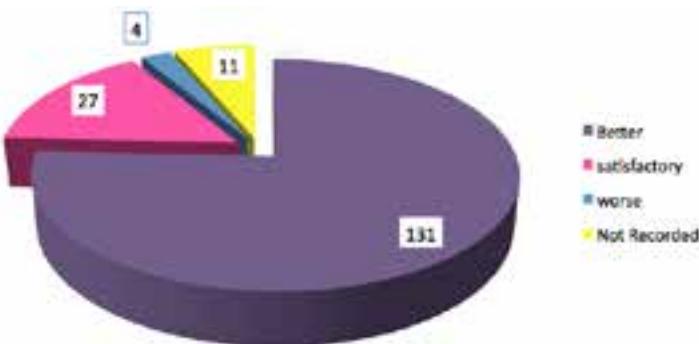
5. Pain assessment for patients with dementia. The in-patient pain team has used a tool for many years for assessing pain in patients with dementia. During 2015, with the help of the Dementia Specialist Nurse, this pain assessment tool became more widely used; this will improve pain management in this vulnerable group of patients.



Patient satisfaction Epidural Analgesia – All Surgical specialities including epidurals for fractured ribs: January to October 2015

93% epidurals were effective, patients rated their overall pain experience as no pain or mild pain for the duration of the epidural. Results were not recorded for 8 patients; these patients had dementia or were confused so unable to record.

Patient satisfaction with epidural pain relief



Safeguarding Vulnerable Service Users

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 Trust is committed to ensuring Safeguarding is an absolute priority and this is evidenced by an increased investment to appoint new team members into the Trust Safeguarding Team.

The Chief Nurse is the Trust's Executive Lead for safeguarding; she is supported by the Assistant Chief Nurse who manages the Safeguarding Vulnerabilities Team. This is now an integrated Team providing specialist input and advice regarding Adult and Children's safeguarding. The team are co-located in one office area to provide team support, flexibility, increased expertise and resilience. The Team now also includes a Lead Nurse for Dementia Care and a Lead Nurse for Learning Disabilities. These posts enhance support for vulnerable patients and together this part of the team leads on all safeguarding adult matters including the Mental Health Act and Deprivation of Liberty Safeguards.

In addition to the co-located team there are also safeguarding team members 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 CSE Nurse is based in the Evolve Team at Riverside which provides services for Child Sexual Exploitation cases.

In addition a Paediatric Liaison Nurse provides specialist input in relation to safeguarding and liaison with the Emergency Department, the Children's Ward and Community Services, including General Practitioners.

The Rotherham NHS Foundation Trust was inspected by the Care Quality Commission (CQC) as part of a wider inspection of the Rotherham Health and Social Care Economy in relation to Children Looked After and Safeguarding procedures and processes. Held between 23 and 27 February 2015, the inspection involved external assessors speaking with staff and service users, reviewing Trust policies and procedure and a review of care pathways.

Following the assessment a detailed action plan was developed and agreed by all agencies involved – The Rotherham NHS Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust, Rotherham Metropolitan Borough Council, Public Health, NHS England and the Rotherham Clinical Commissioning Group. The action plan identified 24 recommendations and to provide assurance of progress against all actions a challenge meeting was established for agencies to describe and provide evidence of achievement of actions.

Specific Trust services included in the review were Safeguarding, Family Health including School Nursing, Maternity, Paediatrics, Genital Urinary Medicine (GUM) and Contraceptive and Sexual Health Services (CASH), Children Looked after Services (LAC) and the Emergency Department. Throughout the last 12 months there has been significant progress on all actions. To provide further assurance, a review of services (a dip sample approach) has been undertaken in order to speak to colleagues and to test out if the changes are now embedded. The findings of this review were very positive.

The Safeguarding Training Strategy has been fully reviewed in line with National Intercollegiate Guidance. Training is mandatory for all Trust colleagues and is provided by a number of approaches including face to face, Safeguarding Information booklets and E-Learning.

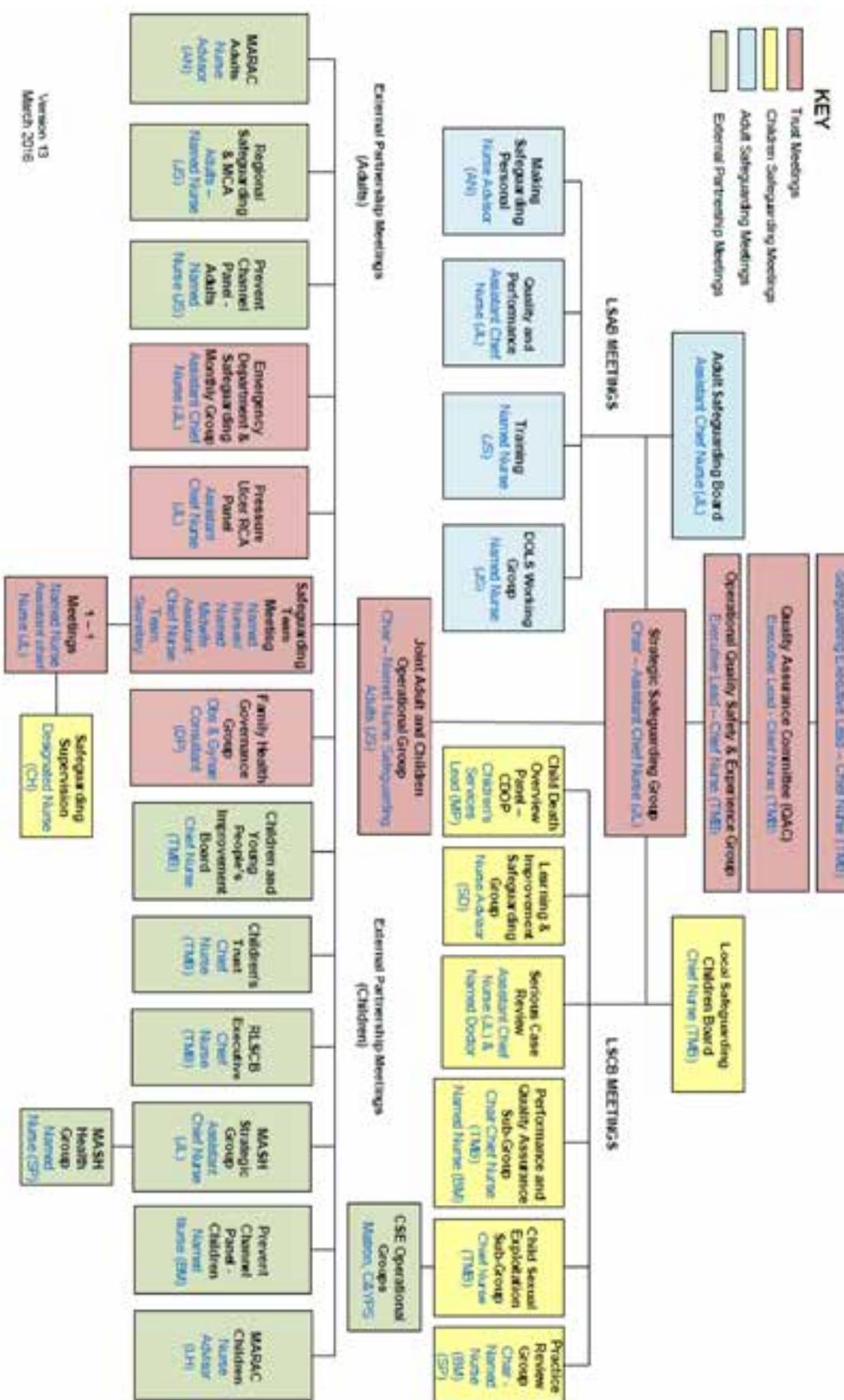
The Trust's Safeguarding Vulnerable Service Users Strategy is embedded in the organisation and key performance indicators against which safeguarding performance is monitored are in place and reported to the Quality Assurance Committee quarterly. In addition a number of safeguarding standards are in place and monitored externally via the Rotherham Clinical Commissioning Group and throughout this year all feedback on safeguarding performance has been really positive. 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.

“Left the appointment totally satisfied with the consultation and advice.”

**Friends and Family patient feedback
Orthopaedic Triage**

The organisational structure for safeguarding is shown in the chart below

How the Trust organises and participates in safeguarding



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 that has access to the MCISS (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).
- Achieve validation against the newly introduced National Macmillan Cancer Support 'Quality in Information and Support Services Standard, (MQUISS)'.

The MCISS in 2015 supported 1011 enquires. In the last 6 months of 2015 intervention from 1.0 WTE MCISS Specialist prevented the need for:

- 8 patient A&E visits
- 118 patient GP appointments
- 31 Consultant contacts
- 56 Nurse Specialist contacts
- 288 other contacts, such as with District Nursing or Social Care.



The MCISS endeavours to work in alliance with allied services from primary care, the Borough Council (RMBC), voluntary, charitable and statutory provider services, consulting them all in the work programme planning of the MCISS in order to foster a collaborative, effective approach that prevents duplication of services. 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 primary care/General Practitioner champions
- Future development of an extensive training programme
- Further development and roll out of Information Prescriptions
- Future development of outreach services in residential care homes in order to try to address the needs of the older population in Rotherham
- Current expansion and consolidation work to foster closer links and collaborative working practices with:
 - RDASH (Rotherham Doncaster and South Humber NHS Foundation Trust) for people with mental health needs
 - 'Speak UP' self-advocacy organisation to look at ways to address needs of people with learning disabilities
 - Rotherham Healthwatch
 - Voluntary Action Rotherham (VAR) through their social prescribing programme
 - Providing Outreach through Urology Services breaking bad news clinics for support to patients and carers in distress.
 - Collaborative working with Health Information Services and key stakeholders to deliver healthy living and cancer awareness campaigns to the local population.

The MCISS have developed Volunteer Services in 2015 and are proud to announce that one of their Volunteers was awarded 'The Rotherham NHS Foundation Hospital Trust Proud Volunteer of the year award'. In addition, the whole MCISS Volunteers as a team were placed as 3rd runners up.

“Everybody working on this ward was very helpful and jolly. They couldn't do enough for you. Thanks to all the staff on CCU ward.”

**Friends and Family patient feedback
Coronary Care Unit**

Patient-led assessments of the care environment

(PLACE) 2015

The 2015 PLACE assessment was conducted with 8 members of the trust, 6 public governors and two members of Healthwatch. They were split into teams of 4 and assessed various areas of the Trust. Whilst there was some reduction from the previous year's scores in some of the sections, there was also a change to some of the questions asked and the recording categories so it is difficult to compare. This year's assessment will continue to involve public governors, Healthwatch and Trust staff.

Trust results 2015	Cleanliness	Food	Food (Organisational)	Ward Food	Privacy Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia
Breathing Space	95.77%	86.48%	85.76%	87.29%	79.73%	93.16%	69.56%
Hospital	96.66%	79.95%	86.84%	78.73%	75.86%	84.78%	59.33%

Table 29 PLACE scores for the Trust (data source: HSCIC)





Clinical Effectiveness

National Waiting Time Targets [source: HSCIC]

The Trust is expected to comply with four national targets for waiting times, covering Cancer, Access, 18 and 52 week referral to treatment time.

Cancer National Waiting Times

What was our goal?

Achieve all cancer national waiting times

Did we achieve this? Yes

Performance against all cancer waiting time standards has been good throughout the year. The report will be updated once the final year-end figures are validated but there are currently no concerns about maintaining this performance to year end.

Table 30 shows the year-end position on cancer waiting time targets in 2015/16 compared with 2014/15.

Metric	Target	TRFT Year end 2014/15	TRFT Year end 2015/16
Cancer 2 week wait from referral to date first seen, all urgent referrals	93%	94.90%	95.12%
Cancer 2 week wait from referral to date first seen, symptomatic breast patients	93%	94.70%	97.43%
Cancer 31 day wait from decision to treat to first treatment	96%	99.40%	98.82%
Cancer 31 day wait for 2nd or subsequent treatment - surgery	94%	100%	98.67%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100.00%
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	92.70%	88.46%
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	100%	98.20%
Consultant Upgrade	TBC	n/a	94.72%

Table 30 Trust performance against national waiting times for cancer services 2014/15 and 2015/16

I have been very poorly while I was on HDU department. I was very well looked after and cared for at all times by every member of staff, from the cleaners to the consultants.

**Friends and Family patient feedback
High Dependency Unit**

All the doctors nurses and other staff were really good to me so kind and caring. A big thank you to them all especially on Ward B1.

**Friends and Family patient feedback
Fitzwilliam Ward**

Improving access: The A&E four hour waiting time target

What was our goal?

To achieve the A&E 4 hour waiting target (at least 95% of patients attending A&E are admitted, transferred or discharged within 4 hours).

Did we achieve this? No

The year-end position is 90.59% (target 95%). In line with the picture of pressures on Emergency Departments (ED) which has emerged across the country, performance against the four hour operational standard has been challenging. The Trust has seen a continuing increase in acuity of patient attendances at ED which is reflected in the increased non-elective admission rate. Many of these admissions have been frail, elderly patients with complex care needs. As a result, the discharge rates have been low and have struggled to keep pace with the admission rate. Length of stay has therefore also subsequently increased as many patients are requiring complex discharge planning. The Trust has opened additional surge beds to manage this increased demand for bed capacity.

The Trust has taken steps to manage and improve performance, recognising that overcrowding in A&E can be improved by managing demand, ensuring clinically efficient processes in emergency care and improving patient flow across the whole hospital. By adopting the SAFER care bundle, the Trust is committing to ensure that all patients:

- Have a senior review (preferably by a Consultant) before midday, every day.
- Are given an Expected Discharge Date as soon as it is clinically appropriate to do so.
- Shall be identified for discharge by 10am where appropriate, with 33% leaving the ward by midday.
- Will have discharge prescriptions (TTOs) with Pharmacy by 3pm the day before discharge whenever possible
- Will have their care reviewed by a senior clinician if their admission exceeds 14 days.

Over the last year the Trust has consolidated its Site Co-ordination process that oversees safe patient movement and manages in-patient capacity. Some of the key actions being undertaken include: management of complex long stay patients, revised ward-based MDT reviews twice daily, co-ordination of admissions and discharges at a detailed level and effective co-ordination of all the external capacity available to the Trust.

What was our goal?

To achieve the 18 week referral to treatment target.

Did we achieve this goal? Partially

Targets for the percentage of patients receiving treatment within 18 weeks from the point of referral have been consistently met throughout the year (table 32).

Within one specialty, Trauma and Orthopaedics, an improvement programme is underway as this target has not consistently been met, however while the focus will be on ensuring improvement in this single area, the target for the Trust overall has been achieved. The Board will continue to monitor performance against targets via the monthly Integrated Performance Report which is presented to the Board by the Chief Executive and the Chief Operating Officer.

What was our goal?

To achieve 52 week referral to treatment target

Did we achieve this goal? No

The steps taken following the breach of this target in 2015/16 have been partially successful in reducing such episodes

“Patient care was excellent, nothing was too much trouble. Staff warm and friendly. The nurses and doctors work very hard, they are under pressure at times but still complete their task.”

**Friends and Family patient feedback
Keppel Orthopaedic Ward**

% of A&E attendances seen within maximum waiting time of 4 hours from arrival to admission / transfer/ discharge													
TRFT	YTD	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
>=95%	90.59%	93.72%	97.42%	96.97%	93.65%	88.63%	93.93%	92.47%	93.67%	85.53%	88.45%	85.83%	77.41%

Table 31 Trust A&E waiting times – percentage against 4hour standard

TRFT	YTD	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
% of Admitted patients waiting less than 18 weeks from point of referral to treatment													
>=90%	92%	93.00%	95.00%	94.00%	95.00%	94.00%	92.00%	92.00%	90.00%	92.32%	90.00%	88.00%	86.00%
% of Non Admitted patients waiting less than 18 weeks from point of referral to treatment													
>=95%	98%	99.00%	99.00%	98.00%	98.00%	97.00%	98.00%	97.00%	97.00%	97.85%	96.00%	97.00%	97.00%
% of patients waiting less than 18 weeks from point of referral to treatment on incomplete pathways													
>=92%	96%	96.00%	97.00%	97.00%	96.00%	95.00%	96.00%	96.00%	96.00%	96.00%	97.00%	96.00%	94.00%

Table 32 Percentage against 18 week RTT target

Number of patients waiting more than 52 weeks on a Referral to Treatment Pathway.													
Target	YTD	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
0	2	1	0	0	0	0	0	0	0	0	0	1	0

Table 33 Percentage waiting against 52 RTT week target.

(One identified in February and closed in March, four identified in March and closed in March and therefore not reported as ‘clock stops’, not as “waiting”.)





Community Services: Investment, Change and Improvement

Significant changes to community services are due in the next 12 months. It can be a struggle to find the right bed in hospital at the right time, that patients often stay too long and that, whenever safe to do so, people often prefer to recover in their own homes.

Clinicians and agencies also need to share information more effectively and manage the resources available as efficiently as possible.

The Trust has therefore promised to deliver a new experience for patients based on integrating hospital, community and home-based care. Better links between colleagues, grouped together in locality multi-disciplinary teams will mean better communication, lower (more appropriate) workloads delivered by the most appropriate service which will lead to improved quality of care.

A partnership between Hospital Services, Community Services, Primary Care (including GPs), the Ambulance service, Social Care and Voluntary Organisations will aim to

- Avoid admission where people can be managed safely in their own home
- Support people to return home from hospital as soon as it's safe to do so
- Reduce length of stay in hospitals (and other care settings)
- Ensure patients are cared for in the most appropriate setting (including their own homes)
- Use technology to deliver specialist support to patients and professionals in the community
- Improve care pathways such as End-of-Life care
- Deliver holistic care for patients within their own homes
- Improve Patient Satisfaction
- Strengthen partnership working

- “** 1) Check, double check, triple checks prior to operation.
2) Care during operation was very good.
3) Felt I was a person and not a number **”**

**Friends and Family patient feedback
Sitwell Ward**

The Trust believes it can deliver because:

- There are Acute and Community services in one trust already
- There are strong partnerships across Rotherham
- Colleagues are committed to making the change and developing new ways of working
- There are already 7-day services in operation
- The Trust has successfully implemented the new Localities Structure required by the GPs, which in turn has strengthened partnership working with GP Practices

Our achievements in 2015/16

- Successful implementation of Locality Lead nurse role, which has strengthened leadership across community teams and has contributed to reduced sickness rates and improved recruitment and retention.
- Strengthened governance arrangements, with robust governance and performance meetings, regular review of quality metrics e.g. risks, incidents, complaints. Locality Leads populate the Community KPI dashboard on a monthly basis, enabling the senior management team to identify any localities not achieving the target performance.
- Introducing monthly newsletters and increased use of Twitter to communicate with the public and colleagues.
- A cohort of senior community nurses have successfully completed clinical supervision training & will be delivering a programme of clinical supervision within each locality. They will also be acting as supervisor of the day within community teams to mirror the in-patient model.
- Weekly staffing ‘Huddles’ and review meetings held in community bases to increase visibility of community managers/leaders.
- Team brief in community to increase engagement of community staff and increase visibility of exec team.
- Detailed Skills Matrix and in depth training plan, strengthened by community MAST days, delivery of Trust essential training and e-learning support in community bases (advanced communication skills).
- Dedicated quality assurance walkabout in community teams.
- Successful staff nurse development programme and secondment to specialist practitioner programme (district nursing).
- Security increased for lone workers out of hours with new ‘buddy’ system.

The Trust will build on this progress with plans for 2016/17:

- Implementation of Integrated Rapid Response Service, co-location and integration of 5 core teams to deliver nursing services aimed at improving the discharge process & reducing unnecessary hospital admissions.
- A new Community Drug Kardex to be rolled out.
- Develop a discharge referral pathway for hospital colleagues to use when discharging patients with palliative care needs or for patients who are near the end of their life.
- Development of a Long Term Conditions Education Programme to support career advancement for community nurses who would like to develop a specialist community nursing role.
- Community specialist nurses continue to develop innovative ways of working with the new Telehealth Heart Failure Nurse post. This post will support patients in managing their own conditions & will improve the patient experience.

The new integrated Emergency Centre (ready in 2017) will be a hub for matching patients to need, making sure they are seen by the right colleagues as quickly as practicable.



Listening into Action



3.5

Changing Culture: engaging and developing colleagues

Safe Staffing

The Trust wants to ensure that it provides safe and compassionate care in hospital and the community. To achieve there have to be safe levels of nursing care, ensuring that staffing levels and skill mix are reviewed to reflect the changing needs of patients.

In line with the National Quality Board Safer Staffing guidance issued in November 2013 and the NICE guidance on safe staffing levels each trust has, since July 2014, been contractually obliged to inform the Trust Board of nursing establishments every 6 months. Information about staffing levels is displayed on each ward.

The Trust also submits data on nursing shift 'fill rates' for each in-patient area, collecting and submitting data on a monthly basis to inform the unify submission, a national data base which identifies how many nursing hours were planned and how many were actually covered.

This is reported both to NHS England and the Operational Quality, Safety, Experience Group each month. This is also supported by a paper that brings together this data with nursing metrics, vacancies, recruitment and any Red flag events, providing the Trust with a comprehensive view of current performance and potential risks.

Although there is no current requirement to collect such data for community nursing, there is a similar system to support planning and safe staffing throughout the Trust as a whole.

Numbers of nurses and skill mix are reviewed every 6 months using the NICE accredited SAFER Nursing Care Tool to ensure establishments reflect the level of need on the wards. Ensuring there are sufficient colleagues of the appropriate grades is fundamental to recruiting, retaining and developing the workforce.



Staff engagement

In order to fulfil the ambition to be an employer of choice and having 'engaged, accountable colleagues', in line with the People Strategy, there is a need to develop a culture built on engagement. In order to achieve this engagement the Trust needs to:

- Ensure it's a really great place to work (employer of choice)
- Listen to colleagues and support them to make decisions
- Develop colleagues to be the best they can be
- Support colleagues to face challenges together

Colleagues are at the heart of everything the Trust does and they have the greatest influence on patient experience. A happy workforce creates satisfied patients and an environment that enables and empowers people to contribute their fullest to delivering excellent services.

A number of initiatives are in place for enabling staff feedback:

The **Staff Survey** is an annual requirement for all NHS Trusts. Colleagues are asked a number of key questions and the results are then compared nationally. The Trust utilises this information to make changes to improve the working lives of colleagues.

Every quarter the **Friends and Family Test** model is used to survey colleagues to determine how likely they are to recommend us as a place to work and as a place to receive treatment. This is done through a variety of online and paper based surveys and the results are used to support improvements.

The Trust has now entered its second year of implementing the Listening into Action (LiA) national programme for improving staff engagement. LiA aims to fundamentally shift the way teams work by empowering colleagues to further enhance patient care. Year 2 has focused on 10 clinically led work streams, aligned to the Trust's strategic and transformation agenda.

In addition, four further executive led LiA engagement sessions have identified key areas of work needed to 'unblock' operational and process issues that impact on the ability of colleagues to efficiently execute activities that ultimately impact on the quality of care delivery.

There are 10 teams running clinically led work streams. Each team has clinical and managerial leaders, supported by a dedicated LiA sponsor group. This group is further engaged with the executive directors. The 10 LiA teams have engaged with colleagues from across the Trust to identify a variety of actions to improve care delivery and process:

1. Acute Medical Unit: Increase bed base, improve frail elderly/ambulatory care
2. 24/7 Teletracking: Further develop clinical prioritisation and patient flow
3. Hydration and Nutrition: Increase knowledge, skills and application of good nutrition and hydration of patients and high risk patients
4. Acute Kidney Injury: increase easy identification of AKI and development of care bundle to support effective management and communication of care needs
5. End of Life Care: To maximise early referral to community services and tailor specialised referral
6. Theatre Utilisation: To further improve utilisation and care pathways
7. Intermediate Care Beds: To develop timely discharge pathways
8. Inappropriate Patient Moves: Reduction in bed moves - none after 21:00
9. Deteriorating Patients: Increase multidisciplinary identification of ill patients and active treatment
10. Domestic Service Review: Freeing clinical time to care through revision of Trust cleaning regimes

Each of these teams have held their Trust wide listening events, engaging with the workforce to surface ideas and promote inclusivity in driving and delivering change to improve patient experiences of care. The only exception was team 8 - 'Inappropriate Patient Moves'. This piece of work was superseded by a dedicated piece of work undertaken by the Chief Nurse, detailed in the implementation of Nursing and Midwifery Standards of Professional Leadership for all In-Patient Environments (Night-time).

Through the LiA network the Trust was privileged and proud to welcome Dr Kate Granger, founder of the #hellomynameis campaign, who endorsed the Trust's approach to production of a sign language video of colleagues signing their names.

This national campaign has been adopted by the Trust recognising the importance of a personal introduction and its impact on patient care and the work of identifying the next cycle of LiA clinically led teams is underway.

The success of this year's work streams was celebrated at the Trust LiA 'Pass It on Event' in April 2016. This will be built on in year 2 as part of the wider staff engagement ambition.

The outcomes from these feedback methods are, where appropriate shared through the relevant communication channels.

Progress is monitored using the LiA Pulse Check questionnaire [see Appendix Four]

Team Brief is a monthly opportunity for all colleagues to find out more about the Trust's priorities and progress. Sessions are hosted by the Chief Executive, Louise Barnett, along with members of the executive team and take place on the Wednesday following the Trust's monthly board meeting. Board meetings take place on the last Tuesday of each month.

Dear Louise is a way for colleagues to write directly to the Chief Executive about anything - comments, compliments or concerns. Colleagues simply click on the 'Dear Louise' button on the Trust intranet, type in the text box and send.

The outcomes from all these feedback methods are, where appropriate shared through the relevant communication channels.

Patient Safety Mentoring

The Chief Nurse commissioned a development opportunity aimed at band 6 patient safety nurse to offer them personal development through action learning sets (ALS). Between February 2015 and February 2016 21 sets were delivered for colleagues. Three groups, each with 6-8 members, worked through a series of topics including:

- Root cause analysis
- Using information
- Utilising Datix
- Delivering Change

Each colleague delivered a personal project; amongst the subjects chosen were:

- Improving medicines management
- Staff engagement
- Learning from incidents
- Improving the delivery of patient care

Feedback to the Chief Executive and Chief Nurse was well received.



NHS Staff Survey: Future Priorities and Targets

The results of the 2015 survey demonstrate some improvement for the Trust on last year's scores although there appears to have also been a positive shift in scores nationally which has resulted in some previous top 20% scores dropping to 'better than average'. There are many opportunities within the Trust for further improvements.

Key Themes for action:

- 1.** Staff satisfaction and motivation at work are consistently lower than the national average, although engagement scores have seen an increase over the last 2 years.
- 2.** Only 88% of respondents agree their role makes a difference to patients.
- 3.** Colleagues report that communication between senior managers and staff needs improvement; further action should and can be taken on highlighting the mechanisms already in place and working, to ensure that senior management are more visible across work areas.
- 4.** Despite having above average scores for appraisal, the quality of the process scores below average. Further work will be undertaken to promote the learning packages for appraisals and ensure learning needs are clearly identified.

Table 34 NHS 2015 Staff Survey results

	2015/16		2014/15		Trust Improvement / Deterioration
Response rate	Trust	National Average	Trust	National Average	+/-
42%	42%	42%	44%	42%	-2%
	2015/16		2014/15		Trust Improvement / Deterioration
Top 5 Ranking Scores	Trust	National Average	Trust	National Average	+/-
Percentage of staff appraised in the last 12 months	94%	86%	95%	85%	-1%
Percentage of staff witnessing potentially harmful errors, near misses or incidents	24%	29%	28%	34%	-4%
Percentage of staff working extra hours	68%	72%	67%	71%	+1%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public	24%	27%	25%	29%	-1%
Percentage of staff experiencing discrimination at work in the last 12 months	7%	10%	8%	11%	-1%
	2015/16		2014/15		Trust Improvement / Deterioration
Bottom 5 Ranking Scores	Trust	National Average	Trust	National Average	+/-
Percentage of staff/colleagues reporting most recent experience of bullying or abuse	20%	38%	40%	38%	-20%
Percentage of staff agreeing that their role makes a difference to patients/service users	88%	91%	86%	91%	+2%
Staff motivation at work*	3.80	3.92	3.68	3.86	+2.2
Percentage of staff reporting good communication between senior management and staff	24%	30%	25%	30%	-1%
Staff recommendation of the organisation as a place to work or receive treatment.*	3.52	3.71	3.42	3.67	+0.1

- 5.** Errors and Incidents score below average in the majority of key factors within this area. There has also been a significant decrease in those reporting their most recent experience of bullying Harassment or abuse (from 40% in 2014 to 20% in 2015).

The Trust will now review the staff survey process, using the existing Listening into Action programme to improve responsiveness to the survey and engage colleagues more effectively in learning and change.

The Trust is obliged to survey a sample of a minimum of 850 of its employees (about 20% of staff); however in 2015 it conducted a full census of all eligible employees. 3,953 staff were eligible to complete the survey and a 42% response rate was achieved. This was 2% lower than the previous year's score but 4% higher than the average response rate for all acute trusts.

For 2016/17 key themes will be identified and tangible actions utilising the Listening into Action methodology will be generated and planned for action. This helps ensure effective prioritisation and enables those at the heart of the required changes to be involved and empowered to take action.

(*These figures (below) are not expressed as a percentage. They are an amalgamation of two or more standards and represent a numerical scale with 1 being very poor and 5 being excellent.)

In response to the survey feedback key themes have been identified and will form topic areas which will be facilitated through Listening into Action methodology. The areas of action identified will be prioritised over the next 2 years. A sample of staff will be surveyed in 2016/17 in order to benchmark activity and outcomes. The results from this will be used to refocused and steer further actions.

In addition to this any divisional hotspots will be identified; any areas not identified in the trust themes will be worked on through a targeted divisional action plan.

The progress made through Listening into Action work streams will be monitored at board level via the Strategic Workforce Committee.

NHS Improvement has asked all Trusts to comment on progress relating to two of the Key Factors in the national staff survey:

● KF 26: Percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months

The Trust has a robust policy supported by training for managers in how to respond effectively with bullying. There are Freedom to Speak Up guardians in place who act as an advocate for any employee with concerns and a confidential hotline where colleagues can obtain support and advice. Trained mediators are available to support colleagues and resolve bullying and harassment issues. During 2016/17 The Trust will complete a review of policy and procedures, moving towards an approach based on mediation and de-escalation.

● KF 21: percentage believing that Trust provides equal opportunities for career progression or promotion

The Trust utilises the NHS Jobs system for all its recruitment activity. The system ensures that candidate's personal data is kept separate when shortlisting. The Trust is currently working on improving the quality of data reporting as part of an on-going commitment to Equality and Diversity within the Trust. As of 30/03/2016, 79% of staff had completed the Equality and Diversity mandatory training module compared with 72.62% in 2014/15.

Further detail on the Trust's staff survey results can be seen in Appendix Five

Table 35a KF 26 result from 2015 Staff Survey

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

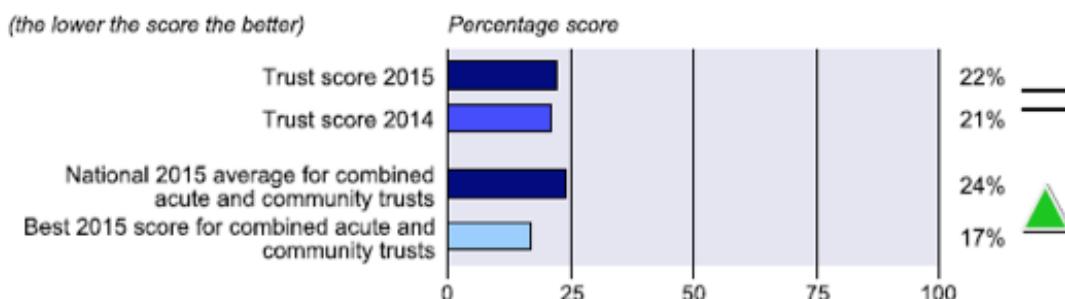


Table 35b KF 21 result from 2015 Staff Survey

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



Personal Development Review and Appraisal

Colleagues have their annual PDR between April and June each year. Training sessions on how to deliver a good quality PDR are currently taking place through to the end of May, alongside training sessions on how to input a PDR via manager Self Service.

At the start of the 2016 3-month cycle, PDR compliance stands at 74.22%.

Delivering Mandatory and Statutory Training

MaST training continues to evolve in delivery methodology and topics being delivered to ensure the staff have the right skills and knowledge to deliver excellent patient care.

A project team have been working in the ESR Oracle Learning Management System (OLM) to align the correct competencies colleagues require to deliver safe care, against their job roles.

This has been especially relevant to children's and adult's safeguarding training, where additional staff groups have now been assigned these topics as a competency requirement. Due to the realignment of competencies there has been a drop in compliance levels as more people are now required to achieve higher level competencies.

The core MaST topics can be seen in table 36 and show a 12.05% overall improvement in compliance from 55.94 to 67.99% over the past 12 months.

Both *Dementia Awareness* and *Prevent* have three year targets of obtaining 100% compliance and both are well ahead of trajectory at year-end.

MAST Competency	% Compliance 2014/15	%Compliance 2015/16 (at date of reporting)	Change
Conflict Resolution	67.43	79.13	+ 11.7
Equality & Diversity	72.62	78.31	+5.69
Fire	61.25	72.72	+11.47
Information Governance	67.28	86.83	+19.35
Display Screen Equipment	57.99	66.11	+8.12
Moving & Handling (All levels)	47.40	55.44	+8.04
Adult Safeguarding (All levels)	58.83	51.48	-7.35
Child Safeguarding (All levels)	69.80	64.56	-5.24
PREVENT Anti-Terrorism	40.62	66.97	+26.35
Dementia Awareness	16.54	69.61	+53.07
Total	55.94	69.09	+ 13.16

Table 36: Take up of core MaST topics

Employee Sickness Rates

Average sickness for short and long term in the Trust is 4.44% for 2015/16

As part of the workforce strategy, the Trust has adopted targets in relation to sickness rates: The aim is to have overall sickness absence at or below 4% by December 2016 and at 3.5% by December 2017



Table 37 Sickness absence rate for 2015/16

Recognising the contribution of colleagues at The Rotherham NHS Foundation Trust

For over five years, the Trust's annual PROUD Awards has provided a great opportunity to highlight, recognise and thank exceptional individuals and teams within the organisation who have made a really positive contribution to delivering high quality care to patients.

In 2014, the Trust was delighted to introduce a new Public Recognition Award. The Public Recognition Award provides a fantastic opportunity for members of the public to nominate individuals and/or teams who have made a real difference.

Members of the public are invited and encouraged to nominate health care professionals and/or support staff who they have found to have delivered exceptional services to patients, their families, friends and loved ones.

At the annual Awards ceremony, winners and runners up are recognised in over 20 categories and a Chief Executive's Award and a Chairman's Award are presented.

Over 330 nominations were received this year – 170 of these coming in from patients or members of the public. At the 2015 ceremony, 31 Awards were given out across 21 categories and almost 200 colleagues attended which brought laughter, success stories, tears and cheers as colleagues took to the stage to collect their awards. Those who attended the event commented on how uplifting it was to mark the successes of those who work tirelessly for their patients.

Colleagues are encouraged to take the positivity and buzz from the awards back to their departments to further boost morale and to once again congratulate their workmates for all they do to ensure they provide excellent healthcare.



“I can recommend this ward to one and all. They are good service all round.”

**Friends and Family patient feedback
Stroke Unit**

“Very caring staff, well organised very good patient care. Could not have asked for better care. Thank you all. Special thanks to Natalie (Staff nurse) what a star!”

**Friends and Family patient feedback
Ward A1**

These are the truly deserving 2015 PROUD Award winners:

Excellence in healthcare Award:

Clare Storer Obstetrics & Gynaecology AND Jennifer Fairbanks, Rotherham Stroke Pathway

Engaged accountable colleagues Award:

Winners: The Employee Relations Advisory Team, Human Resources
Runners Up: Mary Dougan, Office of the Chief Nurse

Trusted open governance Award:

Fiona Middleton, Patient Safety and Risk

Strong financial foundations Award:

June Cadman, Estates & Facilities

Securing the future together Award:

Christine Coulson, X-ray

Right first time Award:

Trevor Pilling, Podiatry & Orthotics

Responsible Award:

Clare Hutchinson, Community Occupational Therapy

Together Award:

Theresa Woodward, Maternity & Sexual Health

Respect Award:

Kristy Rodgers, Alcohol Liaison Service

Safe Award:

Kath Dannatt, Ward A7

Compassion Award:

Jean Williams, Orthopaedic Unit and Susan Nuttall, Domiciliary Neuro Physiotherapy

Most Accomplished Learner Award

Tasmin Jackson, Outpatients

Outstanding Volunteer Award

Winner: Ann Ashton, Macmillan Cancer Information and Support Service
Runner up: Gwen Brailey, Volunteer Service and RVS

Unsung Hero Award

Winner: Medical Records Library Team, Medical Records
Runner up: Rodrigo Baeza, HCA Theatres (Orthopaedics)

Partnership Working Award

Alison Thorp, Voluntary Action Rotherham

Our Top Leader Award

Winner: Ranee Townsend, Community Dental Services
Runner up: Tammy Hayward, Day Surgery

Team of the Year Award

Winners: Ward A6 / PIU Team
Runners up: Therapy Team, In-patient Orthopaedics Therapy Services and A7 Nursing Team, Ward A7

Public Recognition Award

Winner: Rachael Kay, District Nursing, Thurcroft
Runners Up: Angela Morris, Scarborough Suite and Breast Care Nurses, Macmillan Breast Care

Chief Executive's Award

Adult Community Nursing

Chairman's Award

Andrew Jackson, Vascular Access

Lifetime Achievement Award

Julie D'Silva, Endoscopy Unit and Dr Peter Taylor, Photopheresis

Alongside the PROUD awards, in November 2015 the Trust hosted its first ever PROUD week of celebrations including a graduation ceremony to celebrate the work of Health Care Assistant Apprentices, the Long Service Awards for colleagues completing 40 years' of service and the first ever Recognition of Learning Awards, which celebrated the ownership and dedication that colleagues have shown to their own or others' learning and development.

Finally, in November 2015, the Trust also introduced the new 'thank you card' scheme enabling staff to send colleagues an 'e-card', including their own special thank you message! Colleagues at the Trust really engaged with this process resulting in over 750 cards being sent in the first week.

The Trust continues to share positive news with colleagues via a week 'proud' e-newsletter which enables us to share and celebrate the achievements of colleagues all year round.





Summary data

National and local priorities and regulatory requirements: Summary data

The Trust is assessed through the submission of data against a set of national priorities. Table 38 provides data on performance against this range of quality metrics. All data is as at end February 2016 apart from the readmissions and VTE Data which are as at end January, and the cancer targets which are as at end December.

Table 38: summarises the local priorities for 2015/16 and whether the Trust is continuing to monitor them in 2016/17

Measure	DOH*	NHS Improvements	2014/2015		2015/16	
			Year end Position	National Target	Year end Position	National Target
Number of cases - Clostridium Difficile Infection (Cdiff)	x	x	31 cases	24 cases	19 cases	26 cases
Number of cases - MRSA Bacteraemia	x	x	0 cases	0 cases	0 cases	0 cases
Delayed transfers of care	x	x	3.12%	3.5%	3.41%	3.5%
Infant health & inequalities: breastfeeding initiation	x	x	59.71%	66%	60.52%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	97.58%	95%	97.30%	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	94.48%	90%	92.30%	90%
Non - Admitted	x	x	98.99%	95%	97.90%	95%
Incomplete	x	x	97.18%	92.0%	96.20%	92.0%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	0.17%	less than 1%	0.4%	Less than 1%
Patients waiting less than 4 hours A&E	x	x	93.07%	95%	90.59%	95%
Cancelled operations for non-medical reasons	x		0.66%	0.8%	0.8%	0.8%
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		91.07%	90%	89.6%	90%
Patients who spend at least 90% of their time on a stroke unit	x		78.82%	80%	86.1%	80%
Higher risk TIA cases who are scanned and treated within 24 hours	x		82.95%	60%	90%	60%
Elective Adult patients readmitted to hospital within 30 days of discharge from hospital	x		4.75%	6%	5%	6%
Non Elective Adult patients readmitted to hospital within 30 days of discharge from hospital	x		13.15%	11.50%	13.24%	11.5%
* Elective patients 0-15 years readmitted to hospital within 28 days of discharge from hospital	x		2.40%	3%	0.5%	3%
*Elective patients >16 readmitted to hospital within 28 days of discharge from hospital	x		1.40%	3%	2.6%	3%
*Non-Elective 0-15 years patients readmitted to hospital within 28 days of discharge from hospital	x		8.50%	10.40%	8.7%	10.40%
*Non-elective>16years patients readmitted to hospital within 28 days of discharge from hospital	x		10.00%	12.50%	9.8%	12.5%
Ensuring patients have a positive experience of care (Pt survey overall score)	x	x		10	7.9	10
Community care data completeness - activity information completeness		x	100%	100%	100%	100%
Community care data completeness - patient identifier information completeness		x	100%	100%	100%	100%
Community care data completeness - End of life patients deaths at home information completeness		x	100%	100%	100%	100%

Measure	DOH*	NHS Improvements	2014/2015		2015/16	
			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	x	100%	98.0%	100%	98.0%
Surgery	x	x	100%	94.0%	98.70%	94.0%
Radiotherapy	x	x	N/A	94.0%	N/A	94.0%
62-Day Wait For First Treatment (All cancers)						
Patients treated within two months of consultant upgrade	x	x	97.0%	TBC	Awaiting data	TBC
From Screening Service Referral	x	x	96.4%	90.0%	98.20%	90%
Urgent GP Referral	x	x	92.7%	85.0%	88.50%	85%
31-Day Wait For First Treatment (Diagnosis To Treatment)						
All cancers	x	x	99.10%	96.0%	98.80%	96%
Two week wait from referral to date first seen						
All cancers (%)		x	94.14%	93.0%	95.10%	93%
For symptomatic breast patients (cancer not initially suspected)		x	95.03%	93.0%	97.40%	93%
Health visitor numbers against plan	x		56	54 wte	65.48	54 wte

Table 38: Summary of Trust performance against national priorities

“The staff on this ward treated me with dignity and respect. They keep me well informed what was going on all the time I was on the ward. I would not hesitate in recommending the ward to anybody. They're all very friendly. **”**

**Friends and Family patient feedback
Coronary Care Unit**

“I was seen quick, lovely doctor. explained it all really good so i could understand. **”**

**Friends and Family patient feedback
A&E**

“All staff on SAU and B5 have all been lovely. I felt that I have been looked after by caring, professional staff. Thank you Ral, you are a lovely caring nurse. **”**

**Friends and Family patient feedback
Ward B5**

¹⁹ Appendix 3 provides the most recent HSCIC data for readmissions within 28 days. This is included for reference although not current data.

Table 39 summarises the priority indicators for 2015/16 and whether the Trust is continuing to report on them in 2016/17.

Domain	ID	Indicator Name	Rationale for Monitoring	Continued focus 2016/17?
Patient safety	PS_1	Achieve zero 'Never events'	Important measure of patient safety; zero target not achieved in 2015/16	Yes
	PS_2	Rate of patient safety incidents per 1000 bed days	Reflects an effective 'no blame, low threshold', reporting culture	Yes
	PS_3	Percentage of patient safety incidents resulting in severe harm or death	Reflects an effective 'no blame, low threshold', reporting culture and harm free care (Sign up to Safety; NHS Safety Thermometer)	Yes
	PS_4a	Number of patients with c-difficile	Continuing infection Control surveillance	Yes
	PS_4b	Number of patients with MRSA bacteraemia	Continuing infection Control surveillance	Yes
Patient Experience	PE_1	Increasing our responsiveness to patient's needs using a composite indicator of care (from April 2011 baseline)	Links to 'caring' objectives/continuing Trust requirement	No, superseded by Friends and Family Test
	PE_2	Increase in the number of patients assessed using the MUST nutritional tool	Important safety metric	Yes
	PE_3	Complaints response times	Supports improved patient experience and Trust learning	Yes
Clinical Effectiveness	CE_1	Reducing emergency re-admissions to hospital within 28 days of discharge	A measure of clinical effectiveness and the quality of care for patients	Yes
	CE_2	Reducing weekend mortality rates (Is this deaths at weekend, or deaths of patients admitted at weekends or...?)	Integral part of the mortality review process to support Trust learning	Yes
	CE_3	Improve Dementia care using F.A.I.R. (Find, Assess, Investigate, Refer)	Measures progress against Dementia Care Improvement Programme	Yes
Culture	C_1	All applicable staff to have in-year PDR	Supports Caring and Learning Objectives	Yes
	C_2	Increase in Incident Reporting via 'Datix'	Supports 'no blame', low-threshold reporting culture	Yes
	C_3	Staff compliance with MaST training	Supports staff learning objectives and patient safety	Yes
	C_4	Employee sickness rates	Proxy marker reflecting morale and wellbeing of staff	Yes
Data Quality	DQ_1	Data quality Index	Trust requirement – supports DQ improvement programme	Yes
	DQ_2	Blank, Invalid or unacceptable primary diagnosis rates	Trust requirement – supports DQ improvement programme	Yes
	DQ_3	Depth of coding average diagnosis per coded episode	Trust requirement – supports DQ improvement programme	Yes
	DQ_4	Data quality composite indicator	Summary indicator to support progress against Improvement Programme	Yes

Table 39: Monitoring continuing quality indicators in 2016/17



Annexe One

Statement on behalf of the Trust's Council of Governors

The detailed report of progress made against quality improvement initiatives throughout the year 2015/16 and the focus on areas designated as priorities in 2016/17 is seen by Governors as a reflection of the seriousness that the Trust places on quality. Governors also acknowledge the opportunity they have had in the decisions on quality indicators and priorities for the coming year.

Governors view the report as accurate and forthright in relation to the Trust's energies in promoting quality improvements and fully endorse the chosen priorities for the year ahead. As we would expect, as well as promoting new initiatives the Trust will continue to address and reflect on areas where we have not achieved the desired result.

We are pleased to acknowledge that throughout the year, the Trust has continually reacted positively to quality concerns and issues raised by Governors. There has been a substantial amount of effort and focus on the Trust's Mortality Review Process which has resulted in a number of improvements. The objective of reducing the number of long stay patients has also seen substantial progress and we wish to acknowledge that this could not have been achieved without community integration and working in partnership with health, social care and the voluntary sector. We also share the disappointment that although we have achieved our target of reducing avoidable pressure ulcers grade 2 to 4, we have marginally failed to achieve our target of a minimum of 96% Harm Free Care.

We acknowledge that progress is being made in the complaints process but we are still not achieving our targets. Governors hope to see substantial progress with this during the coming year resulting in a quality and robust process. We are pleased to note that the Trust continues to improve in developing care for those living with dementia with a range of initiatives under the leadership of the Specialist Dementia Care Nurse.

Following the CQC inspection in February 2015 the Trust has responded by developing action plans and continues to self-assess to maintain and improve our position.

The Governors share the disappointment of our breach of the 4 hour Accident and Emergency waiting target. Whilst acknowledging the steps being taken and commending the considerable dedication of both management and staff in combating the increasing number of patient attendances, the area continues to be of major concern.

Governors have throughout the year had an important role to play in quality assurance. We have attended the Quality Assurance Committee on a monthly basis which has enabled us to actively participate in continually monitoring and promoting actions in terms of quality improvement. We continue to take part in regular quality walk rounds with senior nurses in the acute part of the Trust. On a quarterly basis, Governors Surgeries at both the hospital and the Rotherham Community Health Centre have continued to be an important vehicle in receiving patient, visitor and staff opinions of our care and services first hand. Although the majority of comments have been positive, any problems or issues arising from the surgeries have been reported and satisfactory action has been taken.

In general, Governors are pleased with the progress made on quality improvements over the year and acknowledge the relationship and openness of the Board members in addressing issues. We will continue to challenge, monitor and influence during the coming year in an attempt to place the Trust in an even better position in terms of quality care for our patients.

A handwritten signature in black ink, appearing to read 'Denis Wray'.

Denis Wray
Public Governor & Lead Governor
28 April 2016

“All staff were extremely friendly and caring. Always there when I needed them. I can't thank the staff enough for all their help.”

**Friends and Family patient feedback
Ward A7**

Statement from NHS Rotherham Clinical Commissioning Group – 28th April 2016

The delivery of high quality care whilst achieving efficiencies has remained a priority and key challenge for both NHS Rotherham Clinical Commissioning Group (RCCG) and The Rotherham NHS Foundation Trust (TRFT) during the financial year of 2015/16. RCCG are particularly keen to highlight the achievements of TRFT in relation to a number of areas which are detailed below.

TRFT has continued to engage with RCCG throughout 2015/16 through Board-to-Board and contractual meetings between the two organisations on a formal basis and also through informal engagement. It is acknowledged that the changes in the Executive Team at the Trust during the previous year are now fully embedded and engagement in committees such as the Clinical Referrals Management Committee and System Resilience Group has significantly improved.

The involvement of senior clinicians from TRFT in the ongoing commissioning and contract management remains strong. In particular, the commitment to the Contract Quality meeting is evidently prioritised by both the Chief Nurse and Medical Director from TRFT which has enabled quality concerns to be raised and assurances given to RCCG in respect of mitigating actions.

RCCG and TRFT participate in an annual programme of clinically led visits, the purpose of which is to facilitate assurance about quality and safety of healthcare services by 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. Four visits have been conducted during 2015/16, these being Maternity, Endoscopy, Paediatrics and Cardiology.

Overall the four visits concluded with positive feedback from RCCG clinicians with a series of recommendations for improvement to be implemented. There were also two follow-up meetings held to consider the improvements made from the Trauma Unit Peer Review and the Stroke Peer Review undertaken in 2014/15 and RCCG were assured that appropriate progress had been made in conjunction with the action plans previously produced. A programme of visits has been agreed to continue throughout 2016/17 along with RCCG representation on the unannounced senior nurse visits to clinical areas where patient/GP feedback has raised concerns.

TRFT reduced the number of Clostridium Difficile cases to below trajectory during 2015/16 and confirmation has been received that five of the cases were as a result of lapse in care following intensive review of each case and actions have been put into place to reduce recurrence. There were no cases of MRSA reported during 2015/16 which is also very positive.

The achievement of the 'seen within 4-hours of attending A&E' target proved to be extremely challenging for all providers this year and TRFT ended the 2015/16 financial year with a performance against the quality standard of 90.65%. The Quarter 3 and Quarter 4 positions were also not achieved. TRFT and RCCG worked closely together to develop and agree robust actions encompassing the whole health economy of Rotherham to address performance issues and the difficulties that were being faced both locally and nationally as a result of an increase in A&E attendances and a national shortage of clinicians in this field.

RCCG were informed of an issue late in 2015/16 in relation to waiting list management in General Surgery which has resulted in a small

number of 52 week wait breaches during 2015/16, none of which have raised concerns in relation to patient safety. TRFT is currently on trajectory to meet its objective in relation to the recovery plan and this continues to be supported by RCCG and NHS England.

TRFT has made positive achievements in terms of providing safe, quality care as evidenced by continual improvement in cancer quality standards which have remained compliant against the national quality standards throughout the year.

In regard to mortality rates, it is noted that the HMSR and SHMI levels are elevated due to a spike in mortality during December 2014/January 2015. RCCG continues to seek assurance through that there will be a return to normal levels once the figures are rebased for the year, although this remains a concern until assurance can be confirmed at year-end.

RCCG wish to acknowledge the excellent work that has continued throughout the year in regard to pressure ulcer management both within the hospital and community environments. Staff campaigns and training have clearly influenced the improvements seen in promoting harm free care for patients and it is recognised as a significant achievement that TRFT have had no reportable avoidable pressure ulcers (Grade 3/4) reported since April 2015 which is a 100% reduction on previous year.

TRFT continue to monitor their achievement against national and regionally agreed safeguarding standards and share this information across the health and social care community to promote collaborative working towards making quality improvements.

Following the CQC CLAS inspection in early 2015, SMART action plans were put in place and RCCG acknowledges the continued effort that TRFT is applying to progression of the actions. TRFT went further than expected by implementing a 'dip sampling' process to assure themselves and commissioners that improvements had been made and compliance was embedded within departments by testing the processes and knowledge of employees. This proactive approach has been shared by RCCG to ensure all partners adopt a similar process of assurance.

Improvement in Dementia care has been supported by RCCG through the Care for Quality and Innovation incentive scheme during 2015/16 and TRFT not only achieved the FAIR (Find, Assess, Investigate, Refer) targets but also ensured that all staff within the Trust have at least bronze level training for dementia and are providing significant support for carers since the appointment of the Specialist Dementia Care Nurse. RCCG colleagues who visited the new 'dementia friendly' ward were impressed with the work that has been done and the standards achieved.

RCCG and TRFT have agreed a number of Incentives Schemes for 2016/17 to support the delivery of improvements in quality for patients. This includes the continuation of the SAFER Care Bundle and 7-Day Working Standards which will help to improve the quality of care and safety of patients and support joint initiatives to reduce length of stay in hospital and treatment in the home environment.

Dr Phil Birks
GP Executive Lead – TRFT Contract
NHS Rotherham CCG

Sue Cassin
Chief Nurse
NHS Rotherham CCG

Statement from Healthwatch Rotherham

Healthwatch Rotherham continues to have an excellent working relationship with The Rotherham Foundation Trust.

Healthwatch CEO is in regular dialogue with The Rotherham Foundation Trust Chief Nurse, likewise the Rotherham Healthwatch Chair and The Rotherham Foundation Trust Chair have an annual meeting.

Healthwatch Rotherham attends Patient Experience Group meetings chaired by the Deputy Chief Nurse to review complaints, comments, compliments and concerns we have received from the public.

We pass on the data we receive about The Rotherham Foundation Trust to help The Rotherham Foundation Trust to gain a wider view of the public's opinions.

Healthwatch Rotherham supported the CQC inspection into The Rotherham Foundation Trust last year (2015) and has been fully involved in the action plan meetings following the report.

Following discussion over the issues raised by the public to Healthwatch Rotherham, a number of changes have been made including:

- Healthwatch Rotherham facilitated a meeting between Deaf Futures and the trust to address the concerns raised by Rotherham Deaf Futures and brought the two parties together with the aim of improved communication, especially around the need for interpreters. Deaf Futures performed a walk-through of hospital services during Deaf Awareness week and also provided deaf awareness training to selected hospital staff.
- Following a complaint raised with Rotherham Hospital a meeting was raised with the Integrated Medicine department. The hospital responded with both the Chief Operating Officer and the Head of nursing from the Division of medicine writing letters to the complainant expressing their sincere condolences. Not only has the patient experience been shared as part of the Hospital patient story for future learning, but the complainant was offered and has accepted to present the story at one of the protected learning time events. The Hospital has openly stated that they are grateful for the feedback and are to make the necessary changes to improve the experience of patients and their relatives at the Trust.
- A person who had a bad experience last year following a broken arm, returned to hospital as they broke the other arm. After the previous experience they were very apprehensive as the first visit made them contact Healthwatch Rotherham to put in a complaint about the experience they had received. The second experience was much better and they could see the changes that the hospital said it was going to make after the complaint implemented and experienced at first hand. The assessment was done immediately and after care sorted before leaving the hospital.

- Discrepancies on the wards on Rotherham Hospital were identified regarding discretionary parking tickets. The hospital is working to make wards more aware about the offer available.

Last year The Rotherham Foundation Trust was piloting the use of a real time food ordering system on three wards using a hand held tablet device. This meant that patients would be able to order food much more quickly without using a tick sheet menu. This pilot project has proved to be very successful and rolled out across the Trust, leading to a better patient experience with regards to meals and nutrition and hydration.

Healthwatch Rotherham has passed on the comments which they have received from the local people of Rotherham to The Rotherham Foundation Trust. These comments have helped to inform The Rotherham Foundation Trust Quality Accounts and focus on areas of improvement for the next year.

Commenting on the quality report - we would like to see the complaint response time being improved and closer to the 90% target. At the time of writing the available data is showing it is way below this target and work to address this is in the priorities for improvement in 2016/17.

We are pleased to see the management of discharge in the priority list for 2016/17 and acknowledge the improvements already made.

Comments received by Healthwatch Rotherham are not always negative, with many positive comments thanking the staff and the Trust for the care that individuals have received.

Healthwatch Rotherham looks forward to continuing to grow and develop our good working relationship with all at The Rotherham Foundation Trust.



Tony Clabby
Healthwatch Rotherham CEO



Formal response from the Rotherham Health Select Commission

A small working group of Members had a presentation and detailed discussion on progress on the quality priorities in December 2015. A presentation on the Quality Account to the full Health Select Commission followed at their meeting in March 2016. The draft document was then circulated for their consideration and comment. Members appreciate receiving this information and asked a number of questions at both meetings in relation to current performance and future challenges.

It is positive to see sustained progress this year towards achieving harm free care with reductions in avoidable falls with harm and avoidable pressure ulcers. Work to improve medicine safety and efficiency will also enable further headway towards the 96% target. HSC also noted the positive scores from the Friends and Family Test, which has been broadened out across more services.

TRFT set a stretching target for timeliness in responding to complaints in 2015-16 which has not been achieved although progress has been made. As this is again a priority for 2016-17 and with new staff and processes Members anticipate further improvement.

As in many areas of the country Members noted the fluctuating performance on the 4 hour target for A&E and the issues which impacted on this measure but expect to see an improvement in 2016-17 prior to the opening of the new Emergency Centre.

As Chair I welcome the positive changes in paediatrics in response to the CQC inspections, such as the joint work with RDaSH, staff training and new appointments to strengthen the staff team in Family Health and Children's services.

The commission agrees with the improvement priorities for 2016-17. Further work on discharge planning, including medication, and reducing lengths of stay in hospital, especially when people are medically fit for discharge, is supported by the HSC. Members recognise that this is a key area requiring continuing integrated work between health, social care and the voluntary/community sector and this will feature in the commission's work programme in 2016-17.

The Health Select Commission appreciates the willingness of the Trust to engage regularly with Members and looks forward to continuing to work closely with the Trust to make sure the people of the borough receive the care they deserve.



Cllr Stuart Sansome
Chair, Health Select Commission
29 April 2016

“Care was very good, felt very well looked after being admitted and reassured by ongoing care. Down to earth people who helped me when I needed it. Thank you.”

**Friends and Family patient feedback
Ward B11**

“Danielle looked after us on delivery suite, came to the ward AND followed us up in community. I wouldn't have coped without her. Having that continuity has helped massively. Thank you.”

**Friends and Family patient feedback
Community Midwives**

“We have stayed here for a few days and me and my baby have been very well looked after. Staff are fantastic.”

**Friends and Family patient feedback
Special Care Baby Unit**



Annexe Two

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.

Monitor 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 2015/16 and supporting guidance
- 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 2015 to April 2016
 - papers relating to Quality reported to the board over the period April 2015 to April 2016
 - feedback from commissioners dated 26/04/2016
 - feedback from governors dated 28/04/2016
 - feedback from local Healthwatch organisations dated 04/05/2016
 - feedback from Overview and Scrutiny Committee dated 29/04/2016
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/04/2015
 - the 2014 national patient survey 21/05/2015
 - the 2015 national staff survey 22/03/2016
 - the Head of Internal Audit's annual opinion over the trust's control environment dated 17/05/2016
 - CQC Intelligent Monitoring Report dated May 2015

- 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 controls 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 and
- the Quality Report has been prepared in accordance with Monitor'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
May 2016

Louise Barnett
Chief Executive
May 2016

“ I just like this hospital, the staff are always helpful and talk to you as a person. ”

**Friends and Family patient feedback
Children's OPD**





Appendix One

Appendix One: Local Clinical Audits Supplement 2015/16

The reports of 241 local clinical audits were reviewed by the provider in 2015-16 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table below).

Table 41: Local clinical audits and actions 2015/16

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
A&E	Audit of Diabetic ketoacidosis protocol adherence	Yes	Guideline regarding access to an insulin sliding scale for use in hyperosmolar non ketotic coma (HONK) and/or for those patients with hyperglycaemia who also present with other problems, to be reviewed and included on SharePoint for use within the Emergency Department. Education in the changeover of guidelines, removal of old guidelines and continuity to medicine has been undertaken.
A&E	Audit of the treatment of open fractures (excluding finger fractures) in the emergency department	Yes	BOAST 4 guideline is to be made more readily available to doctors working in A&E by placing the guideline on SharePoint, doctor's notice boards and sharing at induction. Early orthopaedic involvement to be encouraged. Reviews to be undertaken within the emergency department and expediting transfer to orthopaedic wards. Photography of wounds by patient's camera phones will be clarified with trust policy. Further education of the need for early antibiotics and repeated neurovascular assessment is required during junior doctor induction.
A&E	Time to treat and x-ray audit	Yes	The results to be presented to the Emergency Medicine Business Manager to inform the business case regarding the timeframe of patients arriving at the x-ray department.
A&E	Adherence to COPD discharge guidance from the Emergency Department	Yes	Improve adherence to the COPD discharge guidance by clarifying on SharePoint and updating the induction to encourage discharge as per British Thoracic Society guidelines
A&E	Adherence to Canadian C Spine rules for neck imaging	Yes	Reiterate and educate staff on the use of the Canadian C Spine rules, including teaching, poster, and shop floor education.
A&E	Audit of compliance with a Patient Group Directions (PGD) and completion of records associated with PGD for dihydrocodeine	Yes	To ensure it is clear within the patient record that a drug is given via a PGD, a documentation part will also be added to the assessment.
A&E	Paediatric safeguarding	Yes	Patients who attend the Emergency Department should have a SystmOne safeguarding check and this will be put under the domain of the Emergency Department reception staff. The recording of the details of the accompanying adult to be tightened up by reception staff. A clarifying note to be added to the question on the discharge summary i.e. is the SystmOne check done and green, are the name and relationship of the accompanying adult recorded, are there no concerns from the safeguarding questions.
A&E	Audit of sedation checklist	Yes	Results to be shared via clinical effectiveness and clinical governance meetings. Poster presentation to be displayed on the clinical governance notice board which details the results. Results to be shared with the Consultants and Middle Grades. Teaching on consent and the use of the correct consent form to be delivered. Discharge advice to aid the safe discharge process to be highlighted.
A&E	A&E Medical Documentation Audit	Yes	Discuss and highlight the prescribing of oxygen on arrival at A&E, by including in teaching sessions, highlighting on the notice board and at morbidity and mortality meetings.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
A&E	Acute Kidney Injury	Yes	The results of the audit to be discussed at both the acute/emergency medicine quality governance meetings. The discharge summary to be improved and to include acute kidney injury. Teaching on acute kidney injury to be delivered to emergency department staff.
A&E	Audit of compliance with a PGD and completion of records associated with PGD for ibuprofen	Yes	No actions required.
A&E	Emergency Admissions in Over 70s through A&E	Yes	No actions required.
A&E Integrated Medicine	Alcohol admissions audit	Yes	No actions required.
Anaesthetics	Record keeping for C Section	Yes	Ensure improved recording of the time decisions have been made/ action taken by developing and introducing a sticker to prompt recording of times in the patients notes.
Anaesthetics	Day Surgery Discharge Protocols	Yes	Revise the Day Surgery Care Plan documentation to ensure it is suitable for documenting the discharge criteria. Ensure the Local Anaesthetic and General Anaesthetic criteria are current and suitable. Re-audit when changes have been made to assess whether improvements have been achieved.
Anaesthetics	Annual Suction Audit	Yes	Take a proposal to the Medical Devices Group for funding to replace all mains driven suction units with battery driven units. Promote resuscitation training sessions across the trust. Recommend that each clinical area have a dedicated member of staff/pool of staff members who are responsible for checking suction equipment regularly. Re-audit when actions have been implemented.
Anaesthetics	Audit of Patient Group Direction (PGD) for Entonox for Adults and Children	Yes	Inform Ward Managers of the requirement to write the administration of Entonox in the patients notes and also on the drug card in the section 'drugs administered without a prescription'. Ward Managers to cascade this information to all relevant staff and ensure compliance.
Anaesthetics	Tidal Volumes in Ventilated Patients in Intensive Care	Yes	Adjust charts to incorporate height, predicted body weight and tidal volumes and amend Intensive Care Unit paperwork and admission sheet to incorporate the appropriate targets for ventilation for septic patients.
Anaesthetics	Emergency Equipment Audit	Yes	Ensure emergency equipment checks are completed in line with trust standards by liaising with Matrons for all areas to agree appropriate action.
Anaesthetics	Pre Care Cardiac Arrest Audit	Yes	Present results of the audit to the resuscitation committee and incorporate findings into the trust wide action plan on cardiopulmonary resuscitation.
Anaesthetics	Review of Cardiac Arrest Patients	Yes	Explore decision making around 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions by arranging a lecture by the Trust solicitor in relation to legal issues. Educate staff on DNACPR decisions by developing an e-learning package.
Anaesthetics	Paracetamol Patient Group Direction (PGD) Audit	Yes	No actions required.
Anaesthetics	Unplanned Admissions from Day Surgery 2014	Yes	No actions required.
Anaesthetics	MRX Weekly Operational Check Audit	Yes	No actions required.
Anaesthetics	Epidural analgesia across all surgical specialities 2015	Yes	No actions required.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Anaesthetics	Anaesthesia for elective cardioversion	Yes	No actions required.
Anaesthetics	Documentation 2014 - Anaesthetics	Yes	Improve preoperative assessment documentation by making amendments to the Anaesthetic chart. Increase awareness at the Monday lunchtime staff meeting of the need to improve temperature monitoring and ensure a temperature monitor is available in every theatre. Ensure the next audit documents whether the patient is spontaneously breathing or not to allow accurate presentation of results.
Anaesthetics A&E General Surgery	Re-audit of Fractured Ribs	Yes	Present the audit at 'Grand Round' to increase awareness of the need for early referral to the pain team to ensure timely input into the management of patients. Make the rib fracture protocol available on the 'IGNAS' app so that doctors have easier access to this.
Anaesthetics General Surgery	Post-operative nausea and vomiting following breast surgery	Yes	Introduce Acupins across general anaesthesia and breast surgery patients and roll out training to the Theatre Assessment Unit and Day Surgery Unit on how to use the Acupins.
Anaesthetics General Surgery O&G Urology Orthopaedics	Epidural analgesia across all surgical specialities 2014	Yes	Ensure success of epidurals by advising individuals that if they intend to abandon an epidural insertion, to contact the pain team initially for support (if within working hours).
Anaesthetics O&G	Audit of pain management in open total Abdominal Hysterectomy	Yes	Ensure the pain management protocol is followed and weak opiates prescribed, by presenting at the Anaesthetic Clinical Effectiveness meeting to raise awareness of the guideline.
Anaesthetics Orthopaedics	Prescribing of analgesia against Trust protocol (Fractured Neck of Femur Patients)	Yes	Liaise with Clinical Director to increase the number of fascia iliaca blocks performed in the A&E department. Ensure fascia iliaca blocks are carried out in a timely fashion by delivering training to new doctors. Re-educate prescribers and nurses regarding the analgesia standard. Discuss the use of non-steroidal anti-inflammatory drugs with Orthopaedics department. Include a copy of the standards with the case notes for all patients with a neck of femur fracture.
Anaesthetics, CYP Service, General Surgery	Management of Pain Following Appendicectomy	Yes	No actions required.
Anaesthetics, Trust wide	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	Yes	Present the results of the audit to the General Medical Physicians at the 'Grand Round' in April 2016, jointly with the Trust's legal advisor to ensure that 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms are completed fully and correctly in line with best practice and regional guidelines. Carry out a re-audit, specifically looking for evidence of capacity assessment documented in the clinical notes.
Community Adult Services	Clinical audit of record keeping of local anaesthetic administration within Doncaster Community Dental Service	Yes	To re-iterate to all dentists the need to record the name of the local anaesthetic used, expiry date, batch number and dose administered and to consider the use of labels which are available. To re-audit at a date to be established.
Community Adult Services	Compliance with guidelines on simplified BPE (British Society of Paediatric Dentistry and the British Society of Peridontology)	Yes	All dentists to be emailed the combined results and a copy of the current guidelines. Nurses will be requested to place a BPE probe in all exam kits as a reminder to the dentist. Results to be presented in each area i.e. Doncaster, Barnsley and Rotherham.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Community Adult Services	Clinical audit of the quality of radiographs taken in Doncaster Community Dental Service 2014	Yes	Monitor the standards of radiographs within the Doncaster Community Dental Service by auditing the quality of radiographs using the standards from the National Radiation Protection Board.
Community Adult Services	Audit of compliance to the guidance given in the Patient Group Directive for Betamethasone valerate/clioquinol ointment	Yes	Patient information leaflets to be provided routinely after the treatment has been administered. The need to document the exclusion criteria for treatment to be discussed with the nursing staff.
Community Adult Services	Audit of compliance to the guidance given in the Patient Group Directive for Canesten HC cream	Yes	Patient information leaflets to be provided routinely after the treatment has been administered. The need to document the exclusion criteria for treatment to be discussed with the nursing staff.
Community Adult Services	Audit of compliance to the guidance given in the Patient Group Directive for Trimovate cream	Yes	Patient information leaflets to be provided routinely after the treatment has been administered. The need to document the exclusion criteria for treatment to be discussed with the nursing staff.
Community Adult Services	DNACPR Audit - Community Hospital	Yes	Nursing staff at the Community Unit to be advised of the results. Results to be shared with the care of the elderly Consultants.
CYP Service	Audit of Downs Syndrome	Yes	Establish a list of all children for ensuring all those requiring review at community paediatric clinics and special school clinics are sent timely appointments. Team to check list monthly to ensure children appointed when review due. Establish with audiologist a system for regular recalls for 2 yearly hearing tests. Establish Head Hospital & Community Orthoptist system for regular recalls for 2 yearly vision tests. Ensure all school nurses notify details of all children in their care who have Down's syndrome to named specialists.
CYP Service	Re-audit of time to review acute paediatric medical admissions by medical staff	Yes	Nursing staff to continue doing swift assessment of acute referrals, but to include documentation of reason why a patient was not seen within the recommended time frame. Re-audit in 2016 of longer or busier time period to gain more representative results post CQC impact, with a view to giving consideration to longer opening hours for Children's Assessment Unit (CAU), currently not an option.
CYP Service	Asthma Referrals (audit of adherence to asthma pathways in primary and secondary care)	Yes	Discuss at Care Closer to Home to promote adherence to primary care referral pathway. Triage of respiratory / asthma referrals to be raised at consultant forum, so that Inappropriate Choose and Book / Paediatrician referrals to be forwarded to Asthma Nurse. Revise & relaunch Primary Care Referral Pathway pending publication of NICE Diagnostic Guideline, as part of the primary care paediatric asthma management bundle (if the business plan is approved)
CYP Service	Re-audit of fostering and adoption clinic procedure	Yes	Discuss audit with Social Care. Review list of required paperwork provided for Social Care by the Trust. Liaise with Social Care manager re how Social Workers are informed of required paperwork, and Present Looked After Children (LAC) medical procedure to Social Care staff training event. The Trust LAC appointments clerk to remind SW of required documents and the various consents to be signed. Appointments clerk to monitor paperwork omitted for LAC Dr/Nurse to feedback to Social Care; Investigate the option of Social Care to supply consent and complete paperwork in advance.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
CYP Service	Audit of The National Institute for Health and Care Excellence (NICE) guideline CG149; Antibiotics for early onset neonatal sepsis	Yes	Review other local guidelines and evidence behind NICE guidance. Re-write the new guideline in time for implementation with the new start of junior doctors in Feb 2016. Education of all relevant staff regarding the importance of giving the first dose of antibiotics promptly (within 1 hour of decision). Implement new proforma which forms the notes, and possibly prescription, for all babies started on IV antibiotics for early sepsis. If decision to continue treatment for more than 36 hours, transfer to standard prescription and notes. Develop an information leaflet for parents explaining why their baby needs antibiotics in hospital, and the signs to look for following discharge. Discussion at Consultant meeting regarding only checking gentamicin levels on those who are having a longer course of antibiotics, or moving it to before the 3rd dose? Reaudit once all these changes are in place.
CYP Service	Consent 2014	Yes	Clarify reason why nursing staff are taking consent for Dimercaptosuccinic Acid scan (DMSA) on behalf of Medical Physics. Check whether letter containing information on Synacthen test available, and if not, ensure to always document risks and benefits on Consent form. Include Special Care Baby Unit (SCBU) sample in next audit using BadgerNet to sample Immunisations.
CYP Service	Audit of Lumbar Puncture checklist and Pathway	Yes	Lumbar Puncture should not be performed without checklist proforma, and without verbal consent documented. Disseminate to nurses on wards to implement the form on Children's Ward. Put a big poster in the treatment room, and email new instructions to everybody. Re-audit.
CYP Service	Snapshot re-audit of the investigation and management of urinary tract infections	Yes	Disseminate to nursing staff to ban pads for urine capture, Improve documentation on how urine to be obtained. Establish system for chasing results and protected time for SHOs to complete the tasks. Review method of lab notification of positive results for urine infections. Re-audit.
CYP Service	Audit of the management of results for paediatric in-patients after discharge from the Children's wards	Yes	Procure new printers in Registrar and tier one doctors rooms. Agree system for notifying parents and GPs of results, and for documenting in records. Agree standards and write new guidance for use of jobs list and put in place. Investigate using Electronic Patient Record (EPR) notices as a way of communicating with named consultant. Try out as a way of communicating in practice. Discuss at consultant meeting. Re-audit.
CYP Service	Personalised Asthma Action Plan on Discharge	Yes	Send a memo to all staff to raise awareness of the function of the discharge checklist and enforce its use through the ward manager and on ward rounds, and to start asthma pack on admission. Send a memo to ward clerks advising of correct filing of proforma in discharge section of documentation. Provide staff training to differentiate between Wheezy booklet, Discharge Checklist and Discharge Action plan, so that everyone is aware of the need for each document.
CYP Service	Management of asthma in paediatric outpatients and Inhaler Technique - Assessment and Training	Yes	Ensure Inhaler Technique assessment documented in notes. Ensure asthma action plans are issued to all patients. Create poster encouraging prescribing of age appropriate spacer. Improve documentation of which inhalers are in use.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
CYP Service	Consent Audit 2015	Yes	Review leaflets available on SCBU and in children's clinic to ensure all patients are given written information relevant to the procedure. Poster to be displayed in SCBU, children's clinic, children's ward and Wharncliffe to remind staff of this. Ask SCBU staff to ensure consent is still valid if procedure is done on a different day. Cascade to SCBU nurses to ask/ring parents on day of immunisations to re-confirm prior consent. Consultant to speak SCBU nursing staff to cascade this. Re-audit in one year's time to ensure recommendations have improved results.
CYP Service	Paracetamol Patient Group Direction (PGD77) audit	Yes	No actions required.
CYP Service	GP notifications for Newly Diagnosed Paediatric Diabetic Patients	Yes	No actions required.
CYP Service	Human Papilloma Virus (HPV) Vaccine Patient Group Direction audit	Yes	No actions required.
CYP Service	Re-audit of Paediatrics Outpatient Follow Up Attendances	Yes	No actions required.
CYP Service	Children's Ward Safeguarding Information Pack	Yes	No actions required.
CYP Service O&G	Completion of Safe Sleeping Assessment Form	Yes	Update the Trust's Safe Sleeping Policy to be a joint policy with Rotherham Metropolitan Borough Council (RMBC) and the Clinical Commissioning Group (CCG). Update and refresh the sleep safe assessment and pathway ensuring it assesses risk and vulnerability. Attend a community midwifery team meeting to update staff of changes and the implementation of the new assessment form. Provide clear guidelines for handover communications between midwifery and health visitors/Family Nurse Practitioner (FNP). Provide guidance for midwifery, health visitors and FNP when reassessment and/or escalation are required. Introduce a standard procedure for follow-up assessment in line with contacts through the healthy child programme. Remove the sleep safe assessment form from red book and ensure a system is in place from the 1st of September 2015. To seek agreement support for annual sleep safe training from all services with the aim of reducing deaths from Sudden Infant Death Syndrome (SIDS). Re-audit.
CYP Service, Safeguarding	A Re-audit of Assessment of Looked After children	Yes	Cross check sample from SystmOne with clinic lists for re-audit.
CYP Service, Safeguarding	Re-audit of the management of the Child Protection Medical Reports (Safeguarding)	Yes	A discussion is to be held with the Paediatricians during the clinical effectiveness meeting following presentation of the audit on May 23rd 2016 to consider ways forward that would reduce the time between the child protection medical report being completed and the report being placed on the child's electronic record (SystmOne).
CYP Service, Safeguarding	Timing of Child Protection Medicals (Safeguarding)	Yes	Revise template for written safeguarding reports from Child Protection medicals; Improve timeliness of reports; ensure date and time of start and finish recorded.
Dermatology	Audit of compliance with Patient Group Direction (PGD) for Lidocaine 1% and Adrenalin 1:200000	Yes	A copy of the PGD to be stored in theatre for staff to reference to at administration. Introduce a log in theatre for staff to record any procedures administering medication under the PDG. Discussions to be held with staff regarding action to be taken when patients are not suitable to receive lidocaine 1% and adrenaline 1:200000.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Dermatology	Audit of compliance with Patient Group Direction (PGD) for the administration of botulinum toxin type A (Botox) for hyperhidrosis	Yes	To discuss at the Dermatology Clinical Governance meeting in November 2015 that nursing and medical staff who refer from the outpatient clinic should be reminded to document in the patient case notes that a patient information leaflet has been provided. Also, nursing staff who participate in the Botox session should be informed to ensure that allergy status is documented on each visit.
Dermatology	Documentation 2014	Yes	Discuss at Clinical Governance meeting the recording of time of medical entries and the documentation of designation of author against medical entries in the patient notes.
Dermatology	Consent Audit 2015	Yes	All staff who record consent to be informed of the need to tick the appropriate box regarding the anaesthesia used on the consent form.
Dermatology	Audit of compliance with Patient Group Direction (PGD) for Lidocaine 1% plain	Yes	No actions required.
Dermatology	Re-audit of adherence to Patient Group Direction for the use of 'Metvix' cream as part of photo-dynamic therapy treatment	Yes	No actions required.
Endoscopy	Consent Audit 2015	Yes	Introduce a new process for postal consent.
Endoscopy	Audit of the administration of midazolam to adults prior to endoscopic procedures and flumazenil to adults as a reversal agent for midazolam if required (PGD code 140306s)	Yes	Ensure all patient records document that the drug was given under a Patient Group Direction (PGD) by liaising with the Theatre Systems Information Manager to add new field to InfoFlex system.
Endoscopy	Snapshot audit of consenting outside endoscopy rooms	Yes	No actions required.
Endoscopy	Gastroscopy Audit: Oesophago-Gastric Duodenoscopy January 2015-June 2015	Yes	No actions required.
Endoscopy	ERCP (Endoscopic Retrograde cholangio pancreatography) Jan 2015- June 2015	Yes	No actions required.
Endoscopy	Percutaneous Endoscopic Gastrostomy (PEG) Audit January 2015-June 2015	Yes	No actions required.
Endoscopy	Number of procedures performed by operator (Jan 2015 - June 2015)	Yes	No actions required.
Endoscopy	Number of procedures performed by operator (July 2015-Dec 2015)	Yes	No actions required.
Endoscopy	Colonoscopy completion rate	Yes	Highlight individual results of the audit to each Endoscopist to ensure colonoscopy completion rates are achieved or maintained. Improve documentation of completion of the procedure, polyp data and bowel preparation in the patient record by writing to each Endoscopist highlighting what should be recorded and the appropriate place for this to be recorded.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Endoscopy	Gastroscopy Gastro Intestinal Bleeding (Jul-Dec 14)	Yes	Liaise with nursing staff to ensure Rockall scores are transferred from the red form into the InfoFlex system and therefore included in the audit data. Remind each Endoscopist of their requirement to record information on whether the second part of the duodenum is reached and information on blood transfusions.
Endoscopy	Gastroscopy Gastro Intestinal bleeding (Jan-Jun 14)	Yes	No actions required.
Endoscopy	Unplanned admissions, operations within 8 days, ventilation, perforation, bleeding and 30 day mortality (Jun-Nov 14)	Yes	No actions required.
Endoscopy	Endoscopic Retrograde Cholangio- Pancreatography (ERCP)	Yes	No actions required.
Endoscopy	Endoscopic Retrograde Cholangio- Pancreatography (ERCP)	Yes	No actions required.
Endoscopy	Percutaneous endoscopic gastrostomy (PEG)	Yes	No actions required.
Endoscopy	Percutaneous endoscopic gastrostomy (PEG)	Yes	No actions required.
ENT	Documentation 2014 - ENT	Yes	Improve recording of authors name and designation by introducing stamps. Remind all staff of the need to document all entries in the case notes in black ink and record deletions and alterations appropriately. Liaise with nursing staff to ask for times of entries to be recorded for outpatient appointments.
ENT	Treatment of fractured nasal bones	Yes	Contact CCG referrals lead and A&E Clinical Effectiveness Lead to ensure all GPs and A&E staff are aware of the requirement for patients to be offered a closed reduction of their fracture within 10 days of injury to ensure optimal outcomes. Review arrangements for booking of clinics to ensure patients can be booked within the recommended timeframe.
ENT	Consent Audit 2015	Yes	Remind all colleagues of the need to provide (and document provision of) information leaflets when consenting for procedures.
ENT	Thyroid Surgery Complication Rates	Yes	No actions required.
ENT	Voice outcomes following hemi or total thyroidectomy	Yes	No actions required.
General Surgery	Management of patients going to theatre with suspected appendicitis	Yes	Consider introducing routine use of the Alvarado scoring system by reviewing the potential benefits and quality of evidence to support use. Increase the use of imaging by introducing a lower threshold for the use of diagnostic imaging.
General Surgery	STARsurg discover defining surgical complications in the overweight	Yes	Ward Managers to promote increased use and recording of Body Mass Index, particularly within 24 hours to identify at risk patients. Update the junior doctor induction and booklet to encourage the provision of dietary advice and dietitian referral for overweight and obese patients, in addition to underweight patients.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
General Surgery	Consent 2014 - General Surgery	Yes	Ensure comprehensive documentation of the pros, cons and risks of surgery by obtaining agreement at the Clinical Effectiveness & Governance Meeting that all consultants will document this information in the notes and clinic letter and inform those not present at the meeting of this requirement. Develop and print stickers to ensure consistency of recording of risks for inguinal hernia and laparoscopic cholecystectomy operations. Liaise with pre-assessment staff to ensure documentation of when leaflets are given to patients and inform all staff to ensure this is done. Re-audit when actions have been implemented.
General Surgery	Treatment of Gallstone Disease in Emergency Admissions	Yes	Circulate current NICE guidelines among colleagues. Implement a dedicated 'hot' gallbladder theatre list. Recruit a consultant surgeon to ensure exploration of common bile duct laparoscopically intraoperatively and develop biliary disease pathway. Look into the feasibility of having pre-booked imaging slots for investigation, including assessment of the financial implications. Liaise with Gastroenterology lead to ensure Endoscopic Retrograde cholangio pancreatography (ERCP) is more readily available. Re-audit in 2016.
General Surgery	Clinical Audit of Oxygen Prescriptions on General Surgical Wards	Yes	Ensure oxygen is prescribed in accordance with trust and national guidance by emphasising the importance of oxygen prescriptions at the F1 junior doctor induction and within the induction booklet. Contact nursing staff to observe whether oxygen prescriptions are being documented and feedback where this is not taking place. Contact those responsible for ward rounds to request an improvement in oxygen documentation and liaise with the Clinical Skills Facilitator to determine whether oxygen prescriptions are covered in the trust induction programme.
General Surgery	Recurrent Hernia Repair Laparoscopic/Open at Rotherham District General Hospital	Yes	Raise awareness of the British Hernia Society Guidelines through the Clinical Effectiveness & Governance meeting, in particular for when considering the type of repair for recurrent hernia. Obtain agreement that all hernias should automatically default to a day case procedure. Re-audit, to include why surgery hasn't been performed as a day case.
General Surgery	Audit of NICE guidance on Head Injury	Yes	Liaise with the Emergency Department to ensure clear documentation of neurosurgical advice, including rationale for repeat computed tomography scan (CT) and discharge advice/follow up. Reinforce to all junior doctors to follow guidance on the neuro-observations chart unless informed otherwise and to document the reason for difference, if appropriate. Matron to ensure all nurses make a routine referral to the Neurorehabilitation service early during admission and this to be checked at the post take ward round. Matron to ensure all nurses carry out routine dementia screening as per trust protocol and electronic patient record. Nurses and Junior Doctors to be reminded of the need for routine escalation to half-hourly observations if the patient deteriorates and the need to document discharge advice given.
General Surgery	Consent Audit 2015	Yes	Ensure rules of consenting are included in the next junior doctor induction and induction booklet.
General Surgery	Pre-operative cardio-pulmonary exercise testing in colorectal patients	Yes	Refine referral criteria to ensure appropriate patients are referred for preoperative cardio-pulmonary exercise testing. Continue to monitor progress and the effect of preoperative cardio-pulmonary exercise testing.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
General Surgery Endoscopy	Post polypectomy colonoscopy surveillance	Yes	Take the recommendations from the audit to the Endoscopy User Group meeting for discussion: distribution of current guidelines to each Endoscopist and widely displayed in the department; consideration of all surveillance scopes to be booked centrally by endoscopy (1 or 2 people); consensus as to what age to stop surveillance; documentation if not for further surveillance; surveillance scopes should be colonoscopy not flexi. Re-audit when actions agreed and implemented in full looking at intention for surveillance rather than actual surveillance.
GU Med	Management of HIV in pregnancy re-audit	Yes	Re-audit yearly (depending on the number of pregnant women), collecting data prospectively. Liaise with National Study of HIV in Pregnancy & Childhood (NSHPC), regarding faxing of forms rather than posting. Ensure all forms are photocopied and filed in patients notes. Review in Nov 16.
GU Med	Emergency Hormonal Contraception Patient Group Direction - Ulipristal	Yes	Ensure Annual update in reproductive sexual health knowledge for all Sexual Assault Nurse Examiners
GU Med	Emergency Hormonal Contraception Patient Group Direction - Levonorgestrel	Yes	Annual update in reproductive sexual health knowledge for all Sexual Assault Nurse Examiners
GU Med	Audit of Chlamydia retesting in under 25 year olds	Yes	Administration department to set up re-call list for these patients, and instigate text re-call for patients to re-turn in 3 month for repeat test. Health advisors to change their documentation to ensure patients are aware they need to return in 3 months.
GU Med	Cervical screening in HIV positive females in RGDH GUM department	Yes	Remind staff at Clinical Effectiveness meeting to continue to offer annual cervical screening to HIV positive females; Consider the need for extra administrative support within the HIV team; Agree a local screening policy for females under 25 who are HIV positive. Register re-audit.
GU Med	Patient Group Direction Audit of Etonogestrel Implant	Yes	Adjust SystmOne template to include tick box for: <ul style="list-style-type: none">• "leaflet offered" or "declined"• "Medication given under PGD"• "Informed Consent obtained" Change wording on audit form to say info leaflet "offered" instead of given, as the standard will still be met if leaflet is declined.
GU Med	Patient Group Direction Audit for progestogen Only Pills (POP)	Yes	Adjust SystmOne template to include tick box for: <ul style="list-style-type: none">• "leaflet offered" or "declined"• "Medication given under PGD"• "Informed Consent obtained" Change wording on audit form to say info leaflet "offered" instead of given, as the standard will still be met if leaflet is declined.
GU Med	Patient Group Direction Audit for Medroxyprogesterone	Yes	Adjust SystmOne template to include tick box for: <ul style="list-style-type: none">• "leaflet offered" or "declined"• "Medication given under PGD"• "Informed Consent obtained" Change wording on audit form to say info leaflet "offered" instead of given, as the standard will still be met if leaflet is declined.
GU Med	Patient Group Direction Audit for Lidocaine	Yes	Adjust SystmOne template to include tick box for: <ul style="list-style-type: none">• "leaflet offered" or "declined"• "Medication given under PGD"• "Informed Consent obtained" Change wording on audit form to say info leaflet "offered" instead of given, as the standard will still be met if leaflet is declined.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
GU Med	Patient Group Direction Audit for Combined Oral Contraceptive	Yes	Adjust SystmOne template to include tick box for: <ul style="list-style-type: none"> • “leaflet offered” or “declined” • “Medication given under PGD” • “Informed Consent obtained” Change wording on audit form to say info leaflet “offered” instead of given, as the standard will still be met if leaflet is declined.
GU Med	Audit for Patient Group Direction for Ulipristalacetate (Contraceptive and Sexual Health)	Yes	Adjust SystmOne template to include tick box for: <ul style="list-style-type: none"> • “leaflet offered” or “declined” • “Medication given under PGD” • “Informed Consent obtained” Change wording on audit form to say info leaflet “offered” instead of given, as the standard will still be met if leaflet is declined.
GU Med	Audit for Patient Group Direction for Levongestrel (Contraceptive and Sexual Health)	Yes	Adjust SystmOne template to include tick box for: <ul style="list-style-type: none"> • “leaflet offered” or “declined” • “Medication given under PGD” • “Informed Consent obtained” Change wording on audit form to say info leaflet “offered” instead of given, as the standard will still be met if leaflet is declined.
GU Med	Audit of Partner Notifications at CASH (Contraceptive and Sexual Health Service) for Chlamydia	Yes	Review staffing allocation to replace Health Adviser establishment at CASH to allow for Partner Notifications follow up.
GU Med Safeguarding	Re audit of the use of national Child Sexual Exploitation “spotting the signs” under 18 risk assessment proforma in GU Med	Yes	All reception and administration staff are now aware that all patients under 18 require a proforma to be placed in the notes when the patient attends. Medical and nursing staff should be aware of the proforma and be proactive in obtaining a proforma for any patients who do not have one at their appointment. Keep a supply of the proforma in all clinical rooms. Correct use of the proforma should be taught to all new staff that work in the department, and the need for senior discussion should be highlighted to such staff, even if there are no concerns elicited.
Haematology	Re-audit of virology testing in lymphoma patients requiring monoclonal antibody therapy	Yes	Re-iterate the screening policy to clinicians and the importance of clinical information on request forms by presenting the results to the Haematology Governance meeting. Liaise with Microbiology Laboratory staff to re-iterate the need for Hepatitis B Surface and Core. A pre-treatment Chronic lymphocytic leukaemia (CLL) checklist to be drafted and agreed.
Haematology	Audit of microbiological surveillance in patients on prophylactic Ciprofloxacin	Yes	To continue the use of Cipro prophylaxis for Acute myeloid leukaemia (AML) patients. To liaise with the Microbiology team regarding all inpatients with AML receiving surveillance for the entire admission.
Haematology	Case note review of cancer peer review measures	Yes	The pre-chemo stamp will be amended to contain the Key Workers contact number and the acceptance by the patient of the offered written copy of a letter.
Haematology	Documentation 2014	Yes	A laminated list of the documentation standards will be attached to the notes trolley. Mortality reviews undertaken where documentation standards fall short will be given a NCEPOD score of 3/5.
Haematology	Consent Audit 2015	Yes	Feedback to the team at governance and ward team meeting the requirement of informing patients of the anaesthesia to be used and documenting this on the consent form, where applicable, of providing the patient with an information leaflet and recording which leaflet has been given i.e. bone marrow biopsy and to ensure the consent form is dated by the patient/parent.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Haematology	Treatment of extravasation PGD36	Yes	No actions required.
Haematology, OMFS	Benzydamine HCl (Difflam) Oral Rinse PGD29v2	Yes	No actions required.
Haematology	Paracetamol for mild to moderate pain or pyrexia PGD80	Yes	No actions required.
Haematology, OMFS	Re-audit of maxillofacial referrals for patients with myeloma requiring bisphosphonate therapy	Yes	No actions required.
Integrated Medicine	Automatic alcohol dispensers - are they working?	Yes	Presentation of the results to the Infection Control Committee and discussions with Matron's and Ward Managers. To introduce a log book on each ward for signatory confirmation regarding the alcohol dispensers and whether they are working.
Integrated Medicine	Re-audit of delirium management	Yes	To link the delirium and dementia patient screening tools. Posters to be created regarding delirium management and placed on each ward. Junior doctors to be educated about how to recognise dementia and delirium. A comprehensive geriatric assessment to be carried out on admission.
Integrated Medicine	Radioiodine in the management of benign thyroid disease	Yes	To maintain a database of patients undergoing radioactive iodine treatment.
Integrated Medicine	Review of case notes for patients with a Primary Diagnosis of Acute Kidney Injury as part of CQC mortality alert	Yes	Acute kidney injury bundle to be devised and implemented.
Integrated Medicine	The availability and accessibility of Hypoboxes on all wards and departments	Yes	Hypo Boxes to be moved to the resuscitation trolley and ward managers informed of the transfer. Wards to be made aware that they can contact the Diabetes Centre if there are any problems with the Hypo Box or if they are having issues with replenishing it. To devise and implement a separate audit to highlight how episodes of Hypoglycaemia are treated at the Trust.
Integrated Medicine	Retrospective audit of Teicoplanin levels in patients with osteomyelitis discharged from A5	Yes	Discuss the recommendation to increase the dose of Teicoplanin to 12mg/kg with microbiology, with an aim to changing the policy. Introduce a book on the wards for a record to be kept and monitored of all patients on Teicoplanin. Establish weekly meetings with vascular access to discuss inpatients or outpatients on Teicoplanin, to ensure up to date Teicoplanin levels are available. To undertake a re-audit to look at all patients on Teicoplanin for osteomyelitis to ascertain if the changes implemented have had an impact on therapeutic levels. Results presented to the Medicine Clinical Effectiveness meeting.
Integrated Medicine	Community acquired pneumonia audit 2013/14	Yes	Pneumonia care bundle to be implemented.
Integrated Medicine	Implementation of Pneumonia Care Bundle	Yes	A re-audit of community acquired pneumonia to be carried out.
Integrated Medicine	Primary PCI Pathway Audit	Yes	No actions required.
Integrated Medicine	DEXA	Yes	No actions required.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Integrated Medicine	General Medicine and Elderly Medicine Outpatient Follow Up Attendances	Yes	No actions required.
Integrated Medicine	Emergency Admissions in Over 70s though the Medical Assessment Unit	Yes	No actions required.
Integrated Medicine	Cardiology Outpatient Follow Up Attendances	Yes	No actions required.
Integrated Medicine	Consultant to Consultant Referrals into Medicine Specialties	Yes	No actions required.
Integrated Medicine	Lower Respiratory Tract Disease and Weekend Mortality	Yes	No actions required.
Integrated Medicine	Cardiac Rehabilitation Audit	Yes	No actions required.
Integrated Medicine	Alcohol spot audit	Yes	No actions required.
Integrated Medicine	Time from arrival (on the ward) to clinical assessment on ward B1	Yes	No actions required.
Integrated Medicine General Surgery Orthopaedics	Treatment escalation plans/ DNACPR decisions in current inpatients	Yes	Pilot a Friday ward round pro-forma for 3 weeks across the wards. Undertake a satisfaction survey regarding documentation of treatment escalation plans/do not resuscitate decisions to all doctors, nurses and physiotherapists across the Trust. Introduce a treatment escalation plan proforma.
Lab Med	Photopheresis Central Line Audit	Yes	To set standards regarding the documentation of central venous access device (CVAD) care within the unit. To produce a long term CVAD care plan for use within the ECP department. A CVAD 'passport' to assist in the documentation of line care for patients who are seen at multiple NHS Trusts to be produced.
Lab Med	Documentation 2014	Yes	No actions required.
Neurorehabilitation	Documentation 2014	Yes	The importance of documenting date, time, place, signing entries, printing names and designation to be highlighted at the Clinical Governance meeting.
Neurorehabilitation	Re-audit of management of depression following brain injury	Yes	Appropriate tools to be identified for use in improving adherence to documentation of the initial screen being undertaken and reference to discussion with patient/family/staff.
O&G	Shoulder Dystocia	Yes	Disseminate audit findings via Labour Ward and Wharncliffe handover and display boards of key findings of audit – to improve compliance with standards. Continue prospective audit of cases and feedback early 2017 at Clinical Effectiveness meeting.
O&G	Pre-existing diabetes in Pregnancy	Yes	Develop a Pre Conception Clinic to aim to increase the proportion of women booking with good glycaemic control ($HbA1c < 7\%$) by 2% for patients with type 1 diabetes and 5% for patients with type 2 diabetes to be more closely aligned to the national average. Continue to develop Pre-conception Clinic with CCG and Diabetes Joint Meeting – to reach Type 2 patients. Continue work at introducing Type 2 Education programme on diabetes through diabetes clinical network and adult diabetes team. Encourage all women to consider breastfeeding and document when done. Audit success of breastfeeding and expression in 2017, as part of National Pregnancy in Diabetes Audit (NPID). Change local database to reflect changes required from NICE and NPID for January 2016 data. Register re-audit.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
O&G	Severe Pre-eclamptic toxæmia (PET) and Eclampsia	Yes	Revise guideline stating revised audit standard for severe pre-eclampsia out of hours, to allow review by consultant anaesthetist or Registrar and discuss with Consultant Obstetrician. In eclampsia, ensure Consultant physical review by both obstetric and anaesthetic. Email Supervisors of Midwives Department re learning points and do summary slide for board on Labour Ward (LW) and Wharncliffe relay key audit findings to LW and Wharncliffe handovers / posters. Continue contemporaneous audit and feedback in timely manner – with audit presentation of 2016 data in early 2017
O&G	National Post-Partum Haemorrhage Audit	Yes	Display the information on Labour Ward noticeboard and add to learning points to use Ergometrine as the first additional uterotonic in treating PPH, (give syntocinon bolus first if not had Active Management of the Third Stage of Labour AMTS); Second cannula insertion in all major PPH and be sure to document this; consider Syntometrine for ATSM in high risk patients;
O&G	Audit of case notes - fetal anomalies "late" referrals to Jessops	Yes	Add criteria for timing of referrals for fetal anomalies to antenatal screening database for continuous audit. Ensure all referrals are known to antenatal screening coordinators. Display photos of the team to increase awareness. Ensure attendance of Antenatal screening team at perinatal meetings. Memo to all staff and photos in induction pack for medical staff. Ensure midwives and sonographers in Greenoaks are aware of time criteria for referrals. Letter to be sent to Leeds and Sheffield tertiary unites regarding feedback on referrals. Meet with Jessops Lead to present data and determine referral criteria.
O&G	Re-audit of membrane sweep at end of pregnancy	Yes	To repeat the membrane sweep audit on women who deliver in March 2016 in 6 months from last audit
O&G	Midwifery Maternity Records Audit	Yes	Disseminate results to midwives via: <ul style="list-style-type: none"> • monthly Maternity newsletter • Annual reviews with midwives • Supervisor of midwives notice boards. Disseminate results to midwives, and discuss revision of booklet at Supervisors of Midwives meeting to ensure that patient demographics are recorded on all sheets, including those held in booklets. A space for a demographic sticker could be provided when booklets are reprinted. Discuss revision of audit proforma to include further criteria.
O&G	Audit of completion of patient records and documentation for supply or administration of a drug under a Patient Group Direction (PGD)- Entonox for Adults and Children (PGD32v2)	Yes	Add to learning points, to PGD and midwives exemptions advice notice that: staff on Wharncliffe, Antenatal Day ward, Triage and Labour ward need to document that Entonox is administered under a PGD on the 'Drugs given Without Prescription' section of the Drug cards, and also that Records must show that Entonox is given by inhalation.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
O&G	Re-audit of induction of labour (IOL)	Yes	<p>Hold a multidisciplinary teaching session for trainees, Obs forum, Supervisors of Midwives, Community Midwives, band 7s and leads in Antenatal Day unit and Triage to: Increase awareness of indications and appropriate gestation for induction. Introduce a sticker to aid counselling for induction of labour, including points from NICE Quality Standard 60. All inductions for reduced fetal movements to be discussed with Consultant if practicable. Discuss at diabetes team meeting and update local guidance to move to NICE guidance on IOL for gestational diabetes mellitus (GDM) i.e. will be later gestation e.g. diet controlled Jan 2016. Set guideline criteria for induction of labour in cases of Obstetric Cholestasis. Discuss criteria for Induction of Labour with Staff Grade Anaesthetists at Consultants' Obs forum and Develop strategies for failed IOL management on how to improve consultant input; Focus on ways to reduce Caesarean Section rate from IOL Changeable ones are:</p> <ol style="list-style-type: none"> 1. Failed IOL 2. Second stage C. Section for slow progress. Discuss ways to reduce delays such as considering introduction of outpatient IOL. Labour Ward forum to consider dedicated hour for admission and management each day for inductions. Re-audit in 2017 to monitor compliance
O&G	Audit of operative vaginal delivery	Yes	Add to 6 monthly training to promote appropriateness of analgesia. Relook the total deliveries for the 3/12 period and the information for 12 patients with estimated blood loss (EBL). Break down supervision by Consultant data into level of trainee and time of day. Re-audit and incorporate into audit proforma to focus on women during first pregnancy looking at their care in 2nd stage.
O&G	Audit of outpatient medical management of miscarriage	Yes	To discuss at Gynae forum regarding the need for a second visit if not passed tissue with first miso prostal or giving the patient 2 doses of miso prostal to take home. Consider extending the service to weekends
O&G	Audit of gestational diabetes mellitus	Yes	Update the local guideline on diabetes and pregnancy to meet NICE recommendations. Add new fields to the GDM Access Database. Request GP to check Fasting plasma glucose at 6–13 weeks, by creating discharge letter template in Meditech. Re-audit April 16 – March 2017, to measure compliance with new NICE guideline after implementing the Local guideline.
O&G	Perineal Trauma (3rd and 4th degree tears)	Yes	Include instrumental delivery training on Specialist Registrars' induction programme and at 6 months. Add to leaning points to remind midwives about perineal support. Add 'episiotomy' and perineal protection to the audit proforma to audit proforma for re-audit.
O&G	See and treat (by LETZ) in colposcopy for high grade smear	Yes	Expand the service with 2 consultants
O&G	Consent 2014 (Obs)	Yes	Expand the service with 2 consultants. Add to staff reminders to remember to tick box on both copies of risk stickers. Always try to give the patient's copy to the patient, not just offer, to ensure that they keep all the pertinent information.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
O&G	Audit of repeat Surgical Evacuation for Miscarriage	Yes	Contact coding department to clarify and simplify coding for all Evacuation of Retained Products of Conception (ERPC) / Manual Vacuum Aspiration (MVA) so that all cases of second ERPC can be easily identified. Consultant or senior registrar (ST6-7) to be present for all repeat Evacuation of Retained Products of Conception. Discuss use of ultrasound guidance for all repeat Evacuation of Retained Products of Conception. Disseminate audit action plan, specifying surgeon to be responsible for Datix entry. Discuss Datix completion in Gynaecology forum. Display Datix Gynaecology trigger list in B11 and other Gyna areas. Consider misoprostol PV before repeat Evacuation of Retained Products of Conception. Re-audit to include looking at outcomes of second Evacuation of Retained Products of Conception including length of hospital stay, antibiotics required, need for blood transfusion.
O&G	Re-audit of Cardiotocography (CTG) and Fetal Blood sampling (FBS) in labour (Quarter 1)	Yes	Feedback audit findings to midwives and doctors at labour ward handover and Cardiotocography meetings.
O&G	Consent Audit (Gynae) 2015	Yes	Use risk stickers provided in clinic; Review leaflets available in clinic for Gynae procedures; Consider adding consent form to notes when prepared for pre-op assessment clinic, and for pre-assessment nurses to give information leaflet at assessment, documenting it on the form. Sections on Photography and tissue retention should be crossed out if not applicable.
O&G	Documentation (Gynae) 2015-16	Yes	Put in Learning points for handover as a reminder that each entry must be signed with a legible name and designation, and that the location of patient review must be documented for each entry.
O&G	Swab Counting Audit	Yes	No actions required.
O&G	PG Patient Group Direction Audit of estriol pessaries dispensed in Obstetrics & Gynaecology under patient group direction code 120705 2013-14	Yes	No actions required.
O&G	Patient Group Direction Audit of local anaesthetic to Cervix administered under patient group direction code 120706 2013-14	Yes	No actions required.
O&G	Emergency Hormonal Contraception PGD: Ulipristal	Yes	No actions required.
O&G	Results to Women (1/12/14 - 28/2/15)	Yes	No actions required.
O&G	Results to Women (1/8/14 - 31/10/14)	Yes	No actions required.
O&G	Moderate/ Severe dyskariosis waiting times for colposcopy appointments 1/7/14 - 31/12/14	Yes	No actions required.
O&G	Moderate/ Severe dyskariosis waiting times for colposcopy appointments 1/1/2015 - 30/6/2015	Yes	No actions required.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
O&G	Query invasive or glandular neoplasia waiting times for colposcopy appointments	Yes	No actions required.
O&G	Patient Group Direction for Codeine Phosphate 30mgs	Yes	No actions required.
O&G	Membrane sweep audit at end of pregnancy	Yes	No actions required.
O&G	Time of Review on Admission for Reduced Fetal Movement	Yes	No actions required.
O&G CYP Service	Audit of admissions to Wharncliffe/SCBU or Children's Ward with excessive weight loss >10% and/or hypernatremia	Yes	Discuss with ward midwives to ensure Babies born before 37 weeks are feeding well before discharge and not to assume multiparous mothers are competent at feeding. Consultant Lead to disseminate that a Paediatrician is to document a diagnosis in the notes on first review at admission. Registrars to see all babies readmitted with weight loss before discharge. Establish whether an SHO can discharge if registrar has reviewed and put suitable treatment plan in place.
O&G Lab Med	Audit of Serum Progesterone in Management of Pregnancy of Unknown Location (PUL)	Yes	Early Pregnancy Assessment Unit (EPAU) staff will do Serum HCG and progesterone after Positive UPT at home/GP and scan showed PUL. Inform EPAU nurses staff and junior doctors not to request progesterone if there is a definite gestational sac or retained products of conception. Set up prospective review of P<10 group – consider UPT in 2/52. P=10-20 group – consider repeat HCG in 2 days add into the revised guidelines after completion of the prospective audit.
O&G Safeguarding	Perinatal Domestic Abuse Screening Audit	Yes	The policy for the 'screening and management of domestic abuse in pregnancy' to be re-communicated in all areas within the maternity unit. Re-audit and remove 'seen alone' question from audit.
OMFS	Audit of thermal changes of slow speed handpieces	Yes	Continue to monitor handpieces, replace any hand pieces which repeatedly require servicing and in future do not purchase latch grip hand-pieces.
OMFS	Compliance with investigations for patients admitted with orofacial infections	Yes	Deliver Thursday morning teaching session to increase awareness of the required investigations for orofacial infections. Re-audit to assess whether improvements have been made.
OMFS	Documentation 2014 - OMFS	Yes	Amend the Dental Core Trainee handbook to include a section on documentation requirements. Include session on documentation requirements in new Dental Core Trainee induction.
OMFS	Completion of post traumatic eye observations	Yes	Provide departmental teaching for current and future Dental Core Trainee doctors on the correct eye examinations required for patients who have sustained a traumatic eye injury. Update the Induction booklet to provide further guidance and ensure eye observation charts and guidance is readily available within the 'on call' book.
OMFS	Audit of custom made orbital floor implants	Yes	Develop template for capturing information on post-operative complications and carry out a prospective re-audit.
OMFS	Do OMFS trauma patients receive patient information leaflets about their condition?	Yes	Educate Dental Core Trainees at Induction on the requirement to provide the 'lower jaw fractures' leaflet to patients undergoing surgery for mandibular fractures and record this on consent form. Assess whether improvements have been made following education.
OMFS	Consent Audit 2015	Yes	Ensure information leaflets are provided to all patients and this is documented on the consent form - forms to be moved to a more accessible location. Remind clinicians of the important risks that should be discussed with patients and documented on the consent form. Re-assess performance in June 2016.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
OMFS	Altered sensation following bilateral sagittal split osteotomies (BSSO)	Yes	No actions required.
OMFS	CBCT in pre-surgical assessment of third molar exodontia	Yes	No actions required.
Ophthalmology	The outcomes for patients with Diabetic Macular Oedema treated with intravitreal ranizumab	Yes	Increase number of patients seen and provide treatment at every visit by meeting with the Medical Retina team to consider introduction of a 'one stop clinic' for treatment. Introduce a formal effective pathway for treatment and longer acting treatment by making changes to clinic slots and the structure of sessions. Deliver official training to Ophthalmic nurses to provide injections to patients.
Ophthalmology	Re-audit of Glaucoma assessment for new referrals	Yes	Liaise with doctors and nurses to reinforce that Ophthalmologists should ask the nurses to dilate the pupils for every new patient referred for possible glaucoma or ocular hypertension. Intraocular pressure to be measured before dilation. Look into the use of central corneal thickness (CCT) and liaise with relevant staff to ensure that the pachymetry is working properly.
Ophthalmology	Re-audit of Retinopathy of Prematurity Screening	Yes	Liaise with the Paediatric Department to ensure referrals for eye screening are made or forecast earlier (by 1 week) to ensure babies are seen within the recommended timescales. Amend the audit data collection tool to include information on outstanding health issues and reasons babies may not have been seen in time.
Ophthalmology	Consent Audit 2015	Yes	Contact all doctors to remind them to ask patient's to document their signature in the correct place. Ask nurses to ensure consent is reconfirmed.
Ophthalmology	Cataract Surgery Outcomes – Re-audit	Yes	Raise awareness at the Clinical Effectiveness meeting of the need for dropped nucleus cases to be referred to the Royal Hallamshire Hospital, with a follow up appointment within one month.
Ophthalmology	Ophthalmology Outpatient Follow Up Attendances	Yes	No actions required.
Orthopaedics	Reasons for day of surgery cancellations	Yes	Liaise with the pre-assessment department to improve the assessment process for day surgery patients. Improve communication between the anaesthetist and surgeon by better list planning and joint assessment of potential cancellations. Consider whether it is feasible to have a last minute group of potential elective patients should a cancellation occur. Consider the feasibility of contacting all the next day admissions to check fitness for surgery. Repeat the day cancellation audit to assess whether improvements have been made.
Orthopaedics	Re-audit of blood glucose monitoring in neck of femur fracture patients	Yes	Liaise with Ward Managers to ensure blood glucose is checked as part of the nursing admission for patients admitted with fractured neck of femur.
Orthopaedics	National Ligament Registry: review of current practice	Yes	Review data collection processes to ensure all anterior cruciate ligament reconstruction (ACLR) operations are added to the Registry; secretary to add patient demographics and date of surgery; preoperative Day Surgery Unit physiotherapist to remind the patient on admission to login to smartphone and complete scores for patient related outcome measurements; theatre staff to log in during operation to enter intra-operative findings; and Physiotherapist/Consultant to remind patient before discharge to complete the 6 month follow up patient related outcome measurements.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Orthopaedics	Infected or inappropriate admissions to Keppel ward	Yes	Introduce a standard operating procedure for medical admissions to Keppel Ward to ensure all patients admitted are appropriate. Convert bay 4 and two cubicles on Keppel Ward into Rehabilitation beds specific for Orthopaedics. Develop and introduce an assessment protocol for rehabilitation transfer patients to allow senior nurses to assess and manage the transfer of these patients. Move the GP assessment cubicle to Ward B3/Fitzwilliam Ward. Ensure all inappropriate admissions/transfers are recorded on Datix.
Orthopaedics	Consent 2014 - Orthopaedics	Yes	Provide consent training to junior doctors. Create stickers to ensure all applicable risks and benefits are discussed with patients and this is documented on the consent form. Raise awareness of the need to record whether a copy of the consent form has been given to the patient. Repeat the audit to assess whether improvements have been made following implementation of the action plan.
Orthopaedics	Audit of Fracture Clinic Waiting Times	Yes	Implement the virtual fracture clinic to reduce patient waiting times.
Orthopaedics	A review of the management of displaced paediatric supracondylar humeral fractures at Rotherham Hospital	Yes	Circulate British Orthopaedic Association Standards for Trauma – Guideline 11 and print and display in theatres to ensure: improved documentation of vascular and neurological assessments; post-operative x-rays in the recommended time frame to ensure maintenance of reduction; and treating surgeons to document neurovascular status systematically once he/she is confident there is no risk of vascular compromise or compartment syndrome. Re-audit to assess whether improvements have been made.
Orthopaedics	Audit of Documentation of Senior Ward Reviews	Yes	No actions required.
Orthopaedics	Readmissions 2014-15 (Clinical Effectiveness workstream)	Yes	No actions required.
Orthopaedics	Trauma and Orthopaedics Outpatient Follow Up Attendances	Yes	No actions required.
Palliative Care	Referral Monitoring and Interventions	Yes	Results of the audit to be presented at appropriate forums. A re-audit to be undertaken to assess if improvements have occurred. An audit of time spent on interventions for inpatients to be carried out. To provide education updates to clinicians via presentations at meetings, and within planned educational programmes. Ensure up to date information is available on InSite and upload new information as available.
Palliative Care	Audit of diagnostic testing in outpatient palliative care setting	Yes	No actions required.
Radiology	A&E CT Head Timings Audit - Annual Re-audit	Yes	The importance of reporting A&E CT heads in a timely manner to be re-iterated to the reporters. CT staff to inform the duty radiologist once a CT head has been performed.
Radiology	Diagnostic Reference Levels in Nuclear Medicine	Yes	Results to be presented at the Nuclear Medical Staff meeting in June 2015. Re-iteration to be given to all staff to ensure that patient doses are recorded on the request card and on Agfa RIS and reminded of the local diagnostic reference levels (DRLs), to ensure they remain within 10% of these.
Radiology	Polytrauma CT Audit	Yes	Discuss with CT staff the need to improve documentation for overruling EGFR/LMP. Discuss with Radiologists the need to report scans within the 1 hr timeframe.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Radiology	Consent 2014	Yes	All staff to be reminded in departmental meetings to ensure that consent forms are signed by the clinician and the patient.
Radiology	Consent Audit 2015	Yes	Re-iteration to staff at quality governance meeting that consent forms should be dated in the appropriate place by the clinician/patient and that information leaflets regarding the procedure should be provided to patients.
Radiology	Clinical evaluation of Medical Exposure to radiation	Yes	Results of this audit will be forwarded to the Clinical Effectiveness lead in Orthopaedics for comments from the division.
Radiology	National Audit of Radiology Alert Systems (Royal College of Radiologists)	Yes	No actions required.
Radiology	British Nuclear Medicine Society (BNMS) Datscan National Audit 2015	Yes	No actions required.
Radiology	Gadolinium based contrast media PGD 37v2	Yes	No actions required.
Radiology CYP Service	National Audit of Standards for the provision of Paediatric Radiology 2013	Yes	Confirm with Sheffield Hallam University that all newly appointed radiographers will have undergone specialist training at Sheffield Children's Hospital (SCH) in respect of children's imaging. Radiographers imaging children should be encouraged and able to attend paediatric specific Continuous Professional Development courses. Discussions to be held with SCH radiologists regarding 24/7 access to a specialist paediatric radiology / neurology opinion. Funding arrangements to support access to second opinion will be determined with Children and Young People's Health Service.
Rheumatology	Regional audit of Giant Cell Arteritis management as per British Society of Rheumatology Guidelines (2010)	Yes	Carry out an in-depth local audit to fully understand where improvements may be required.
Rheumatology	Biologic Treatment (Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis)	Yes	Liaise with the audit system software suppliers to clarify how the online reports are produced. Establish a working group to consider the implementation of a biologics clinic where patients are seen by a clinical nurse specialist.
Rheumatology	Audit of compliance with RGH protocol on the initial management of Giant Cell Arteritis	Yes	Raise awareness of the clinical importance, understanding of blood tests and prompt biopsies for patients with suspected Giant Cell arteritis with Ophthalmology colleagues by delivering a teaching session. Set up a system to prospectively monitor Giant Cell Arteritis referrals and subsequent management.
Rheumatology, Therapy Services & Dietetics	Audit of anti-smoking advice and weight loss strategy advice	Yes	Source or develop resources to offer to patients with advice on weight loss and smoking cessation.
Safeguarding	To audit the use of the mental capacity guidance when proposing serious treatment for patients who lack the capacity to consent	Yes	Raise awareness of the Mental Capacity Act (MCA) and legal framework; Incorporate Discussion of MCA as part of Trust Consent training; Use named Doctor for Adult Safeguarding to promote and improve use of Consent Form 4. Present audit at Joint Adults And Children Safeguarding Operational Group (JACSOG) and circulate to heads of departments for cascading.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Safeguarding CYP Service	Retrospective Audit of SystmOne Child Health Records to determine the timeliness of flagging of records following discussion at Multi Agency Risk Assessment Conference (MARAC) (Safeguarding)	Yes	Streamline flagging of records on SystmOne by establishing a SOP for the Data Quality team to flag all cases following bimonthly MARAC meetings.
Safeguarding, Trust wide	Croydon Action Plan - re-audit of nursing care plans to include information regarding children in the family and other significant family members	Yes	Raise awareness in all Teams as to why it is important to collate information of children or dependents, in particular if a patient has been admitted following suicide attempt or self-harm. Full review of care plans and Nursing Records to include information in relation to children or dependents. Include a new section at the beginning of assessment: 'This is me' - a summary of 'who I am in relation to my circumstances and background'. Implement the new process 'Safeguarding – Additional Family Information of Patients Considered Potentially at Risk (Attempted Suicide or Self Harm)' Form.
Therapy Services & Dietetics	Lower Back Pain	Yes	Improved questioning, documentation of a full history and chronology of the presented condition and/or in relation to any previous low back pain and treatments is required. All clinicians made aware of this outcome. Improved documentation of objective examination at initial assessment is required. All clinicians made aware of this outcome, to make sure to question and document a full history and chronology of the presented condition and /or in relation to any previous low back pain and treatments. All clinicians should be mindful of providing more advice regarding self-management and remaining active and carrying out better documentation of this. More written educational material should be given to patients. Responsibility of checking levels of educational material available and re-ordering of stock to be determined. Clinicians to improve in the documentation regarding exercise programs offered to patients.
Therapy Services & Dietetics	A review of the current monitoring at annual review for patients with Coeliac Disease	Yes	To arrange to meet with the Gastroenterologists at the Trust to discuss the findings and determine further action.
Therapy Services & Dietetics	Audit of compliance by Orthopaedic physiotherapy practitioner to the injection Patient Group Directions within Therapy Services	Yes	Staff to complete the annual CPR/Anaphylaxis training and to continue with the requirements of their continued personal development, supervision and training. The arthritis research UK leaflet on 'local steroid injections' to be used as the patient information leaflet. The 'MSK injection checklist' is to be utilised when writing up patient notes onto SystmOne.
Therapy Services & Dietetics	Audit of paediatric coeliac disease patients current dietetic practice compared with published and departmental guidelines	Yes	To develop a written clinical checklist in line with NICE/ British Society Of Paediatric Gastroenterology, Hepatology And Nutrition (BSPGHAN) guidelines for the monitoring of children with coeliac disease. Children with Type 1 Diabetes as well as Coeliac Disease will be offered a Coeliac Annual Review appointment.
Therapy Services & Dietetics	Phone Triage Quality Audit - continuation from 2013-14 audit cycle	Yes	Introduce a 'quick' button on the phone triage template to send the clinician to the dysphagia risk assessment on the outcomes template and consider ways to address poor evidence of oromotor functioning. A phone triage SOP to be completed. Increase timetabling to work towards a target of 4 working days maximum wait for initial contact. Meeting to be held with the service evaluation lead to discuss the use of a service evaluation form for users.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Therapy Services & Dietetics	Implementation of Re-Feeding Action plan advised by Dietician in line with Trust Re-Feeding Guidelines	Yes	Regular education and training sessions for hospital medical and nursing staff on the implementation of re-feeding action plans to be delivered.
Therapy Services & Dietetics	Documentation 2014 (scanning of new referrals into SystmOne)	Yes	To reinforce to the administration team the standard of 2-3 working days for the scanning of new referrals and continue to monitor this. Aim for all documentation i.e. letters, reports to be scanned within 2-3 working days of receipt. Identify additional templates/documents which could be added to SystmOne to reduce paper documentation for scanning.
Therapy Services & Dietetics	Audit of OPP referrals for MRI imaging of the spine and periphery	Yes	Orthopaedic Physiotherapy Practitioners (OPPs) to be given a paper copy of the Group Protocol regarding referral of patients for an MRI and given time to understand and discuss its implications. OPPs to also be informed of where to find this document on the shared K drive. Discussion at OPP meeting to review what qualifies as an urgent or a routine scan and the need to document and justify the speed of the scan in medical records. Discuss the correct recording of referrals on the IMPAX database.
Therapy Services & Dietetics	Audit of dietetic referrals received from Rotherham Care Homes for older adults	Yes	Dietetic care home team to determine the training needs of care home staff and agree a timescale for offering training.
Therapy Services & Dietetics	Enteral feeding in Critical Care: Prescribed vs Delivered Feeds	Yes	To disseminate findings to colleagues at a critical care governance meeting or a suitable alternative forum. To include additional information on the prevention of enteral feeding issues in all critical care training programmes. Carry out research into current evidence base for nutritional requirements in critical care.
Therapy Services & Dietetics	Re-audit of compliance by Orthopaedic Physiotherapy Practitioners to the injection Patient Group Directions within Therapy Services	Yes	No actions required.
Therapy Services & Dietetics	Therapy Intervention Audit	Yes	No actions required.
Trust wide	Medicines Management Audit	Yes	Matrons and senior medics to take responsibility for ensuring all areas for improvement are conveyed to staff and to monitor regularly. These include: spot checks of secure storage; daily fridge temperature checks; Daily checking of Controlled drug stock; Accurate completion of Controlled drugs register; Drug kardex training to enhance full documentation and timing of prescriptions, location, allergy status, patient and staff details on Drug kardex; Ensure availability of pharmacist at ward rounds; Timeliness and full documentation of fluid infusions; Correct use of non-administration codes; Checking expiry dates, infection control and providing information to patients.
Trust wide	Standards for acutely ill patients in hospital	Yes	Cascade standard to Senior Managers, Ward Managers and Matrons that all patients on the 4-sided Patient at Risk (PAR) chart must have a minimum of 3.5 to 4.5 hourly observations over a 24 hour period. This must be increased to hourly if the patient triggers i.e. score ≥ 3 . 221 bleep holder to spot check PAR charts regularly. Senior nurses to educate and support staff in the completion of charts. Ward managers MUST ensure all staff are trained by Outreach team on the Early Warning Scoring System (EWSS). Re-audit.

Clinical Service Unit/ Foundation Unit	Audit Title	Reviewed	Action(s) to Improve Quality of Care
Urology	Suspected Urological Cancer Audit	Yes	Contact the Clinical Information Development Manager to ascertain whether the Meditech system can be updated to include recent Urea and Electrolytes results into the CT scanning request form, in order to avoid any unnecessary delays. Meet with radiology to look at capacity for 'hot' CT scan reporting or using alternative clinic dates to increase the speed of reporting.
Urology	Audit of Urology Readmissions within 28 days	Yes	Ensure all patients receive information on who to contact if they have problems after discharge - contact all ward nurses and junior doctors to ensure this information is provided to patients prior to discharge.
Urology	Consent Audit 2015	Yes	Remind all staff at the Clinical Effectiveness meeting to ensure extra procedures are identified, and consent for photocopy/tissue samples is obtained and recorded on the consent form. Discuss with Clinical Effectiveness Lead for Anaesthetics regarding who is responsible for documenting the type of Anaesthetic to be used. Check with the pre-admission centre whether leaflets are provided and where this is documented. Introduce stickers to document which information leaflets have been provided.
Urology	Stress urinary incontinence in women/vaginal tape audit	Yes	No actions required.
Urology	PCNL audit (Percutaneous Nephrolithotomy audit) on BAUS website database	Yes	No actions required.

“Fantastic service.quickly waiting times and friendly staff. much much better than the apalling service at the walk in centre.”

**Friends and Family patient feedback
A&E**

“Lucas has been to the talking tots and I feel the one-to-one is more helpful to Lucas and is getting better at talking due to this service.”

**Friends and Family patient feedback
Children's S and L**

“Katarina was absolutely fantastic. Very impressed with help, info and knowledge. Maria and the delivery team were brilliant. Everything explained, made to feel special.”

**Friends and Family patient feedback
Delivery Suite**



Appendix Two

Appendix Two: CQC Maternity Services Review 2015

The results were published on 15 December 2015. The Trust uses national surveys to find out about the experiences of people who receive care and treatment.

During the summer of 2015, a questionnaire was sent on behalf of CQC to all women who gave birth in February 2015.

Responses were received from 91 patients at The Rotherham NHS Foundation Trust.

Table 41: Maternity services survey results 2015 [source; CQC]

Patient survey	Patient response	Compared with other trusts
Labour and birth	8.9/10	About the same
Advice at the start of labour: For being given appropriate advice and support	8.1/10	About the same
Moving during labour: For being able to move around and choose the most comfortable position during labour	7.9/10	About the same
Skin to skin contact: For having skin to skin contact with the baby shortly after the birth	9.7/10	Better
Partner involvement: For the partner being involved as much as they wanted	9.8/10	About the same
Staff during labour and birth	8.7/10	About the same
Staff introduction: For staff introducing themselves	9.1/10	About the same
Being left alone: For not being left alone by midwives or doctors at a time when it worried them	9.1/10	About the same
Raising concerns: For raising a concern and having it been taken seriously	7.8/10	About the same
Reasonable response time during labour: For feeling that, if they needed attention during labour and birth, a member of staff helped them within a reasonable amount of time	8.6/10	About the same
Clear communication: For feeling they were spoken to in a way they could understand during labour and birth	9.1/10	About the same
Involvement in decisions: For being involved enough in decisions about their care during labour and birth	8.7/10	About the same
Respect and dignity: For being treated with respect and dignity	9.4/10	About the same
Confidence and trust: For having confidence and trust in the staff caring for them during labour and birth	9.0/10	About the same

Patient survey	Patient response	Compared with other trusts
Care in hospital after the birth	7.5/10	About the same
Length of hospital stay: For feeling their stay in hospital after the birth was the right amount of time	7.1/10	About the same
Reasonable response time after the birth: For feeling that, if they needed attention after the birth, a member of staff helped them within a reasonable amount of time	7.2/10	About the same
Information and explanations: For feeling they were given the information and explanations they needed after the birth	8.2/10	Better
Kind and understanding car: For feeling they were treated with kindness and understanding by staff after the birth	8.2/10	About the same
Partner length of stay: For feeling like their partner who was involved in their care was able to stay with them as much as they wanted	4.8/10	About the same
Cleanliness of room or ward: For how clean the hospital room or ward was	8.8/10	About the same
Cleanliness of toilets and bathrooms: For how clean the toilets and bathrooms were	8.5/10	About the same



Appendix Three: Readmissions within 28 days

HSCIC have not yet updated this data (see message below) and will not now do so until August 2016. The Trust uses CHKS as an alternative way of validating this data, but still collects the data as part of the performance dashboard for the Board. The latest figures are:

Table 42: Trust readmissions data as at January 2016

'Unfortunately the publication for emergency readmissions to hospital within 28 days of discharge indicators has been delayed while HSCIC bring their production in-house from an external contractor. HSCIC are currently reviewing the methodology and specifications which will have an impact on when they will actually be published'. (source: HSCIC website)

Measure	2014/15		2015/16	
	Year end Position	National Target	End February Position	National Target
Elective patients 0-15 years readmitted to hospital within 28 days of discharge from hospital	2.40%	3%	0.5%	3%
Elective patients >16 readmitted to hospital within 28 days of discharge from hospital	1.40%	3%	2.6%	3%
Non-Elective 0-15 years patients readmitted to hospital within 28 days of discharge from hospital	8.50%	10.40%	8.7%	10.40%
Non-elective>16years patients readmitted to hospital within 28 days of discharge from hospital	10.00%	12.50%	9.8%	12.5%

In the meantime, the latest available readmissions indicators are available on the HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>) at Compendium of Population Health Indicators > Hospital Care > Outcomes > Readmissions are the 2011-12 figures. CHKS and HSCIC use different methodology for validating data so figures will vary.



Appendix Four

Appendix Four: Listening Into Action 'Pulse Check' Questions

Year 2 has seen an improvement in all pulse check questions with the exception of question 1 (0.18% lower score).

Table 43: Trust LiA pulse check scores for 2015

The Rotherham Foundation Trust Pulse Check scores	Year One	Year Two	Change	All LiA Trusts year two	Year two comparison
Q1: I feel happy and supported working in my team/department/service	55.57%	55.39%	(-0.18%)	52.22%	above average
Q2: Our organisational culture encourages me to contribute to changes that affect my team/department/service	37.27%	40.17%	(+2.9%)	39.16%	above average
Q3: Managers and leaders seek my views about how we can improve our services	35.28%	38.44%	(+3.16%)	38.33%	above average
Q4: Day-to-day issues and frustrations that get in our way are quickly identified and resolved	21.13%	23.6%	(+2.47%)	23.95%	below average
Q5: I feel that our organisation communicates clearly with staff about its priorities and goals	33.77%	39.31%	(+5.54%)	35.95%	above average
Q6: I believe we are providing high quality services to our patients/service users	59.06%	60.02%	(+0.96%)	54.43%	above average
Q7: I feel valued for the contribution I make and the work I do	39.43%	41.04%	(+1.61%)	38.18%	above average
Q8: I would recommend our Trust to my family and friends	45.09%	48.55%	(+3.46%)	49.65%	below average
Q9: I understand how my role contributes to the wider organisational vision	55.75%	58.57%	(+2.82%)	56.28%	above average
Q10: Communication between senior management and staff is effective	26.07%	29.09%	(+3.02%)	29.21%	below average
Q11: I feel that the quality and safety of patient care is our organisation's top priority	53.22%	58.86%	(+5.64%)	53.63%	above average
Q12: I feel able to prioritise patient care over other work	43.95%	50.96%	(+7.01%)	47.11%	above average
Q13: Our organisational structures and processes support and enable me to do my job well	29.98%	30.44%	(+0.46%)	32.08%	below average
Q14: Our work environment, facilities and systems enable me to do my job well	31.13%	31.98%	(+0.85%)	32.03%	below average
Q15: This organisation supports me to develop and grow in my role	34.32%	35.74%	(+1.42%)	37.08%	below average

Portal (<https://indicators.ic.nhs.uk/webview/>) at Compendium of Population Health Indicators > Hospital Care > Outcomes > Readmissions are the 2011-12 figures. CHKS and HSCIC use different methodology for validating data so figures will vary.



Appendix Five

Appendix Five: Staff Survey 2015 – changes in key findings

Table 44: Trust staff survey results for 2015 and changes since 2014

Changes in the key findings for The Rotherham NHS Foundation Trust since the 2014 survey				
	2014 score	2015 score	change	Statistically significant?
Response Rate (%)	44	42	-2	-
Staff pledge 1: To provide all staff with clear roles, responsibilities and rewarding jobs				
KF1: staff recommendation of the organisation a place to work or receive treatment	3.42	3.52	0.10	Yes
KF2: Staff satisfaction with the quality of work and patient care they are able to deliver	-	3.85	-	-
KF3 % agreeing that their role makes a difference to patients/service users	-	88	-	-
KF4: Staff motivation at work	3.68	3.80	0.12	Yes
KF5: Recognition and value of staff by managers and the organisation	-	3.33	-	-
KF8: Staff satisfaction with level of responsibility and involvement	3.81	3.83	0.02	No
KF9: Effective team working	-	3.70	-	-
KF14: staff satisfaction with resourcing and support	-	3.27	-	-
Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential				
KF10: support from immediate managers	3.67	3.68	0.01	No
KF11: % appraised in last 12 months	95	94	-1	No
KF12: quality of appraisals	-	2.92	-	-
KF13: quality of non-mandatory training, learning or development	-	3.97	-	-

“ You guys listen carefully to our concerns and issues. Give us the best possible advice available and the staff are really friendly. ”

**Friends and Family patient feedback
Child Development Centre**

Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety

Health and Well-being

KF15: % staff satisfied with the opportunities for flexible working	-	47	-	-
KF16: % working extra hours	67	68	1	No
KF17: % suffering work related stress in the last 12 months	39	37	-2	No
KF18: % feeling pressure in last 3 months to attend work when feeling unwell	64	63	0	No
KF19: Organisation and management interest in and action on health/well-being	-	3.59	-	-

Violence and Harassment

KF22: % experiencing physical violence from patients, relatives or the public in the last 12 months	13	12	-1	No
KF23: % experiencing physical violence from staff in the last 12 months	3	1	-1	Yes
KF24: % reporting most recent experience of violence	50	48	-2	No
KF25: % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	24	24	0	No
KF26: % experiencing harassment, bullying or abuse from staff in last 12 months	21	22	1	No
KF27: % reporting most recent experience of harassment, bullying or abuse	40	20	-20	Yes

Staff Pledge 4: to engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services

KF6: % reporting good communication between senior management and staff	25	24	-1	No
KF7: % able to contribute towards improvements at work	63	65	2	No

Additional Theme: Equality and Diversity

KF20: % experiencing discrimination at work in last 12 months	8	7	-1	No
KF21: % believing the organisation provides equal opportunities for career progression and promotion	89	89	-1	No

Additional Theme: Errors and Incidents

KF28: % witnessing potentially harmful errors, near misses or incidents in the last month	28	24	-4	Yes
KF29: % reporting errors, near misses or incidents in the last month	90	88	-2	No
KF30: Fairness and effectiveness of procedures for reporting errors, near misses or incidents in the last month	-	3.60	-	-
KF31: Staff confidence and security in reporting unsafe clinical practice	3.54	3.56	0.02	No

Additional Theme: Patient Experience Measures

KF32: Effective use of patient/service user feedback	3.51	3.59	0.08	Yes
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Independent Auditor's report to the Council of Governors of The Rotherham NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of The Rotherham NHS Foundation Trust to perform an independent assurance engagement in respect of The Rotherham NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

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 criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance issued by Monitor.

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 is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance 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 inconsistent with:

- board minutes and papers for the period April 2015 to April 2016;
- papers relating to quality reported to the Board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from Healthwatch Rotherham;
- feedback from Rotherham Health Select Commission;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment; and
- the latest CQC Intelligent Monitoring Report.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Rotherham NHS Foundation Trust as a body, to assist the Council of Governors in reporting the 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 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 The Rotherham NHS Foundation Trust for our work or this report, except 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'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller 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.

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 affect 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 of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by The 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 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.



KPMG LLP
Chartered Accountants
Leeds

26 May 2016



Acronyms

A&E	Accident & Emergency Department	LSAB	Local Safeguarding Adult Board
CEO	Chief Executive Officer	LSCB	Local Safeguarding Children Board
CEPOD	Confidential Enquiry into Perioperative Deaths	MAST	Mandatory and Statutory Training
CLAS	Children Looked After and Safeguarding	MCA	Mental Capacity Act 2005
CMACE	Centre for Maternal and Child Enquiries	MCIS	Macmillan Cancer Information Support Base
CHKS	Comparative Health Knowledge System,	MDT	Multi-Disciplinary Team
CCG	Clinical Commissioning Group	MRSA	Methicillin-resistant staphylococcus aureus
C-difficile	Clostridium Difficile	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
CGM	Continuous Glucose Monitoring	NCISH	National Confidential Enquiry into Suicide and Homicide by people with mental illness
CQC	Care Quality Commission	NHFD	National Hip Fracture Database
CQUIN	Commissioning for Quality and Innovation	NPSA	National Patient Safety Agency
CSE	Child Sexual Exploitation	NRLS	National Reporting and Learning System
Datix	Computer software used by health services for risk management and reporting incidents	OQSEG	Operational Quality, Safety and Experience Group (during 2016 operational clinical governance arrangements will be delegated to Clinical Divisions)
DNACPR	Do not attempt cardio-pulmonary resuscitation	PALS	Patient Advice and Liaison Service
DQI	Data Quality Index	PAR	Patient at Risk chart
DH	Department of Health	PHSO	Parliamentary and Health Service Ombudsman
DoLS	Deprivation of Liberty Safeguards	PIR	Post Infection Review
EDD	Expected Date of Discharge	PERC	Pulmonary Embolism Rule-out Criteria
EPR	Electronic Patient Record System	PROMS	Patient Reported Outcome Measures
FFFAP	Falls, Fragility and Fracture Audit Programme	PDR	Personal Development Review
GP	General Practitioner	QAC	Quality Assurance Committee
HCAI	Healthcare acquired infection	RTT	Referral to Treatment
HES	Hospital Episode Statistics	SHMI	Summary level Hospital Mortality Indicator
HFC	Harm Free Care	SI	Serious Incident
HRG	Healthcare Resource Groups	SWC	Strategic Workforce Committee
HSCIC	Health and Social Care Information Centre	TRFT	The Rotherham NHS Foundation Trust
HSMR	Hospital Standardised Mortality Ratio	WHO	World Health Organisation
IPC	Infection Prevention and Control	WNAS	Ward Nursing Accreditation System
IOFM	Intra Operative Fluid Management		
LiA	Listening into Action		
KPI	Key Performance Indicator		

Glossary of Terms

APGAR Score

Apgar is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score shows how well the baby is doing outside the mother's womb. The test measures breathing effort, heart rate muscle tone, reflexes and skin colour.

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

Delirium

Delirium is defined as a transient, usually reversible, cause of cerebral dysfunction and manifests clinically with a wide range of neuropsychiatric abnormalities. It can occur at any age, but it occurs more commonly in patients who are elderly and have compromised mental status.

Dr Foster

A provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public

FFFAP

Falls and Fragility Fracture Audit Programme, led by the Royal College of Physicians, gathering and analysing data on serious harms across the NHS

FYFV

The Five Year Forward View is NHS England's plan for a sustainable health service. It will be delivered via 44 local Sustainability and Transformation Plans; the Trust is part of a plan covering the population of South Yorkshire and Bassetlaw.

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.

John's Campaign

A national campaign to win the right for relatives and carers to stay with people with dementia in hospital

Listening into Action

A method used by the Trust to support change

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 Improvement

NHSI was launched on 1 April 2016. It was formed from the two previous regulators, Monitor and the Trust Development Authority (TDA).

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.

SAFER Care Bundle

A set of simple rules that if followed routinely will help improve patient flow, patient experience and reduce length of stay across adult inpatient wards (in acute hospitals).

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

UNIFY

A national database managed by NHS England that collates and monitors nurse staffing levels in hospitals

Vanguard Projects

NHS England has approved a series of local projects with the common aim of developing innovative solutions to improve health and social care. The Trust is a partner in the Working Together Partnership that brings together seven acute trusts across South and Mid Yorkshire and North Derbyshire.

Annual Accounts for the year ended 31 March 2016

Foreword to the Accounts

These accounts, for the year ended 31 March 2016, have been prepared by The Rotherham NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.



Louise Barnett
Chief Executive
24 May 2016

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 Monitor.

Under the NHS Act 2006, Monitor 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 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 *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, 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* 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 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 him/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 Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.



Louise Barnett
Chief Executive
24 May 2016

Statement of Comprehensive Income

		2015/16	2014/15
	Note	£000	£000
Operating income from patient care activities	3	221,582	222,230
Other operating income	4	19,407	20,475
Total operating income from continuing operations		240,989	242,705
Operating expenses	5, 6	(247,026)	(240,019)
Operating surplus/(deficit) from continuing operations		(6,037)	2,686
Finance income	9	51	69
Finance expenses	10	(551)	(558)
PDC dividends payable		(2,296)	(2,058)
Net finance costs		(2,796)	(2,547)
Share of profit / (loss)		-	-
Gains/ (losses) arising from transfers by absorption		-	-
Movement in the fair value of investment property and other investments		-	-
Corporation tax expense		-	-
Surplus/(deficit) for the year from continuing operations		(8,833)	139
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		-	-
Surplus/(deficit) for the year		(8,833)	139
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments		-	-
Revaluations	13	(594)	19,147
Share of comprehensive income from associates and joint ventures		-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability/asset		-	-
Other reserve movements		-	(2)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments		-	-
Recycling gains/(losses) on available-for-sale financial investments		-	-
Total comprehensive income/(expense) for the period		(9,427)	19,284

Statement of Financial Position

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	11	9,489	9,881
Property, plant and equipment	12	105,830	99,465
Trade and other receivables	15	56	68
Total non-current assets		115,375	109,414
Current assets			
Inventories	14	3,101	3,130
Trade and other receivables	15	13,231	11,284
Cash and cash equivalents	16	3,609	9,347
Total current assets		19,941	23,761
Current liabilities			
Trade and other payables	17	(22,836)	(22,932)
Other liabilities	19	(1,553)	(1,317)
Borrowings	20	(3,517)	(2,976)
Other financial liabilities	18	(96)	(96)
Provisions	22	(1,073)	(629)
Total current liabilities		(29,075)	(27,950)
Total assets less current liabilities		106,241	105,225
Non-current liabilities			
Borrowings	20	(25,608)	(14,125)
Other financial liabilities	18	(1,938)	(2,034)
Provisions	22	(958)	(1,902)
Total non-current liabilities		(28,504)	(18,061)
Total assets employed		77,737	87,164
Financed by			
Public dividend capital		73,403	73,403
Revaluation reserve		19,700	20,458
Income and expenditure reserve		(15,366)	(6,697)
Total taxpayers' equity		77,737	87,164

The notes on pages 272 to 313 form part of these accounts.

Name
Position
Date

Louise Barnett
Chief Executive
24-May-16

Statement of Changes in Equity for the year ended 31 March 2016

	Available for sale						Income and expenditure		
	Public dividend capital	Revaluation reserve	investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total		
	£000	£000	£000	£000	£000	£000	£000	£000	
Taxpayers' and others' equity at 1 April 2015 - brought forward	73,403	20,458	-	-	-	(6,697)	87,164		
Surplus/(deficit) for the year	-	-	-	-	-	(8,833)	(8,833)		
Other transfers between reserves	-	(30)	-	-	-	30	-		
Impairments	-	-	-	-	-	-	-		
Revaluations	-	(594)	-	-	-	-	(594)		
Transfer to retained earnings on disposal of assets	-	(134)	-	-	-	134	-		
Other reserve movements	-	-	-	-	-	-	-		
Taxpayers' and others' equity at 31 March 2016	73,403	19,700	-	-	-	(15,366)	77,737		

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital £000	Available for sale				Merger reserve £000	Income and expenditure reserve £000	Total £000
		Revaluation reserve £000	investment reserve £000	Other reserves £000				
Taxpayers' and others' equity at 1 April 2014	73,402	1,429	-	-	-	-	(6,952)	67,879
At start of period for new FTs	-	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	-	139	139
Other transfers between reserves	-	(118)	-	-	-	-	118	-
Impairments	-	-	-	-	-	-	-	-
Revaluations	-	19,147	-	-	-	-	-	19,147
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-	-
Other reserve movements	1	-	-	-	-	-	(2)	(1)
Taxpayers' and others' equity at 31 March 2015	73,403	20,458	-	-	-	-	(6,697)	87,164

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.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(6,037)	2,686
Non-cash income and expense:			
Depreciation and amortisation	5.1	5,907	6,981
Income recognised in respect of capital donations	4	-	(11)
(Increase)/decrease in receivables and other assets		(1,931)	711
(Increase)/decrease in inventories		29	(319)
Increase/(decrease) in payables and other liabilities		(418)	1,108
Increase/(decrease) in provisions		(500)	(338)
Other movements in operating cash flows		(96)	(101)
Net cash generated from/(used in) operating activities		(3,046)	10,717
Cash flows from investing activities			
Interest received		51	69
Purchase of intangible assets		(580)	(351)
Purchase of property, plant, equipment and investment property		(11,178)	(6,362)
Net cash generated from/(used in) investing activities		(11,707)	(6,644)
Cash flows from financing activities			
Movement on loans from the Department of Health		12,375	(2,625)
Capital element of finance lease rental payments		(351)	(536)
Interest paid on finance lease liabilities		(32)	(65)
Other interest paid		(519)	(523)
PDC dividend paid		(2,458)	(1,508)
Net cash generated from/(used in) financing activities		9,015	(5,257)
Increase/(decrease) in cash and cash equivalents		(5,738)	(1,184)
Cash and cash equivalents at 1 April		9,347	10,531
Cash and cash equivalents at 31 March	16.1	3,609	9,347

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the FT ARM which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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, inventories and certain financial assets and financial liabilities.

Going concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trusts' Annual Reporting Manual the financial statements have been prepared on a going concern basis as the Trust does not either intend to apply to the Secretary of State for the dissolution of the Trust without the transfer of the services to another entity, or consider that this course of action will be necessary. The Trust is also required to disclose material uncertainties in respect of events or conditions that cast doubt upon the going concern ability of the Trust and these are disclosed below.

Despite having delivered a financial out-turn for 2015/16 of £8,883K deficit, the Board of Directors has recently approved and submitted a financial plan to NHS Improvement to deliver a surplus of £6,600K for 2016/17, albeit with significant agreed non-recurrent support, both nationally and locally. The Trust does not foresee and thus, has not applied for any additional financial support, in helping to deliver this out-turn position. However, as with any plan, there are potential risks to its delivery, although the Board of Directors is confident that these can be successfully mitigated via the use of specific earmarked reserves and contingencies.

Having considered these risks in the context of the Trust's financial plan, the Board of 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.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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.

Note 1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement 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.

Pension 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 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. 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.4 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 1.5 Property, plant and equipment

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 and
- the cost of the item can be measured reliably.
- 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- 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.

Measurement

Valuation

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. Land and buildings used for the Trust's services or for administrative purposes are shown in the Statement of Financial Position at their revalued amounts, being the fair value at the date of the revaluation less any subsequent accumulated depreciation and impairment losses. It is the Trust's policy to perform a revaluation after there has been significant movements in the building cost index, and this could mean annual revaluations. If there are no significant movements then the Trust will perform a full valuation every five years with an interim valuation in the third year. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors' 'Red Book' (RICS) Appraisal and Valuation Manual. Fair values are determined as follows:

- Land and non-specialised buildings - market equivalent asset valuation
- Specialised buildings - depreciated market equivalent asset valuation
- Non-operational property and surplus land - market equivalent asset valuation

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

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.

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.

Estimated useful lives and residual values are reviewed each year end with the effect of any material changes recognised on a prospective basis.

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 are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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'.

Impairments

In accordance with the *FT ARM*, 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.

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 ie:

- 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. 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.

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.

Useful Economic lives of property, plant and equipment

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
Land	-	-
Buildings, excluding dwellings	3	88
Dwellings	24	24
Plant & machinery	5	15
Transport equipment	7	13
Information technology	5	18
Furniture & fittings	10	10

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.

Note 1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold 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 and where the cost of the asset can be measured reliably and they have a cost of at least £5000.

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.

Expenditure on development is capitalised only where 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 and
- 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.

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.

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 under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

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		
Information technology	-	-
Development expenditure	-	-
Other	-	-
Intangible assets - purchased		
Software	5	20
Licences & trademarks	5	10
Patents	-	-
Other	-	-
Goodwill	-	-

Note 1.7 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 1.8 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 1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "loans and receivables".

Financial liabilities are classified as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

At present the Trust does not hold any financial assets or financial liabilities held for trading.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined by the amount at which the asset could be exchanged or liability settled, in an arm's length transaction. This is the transaction price.

Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation 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 split 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.

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.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11 Provisions

The NHS foundation 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. 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.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22.1 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The NHS foundation 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 the NHS Litigation Authority 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 1.12 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 entity's control) are not recognised as assets, but are disclosed in note 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 23, 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 entity'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 1.13 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. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation 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 the audit of the annual accounts.

Note 1.14 Value added tax

Most of the activities of the NHS foundation 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 1.15 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 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 1.16 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 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation 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 1.18 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 NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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 1.19 Transfers of functions to / from other NHS bodies / local government bodies

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.

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.

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year:

IFRS 11 (amendment) – acquisition of an interest in a joint operation, expected to be effective from 2016/17.

IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation, expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants, expected to be effective from 2016/17.

IAS 27 (amendment) – equity method in separate financial statements, expected to be effective from 2016/17.

IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets, expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception, expected to be effective from 2016/17.

IAS 1 (amendment) – disclosure initiative, expected to be effective from 2016/17.

IFRS 15 Revenue from contracts with customers, expected to be effective from 2017/18.

Annual improvements to IFRS: 2012-15 cycle, expected to be effective from 2017/18.

IFRS 9 Financial Instruments, expected to be effective from 2017/18.

Note 1.22 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Management do not consider that there are any estimates which create a significant risk of causing a material uncertainty. However, the following are areas of estimation or judgement which have a major effect on the amounts recognised in the financial statements:

Provisions for injury benefit claims/early retirements/third party and property liability and the cost of annual leave carried forward (note 22.1) and impairments of receivables (note 15.2)

Income Accruals. Included in the income figure is an estimate for partially completed spells, i.e. treatment for admitted patients which is ongoing at the close of 31 March each year. This income is estimated based on the average specialty tariff applicable to each spell and adjusted for the portion of work completed at the end of the financial year.

Expenditure Accruals

Depreciation rates applied to property, plant and equipment (notes 1.5 and 1.6) ; and

Valuation methodologies and external indices applied to the valuation of Land and Buildings conducted by the District Valuer

Note 2 Operating Segments

All of the Foundation 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. Similarly, the large majority of the Foundation Trust's revenue originates with the UK Government. 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 Foundation Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Board of Directors review the financial position of the Foundation 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 Foundation 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.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2015/16 £000	2014/15 £000
Elective income	34,883	35,998
Non elective income	49,068	51,448
Outpatient income	34,577	34,900
A & E income	8,491	7,770
Other NHS clinical income	56,896	54,119
Community services income from CCGs and NHS England	36,240	36,288
Private patient income	55	65
Other clinical income	1,372	1,642
Total income from activities	221,582	222,230

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	2015/16 £000	2014/15 £000
CCGs and NHS England	208,251	210,177
Local authorities	7,970	5,977
Other NHS foundation trusts	-	54
NHS other	1,815	24
Non-NHS: private patients	55	65
Non-NHS: overseas patients (chargeable to patient)	4	15
NHS injury scheme (was RTA)	1,201	1,484
Non NHS: other	2,286	4,434
Additional income for delivery of healthcare services	-	-
Total income from activities	221,582	222,230

Of which:

Related to continuing operations	221,582	222,230
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2015/16 £000	2014/15 £000
Income recognised this year	4	15
Amounts written off in-year	24	-

Note 4 Other operating income

	2015/16 £000	2014/15 £000
Research and development	408	1,377
Education and training	6,501	6,325
Receipt of capital grants and donations	7	11
Charitable and other contributions to expenditure	-	5
Non-patient care services to other bodies	2,487	2,155
Rental revenue from operating leases	339	481
Rental revenue from finance leases	96	96
Other income	9,569	10,025
Total other operating income	19,407	20,475
Of which:		
Related to continuing operations	19,407	20,475
Related to discontinued operations	-	-

Analysis of other Operating Revenue - 'Other'

Car Parking	589	634
Estates Recharges	283	463
IT Recharges	299	129
Pharmacy Sales	364	973
Clinical Tests	667	520
Catering	15	15
Staff Recharges	1,109	986
Non clinical (SLA)	3,827	3,813
Non clinical (Non SLA)	1,194	1,401
Staff Accommodation Rentals	52	36
Staff Contributions to Employee Benefit Schemes	592	559
Property Rentals	578	496
	9,569	10,025

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, 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 license 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:

	2015/16 £000	2014/15 £000
services	220,153	220,523
Income from services not designated as commissioner requested services	20,836	22,182
Total	240,989	242,705

Note 5.1 Operating expenses

	2015/16	2014/15
	£000	£000
Services from other NHS bodies	28	-
Employee expenses - executive directors	1,086	1,301
Remuneration of non-executive directors	162	161
Employee expenses - staff	163,755	158,504
Supplies and services - clinical	27,725	26,639
Supplies and services - general	3,997	4,505
Establishment	2,027	2,082
Research and development	27	9
Transport	1,358	1,488
Premises	9,361	8,783
Increase/(decrease) in provision for impairment of receivables	263	522
Inventories written down	-	(150)
Drug costs	3,950	3,481
Inventories consumed	14,204	13,234
Rentals under operating leases	2,885	3,358
Depreciation on property, plant and equipment	4,935	5,712
Amortisation on intangible assets	972	1,269
Audit fees payable to the external auditor		
audit services- statutory audit	58	80
other auditor remuneration (external auditor only)	18	183
Clinical negligence	7,693	5,236
Legal fees	125	101
Consultancy costs	275	119
Internal audit costs	97	86
Training, courses and conferences	515	605
Patient travel	154	498
Redundancy	101	26
Early retirements	-	17
Hospitality	6	9
Insurance	294	313
Other services, eg external payroll	839	939
Losses, ex gratia & special payments	26	445
Other	90	464
Total	247,026	240,019
Of which:		
Related to continuing operations	247,026	240,019
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

	2015/16 £000	2014/15 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	18	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	183
Total	18	183

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2014/15: £1m).

Note 6 Employee benefits

	Permanent	Other	2015/16 £000	2014/15 £000
Salaries and wages	125,656	-	125,656	120,491
Social security costs	8,675	-	8,675	8,681
Employer's contributions to NHS pensions	14,952	-	14,952	14,463
Pension cost - other	18	-	18	8
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Agency/contract staff	-	15,540	15,540	16,162
Total gross staff costs	149,301	15,540	164,841	159,805
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	149,301	15,540	164,841	159,805
Of which				
Costs capitalised as part of assets	-	-	-	-

Note 6.1 Retirements due to ill-health

During 2015/16 there were 4 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £326k (£17k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 6.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16 £000	2014/15 £000
Salary	1085	613
Taxable benefits		
Performance related bonuses		
Employer's pension contributions	95	65
Total	1,180	678

Further details of directors' remuneration can be found in the remuneration report.

Note 7 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 6.

Note 8 Operating leases

Note 8.1 The Rotherham NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where The Rotherham NHS Foundation Trust is the lessor.

The Trust leases out units that are in the concourse area of the main hospital building.

	2015/16 £000	2014/15 £000
Operating lease revenue		
Minimum lease receipts		
Minimum lease receipts	339	481
Contingent rent	-	-
Other	-	-
Total	339	481
 Future minimum lease receipts due:		
- not later than one year;	337	481
- later than one year and not later than five years;	943	1,613
- later than five years.	941	1,081
Total	2,221	3,175

Note 8.2 The Rotherham NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Rotherham NHS Foundation Trust is the lessee.

	2015/16 £000	2014/15 £000
Operating lease expense		
Minimum lease payments		
Minimum lease payments	2,885	3,358
Contingent rents	-	-
Less sublease payments received	-	-
Total	2,885	3,358
 Future minimum lease payments due:		
- not later than one year;	2,447	3,040
- later than one year and not later than five years;	1,384	1,249
- later than five years.	1,889	1,251
Total	5,720	5,540
Future minimum sublease payments to be received	-	-

Note 9 Finance income

Finance income represents interest received on assets and investments in the period.

	2015/16 £000	2014/15 £000
Interest on bank accounts	48	66
Interest on loans and receivables	3	3
Total	51	69

Note 10.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2015/16 £000	2014/15 £000
Interest expense:		
Loans from the Department of Health	519	491
Finance leases	32	65
Interest on late payment of commercial debt	-	2
Total interest expense	551	558
Other finance costs	-	-
Total	551	558

Note 10.2 The late payment of commercial debts (interest) Act 1998

	2015/16 £000	2014/15 £000
Amounts included within interest payable arising from claims made under this legislation	-	2
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 11.1 Intangible assets - 2015/16

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	17,620	-	17,620
Transfers by absorption	-	-	-
Additions	86	494	580
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	(17)	-	(17)
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Gross cost at 31 March 2016	17,689	494	18,183
Amortisation at 1 April 2015 - brought forward	7,739	-	7,739
Transfers by absorption	-	-	-
Provided during the year	972	-	972
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	(17)	-	(17)
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2016	8,694	-	8,694
Net book value at 31 March 2016	8,995	494	9,489
Net book value at 1 April 2015	9,881	-	9,881

Note 11.2 Intangible assets - 2014/15

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	18,923	-	18,923
Transfers by absorption	-	-	-
Additions	-	-	-
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	-	-
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	(1,303)	-	(1,303)
Valuation/gross cost at 31 March 2015	17,620	-	17,620
Amortisation at 1 April 2014 - as previously stated	7,773	-	7,773
Transfers by absorption	-	-	-
Provided during the year	1,269	-	1,269
Impairments	-	-	-
Reversals of impairments	-	-	-
Reclassifications	-	-	-
Revaluations	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	(1,303)	-	(1,303)
Amortisation at 31 March 2015	7,739	-	7,739
Net book value at 31 March 2015	9,881	-	9,881
Net book value at 1 April 2014	11,150	-	11,150

Note 12.1 Property, plant and equipment - 2015/16

	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	Land £'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Valuation/gross cost at 1 April 2015 - brought forward	6,450	81,754	1,908	1,559	27,484	197	4,098	- 123,450
Prior period adjustments		839	-	-	61	(11)	(330)	- 59
Valuation/gross cost at 1 April 2015 restated	6,450	82,593	1,908	1,559	27,545	186	3,268	- 123,509
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	3,938	-	5,837	1,470	-	469	180 11,894
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	-	-	(651)	(185)	82	16	104	- 17 (651)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2016	6,450	85,880	1,908	7,211	29,097	202	3,841	180 134,769
Accumulated depreciation at 1 April 2015 - brought forward	-	406	501	-	20,480	121	2,477	- 23,985
Prior period adjustments	-	839	-	-	61	(11)	(830)	59
Depreciation at 1 April 2015 restated	1,245	501	-	20,541	110	1,647	-	24,044
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	3,065	68	-	1,201	26	575	- 4,935
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	(2)	2	-	-	17	-	17
Revaluations	-	-	-	(52)	-	(5)	-	(57)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-
Disposals/ derecognition	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2016	-	4,308	571	-	21,690	153	2,217	- 28,939
Net book value at 31 March 2016	6,450	81,572	1,337	7,211	7,407	49	1,624	180 105,830
Net book value at 1 April 2015	6,450	81,348	1,407	1,559	7,004	76	1,621	- 99,465

In the 2015/16 disclosure note immaterial prior period adjustments in respect 2014/15 have been made in respect of revaluation errors from that financial year.

Note 12.2 Property, plant and equipment - 2014/15

	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Valuation/gross cost at 1 April 2014	6,450	81,182	1,908	185	26,400	197	4,173	1,939
Valuation/gross cost at start of period as FT	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-
Additions - purchased/ leased/ grants/ donations	-	1,920	-	1,374	-	-	-	-
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	-	(340)	-	-	-	-	-	(340)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(1,008)	-	(2,115)	-	(312)	(1,939)	(5,374)
Valuation/gross cost at 31 March 2015	-	572	-	1,374	1,084	-	(75)	(1,939)
Accumulated depreciation at 1 April 2014	-	17,845	433	-	20,751	95	2,071	1,939
Depreciation at start of period as FT	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	3,056	68	-	1,844	26	718	-
Impairments	-	-	-	-	-	-	-	5,712
Reversals of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Revaluations	-	(19,487)	-	-	-	-	-	(19,487)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(1,008)	-	(2,115)	-	(312)	(1,939)	(5,374)
Accumulated depreciation at 31 March 2015	-	(17,439)	68	-	(271)	26	406	(1,939)
Net book value at 31 March 2015	-	18,011	(68)	1,374	1,355	(26)	(481)	-
Net book value at 1 April 2014	6,450	63,337	1,475	185	5,649	102	2,102	20,165
								79,300

Note 12.3 Property, plant and equipment financing - 2015/16

	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2016								
Owned	6,450	80,355	-	7,211	7,299	49	1,624	180
Finance leased	-	1,217	1,337	-	108	-	-	2,662
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-
PFI residual interests	-	-	-	-	-	-	-	-
Government granted	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-
NBV total at 31 March 2016	6,450	81,572	1,337	7,211	7,407	49	1,624	180
<u>105,830</u>								

Note 12.4 Property, plant and equipment financing - 2014/15

	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2015								
Owned	6,450	80,073	-	1,559	6,631	76	1,572	-
Finance leased	-	1,275	1,407	-	373	-	49	3,104
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-
PFI residual interests	-	-	-	-	-	-	-	-
Government granted	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-
NBV total at 31 March 2015	6,450	81,348	1,407	1,559	7,004	76	1,621	-
<u>99,465</u>								

Note 13 Revaluations of property, plant and equipment

During 2014/15 and in line with IAS 16 The Trust's land and buildings were revalued as at the 31 March 2015.

Valuations are 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. Valuations are undertaken by an independent valuer.

In order to meet the underlying objectives established by International Financial Reporting Standards and the application of IAS 16 changes to the assumptions when valuing specialised operational assets were applied.

In particular, 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 assumed 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.

The useful life of equipment assets have been reviewed up from 5 to 10 years on the basis that the revised useful life is more reflective of the pattern of economic consumption of these assets.

Note 14 Inventories

	31 March 2016 £000	31 March 2015 £000
Drugs	684	741
Work In progress	-	-
Consumables	2,285	2,291
Energy	132	98
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	3,101	3,130

Inventories recognised in expenses for the year were -£30,880k (2014/15: -£27,496k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

Note 15.1 Trade receivables and other receivables

	31 March 2016 £000	31 March 2015 £000
Current		
Trade receivables due from NHS bodies	2,458	3,727
Other receivables due from related parties	3,759	3,593
Provision for impaired receivables	(1,308)	(1,895)
Prepayments (non-PFI)	3,126	2,228
Accrued income	3,839	2,354
PDC dividend receivable	4	-
VAT receivable	857	392
Other receivables	496	885
Total current trade and other receivables	<u>13,231</u>	<u>11,284</u>
Non-current		
Other receivables	56	68
Total non-current trade and other receivables	<u>56</u>	<u>68</u>

Note 15.2 Provision for impairment of receivables

	2015/16 £000	2014/15 £000
At 1 April	1,895	1,373
Increase in provision	729	522
Amounts utilised	(850)	-
Unused amounts reversed	(466)	-
At 31 March	1,308	1,895

The level of impairment is based upon analysis of the type of debtors, the age of the debt and any specific intelligence relevant to individual debtors

Note 15.3 Analysis of impaired receivables

	31 March 2016		31 March 2015	
	Trade receivables £000	Other receivables £000	Trade receivables £000	Other receivables £000
	Ageing of impaired receivables		Total	
0 - 30 days	156	-	541	1
30-60 Days	5	3	38	6
60-90 days	4	7	2	15
90- 180 days	92	30	100	36
Over 180 days	305	707	612	544
Total	562	747	1,293	602
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,003	-	770	5
30-60 Days	336	11	245	25
60-90 days	54	22	243	62
90- 180 days	479	107	110	156
Over 180 days	147	1,755	177	2,335
Total	2,019	1,895	1,545	2,583

The majority of the debts owed to the Trust fall within the Whole of Government Accounts Boundary (i.e. the United Kingdom Public Sector). As such the credit risk associated with receivables neither past their due date or not impaired is not viewed as a high risk by the Trust as it is unlikely that institutions within these sectors will not be able to pay their debts.

Note 16.1 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.

	2015/16 £000	2014/15 £000
At 1 April	9,347	10,531
Transfers by absorption	-	-
Net change in year	(5,738)	(1,184)
At 31 March	3,609	9,347
Broken down into:		
Cash at commercial banks and in hand	338	303
Cash with the Government Banking Service	3,271	9,044
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	3,609	9,347
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	3,609	9,347

Note 16.2 Third party assets held by the NHS foundation trust

The Rotherham NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016 £000	31 March 2015 £000
Bank balances	1	-
Monies on deposit	-	-
Total third party assets	1	-

Note 17 Trade and other payables

	31 March 2016 £000	31 March 2015 £000
Current		
Receipts in advance	-	-
NHS trade payables	576	1,054
Amounts due to other related parties	2,124	2,816
Other trade payables	4,185	3,875
Capital payables	1,073	357
Social security costs	1,433	1,411
VAT payable	37	56
Other taxes payable	1,303	1,381
Other payables	58	53
Accruals	12,047	11,771
PDC dividend payable	-	158
Total current trade and other payables	22,836	22,932
Non-current		
Receipts in advance	-	-
NHS trade payables	-	-
Amounts due to other related parties	-	-
Other trade payables	-	-
Capital payables	-	-
VAT payable	-	-
Other taxes payable	-	-
Other payables	-	-
Accruals	-	-
Total non-current trade and other payables	-	-

Note 18 Other financial liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	96	96
Total	96	96
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	1,938	2,034
Total	1,938	2,034

Note 19 Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	1,553	1,317
Deferred PFI credits	-	-
Lease incentives	-	-
Total other current liabilities	1,553	1,317
Non-current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	-	-
Deferred PFI credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	-	-

Note 20 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health	3,375	2,625
Other loans	-	-
Obligations under finance leases	142	351
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	-	-
Total current borrowings	3,517	2,976
Non-current		
Loans from the Department of Health	25,563	13,938
Other loans	-	-
Obligations under finance leases	45	187
Obligations under PFI, LIFT or other service concession contracts	-	-
Total non-current borrowings	25,608	14,125

Note 21 Finance leases

Obligations under finance leases where The Rotherham NHS Foundation Trust is the lessee.

	31 March 2016 £000	31 March 2015 £000
Gross lease liabilities	187	538
of which liabilities are due:		
- not later than one year;	142	351
- later than one year and not later than five years;	45	187
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	187	538
of which payable:		
- not later than one year;	142	351
- later than one year and not later than five years;	45	187
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as an expense in the period	-	-

Note 22.1 Provisions for liabilities and charges analysis

	Pensions - former directors £'000	Pensions - other staff £'000	Other legal claims £'000	Agenda for change £'000	Re- structuring £'000	Continuing care £'000	Equal pay £'000	Redundancy £'000	Other £'000	Total £'000
At 1 April 2015	-	2,003	-	-	-	-	-	-	528	2,531
Transfers by absorption	-	-	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	-	-	-	-	-	-	-	-
Utilised during the year	-	(82)	-	-	-	-	-	-	-	917
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-	-	(82)
Reversed unused	-	(884)	-	-	-	-	-	-	-	(451)
Unwinding of discount	-	-	-	-	-	-	-	-	-	(1,335)
At 31 March 2016	-	1,037	-	-	-	-	-	-	994	2,031
Expected timing of cash flows:										
- not later than one year;	-	79	-	-	-	-	-	-	994	1,073
- later than one year and not later than five years;	-	306	-	-	-	-	-	-	-	306
- later than five years.	-	652	-	-	-	-	-	-	-	652
Total	-	1,037	-	-	-	-	-	-	994	2,031

The pensions provision relates to the ongoing costs of making early payment of pensions. The "other" category relates to liabilities to third parties/property expenses (administered by the NHS Litigation Authority) plus the cost of annual leave carried forward. 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. At present there is no expectation that the Trust will receive any reimbursement in respect of these provisions.

£39,560,184 is included in the provisions of the NHS Litigation Authority as at 31st March 2016 in respect of clinical negligence liabilities of the Trust (2014/15 £30,975,029)

Note 22.2 Clinical negligence liabilities

At 31 March 2016, £39,511k was included in provisions of the NHSLA in respect of clinical negligence liabilities of The Rotherham NHS Foundation Trust (31 March 2015: £30,975k).

Note 23 Contingent assets and liabilities

	31 March 2016 £000	31 March 2015 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	(73)	(45)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(73)	(45)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(73)	(45)
Net value of contingent assets	-	-

The timing of any potential cashflows is difficult to quantify as the contingent liabilities are notified to the Trust by the NHS Litigation Authority, based on cases they are aware of. At present the Trust is unaware of the potential for a contingent liability to crystallise and be subject to possible reimbursement

Note 24 Contractual capital commitments

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	3,921	9,650
Intangible assets	-	-
Total	3,921	9,650

The capital commitments relate to the Pharmacy Aseptic Suite and the new Emergency Centre

Note 25 Financial instruments

Note 25.1 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.

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 2016 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 25.2 Financial assets

	Assets at fair value				
	Loans and receivables £000	through the I&E £000	Held to maturity £000	Available- for-sale £000	Total £000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	5,461	-	-	-	5,461
Other investments	-	-	-	-	-
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	3,609	-	-	-	3,609
Total at 31 March 2016	9,070	-	-	-	9,070

	Assets at fair value				
	Loans and receivables £000	through the I&E £000	Held to maturity £000	Available- for-sale £000	Total £000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	4,680	-	-	-	4,680
Other investments	-	-	-	-	-
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	9,347	-	-	-	9,347
Total at 31 March 2015	14,027	-	-	-	14,027

Note 25.3 Financial liabilities

	Liabilities at fair value		
	Other financial liabilities £000	fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2016			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	28,938	-	28,938
Obligations under finance leases	187	-	187
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	20,063	-	20,063
Other financial liabilities	-	-	-
Provisions under contract	2,031	-	2,031
Total at 31 March 2016	51,219	-	51,219

	Other financial liabilities	fair value through the liabilities	I&E	Total
	£000	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015				
Embedded derivatives	-	-	-	-
Borrowings excluding finance lease and PFI liabilities	16,563	-	-	16,563
Obligations under finance leases	538	-	-	538
Obligations under PFI, LIFT and other service concession contracts	-	-	-	-
Trade and other payables excluding non financial liabilities	19,928	-	-	19,928
Other financial liabilities	-	-	-	-
Provisions under contract	2,531	-	-	2,531
Total at 31 March 2015	39,560	-	-	39,560

Note 25.4 Maturity of financial liabilities

	31 March 2016 £000	31 March 2015 £000
In one year or less	25,657	25,623
In more than one year but not more than two years	3,375	2,625
In more than two years but not more than five years	6,937	6,812
In more than five years	15,250	4,500
Total	51,219	39,560

Note 26 Losses and special payments

	2015/16		2014/15	
	Total number of cases	Total value of cases Number £000	Total number of cases	Total value of cases Number £000
Losses				
Cash losses	12	1	7	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	144	780	94	322
Stores losses and damage to property	-	-	-	-
Total losses	156	781	101	322
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	-	-	-	-
Special severance payments	-	-	-	-
Ex-gratia payments	33	47	60	123
Total special payments	33	47	60	123
Total losses and special payments	189	828	161	445
Compensation payments received	-	-	-	-

Note 27 Related parties

	Receivables		Payables	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Barnsley Hospital NHS Foundation Trust	559	885	2,588	1,098
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	939	185	1,093	173
Rotherham, Doncaster and South Humber NHS Foundation Trust	93	180	0	27
Sheffield Teaching Hospitals NHS Foundation Trust	377	336	607	1,045
Sheffield Children's NHS Foundation Trust	57	10	111	234
NHS Barnsley CCG	70	0	52	247
NHS Bassetlaw CCG	4	64	0	0
NHS Doncaster CCG	0	213	98	334
NHS North Derbyshire CCG	68	14	1	9
NHS Rotherham CCG	1,778	1,767	1,278	1,124
NHS Sheffield CCG	447	91	33	92
Health Education England	0	0	0	0
NHS England	743	949	335	0
Rotherham Borough Council	385	498	356	149
HM Revenue & Customs	857	0	2,773	2,792
NHS Pension Scheme	0	0	0	1,987
NHS Blood and Transplant	0	0	0	29
NHS Litigation Authority	0	0	13	0
NHS Property Services	0	1	811	51
	6,377	5,193	10,149	9,391
 Income				
2015/16		2014/15	Expenditure	
£000		£000	£000	
Barnsley Hospital NHS Foundation Trust	892	820	5,963	5,159
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	917	606	1,349	922
Rotherham, Doncaster and South Humber NHS Foundation Trust	640	1,208	124	146
Sheffield Teaching Hospitals NHS Foundation Trust	1,837	1,445	4,219	4,487
Sheffield Children's NHS Foundation Trust	71	47	1,111	1,079
NHS Barnsley CCG	13,235	13,083	0	122
NHS Bassetlaw CCG	626	737	0	0
NHS Doncaster CCG	4,394	4,394	0	1
NHS North Derbyshire CCG	561	487	2	0
NHS Rotherham CCG	168,722	168,708	14	11
NHS Sheffield CCG	5,407	5,079	0	92
Health Education England	6,047	5,295	0	0
NHS England	16,793	19,751	0	0
Rotherham Borough Council	8,584	6,587	565	744
HM Revenue & Customs	0	0	8,675	8,681
NHS Pension Scheme	0	24	14,952	14,463
NHS Blood and Transplant	16	20	863	912
NHS Litigation Authority	0	0	7,944	4,699
NHS Property Services	206	377	2,479	1,894
Total	228,948	228,668	48,260	43,412



Independent Auditor's report to the Council of Governors of The Rotherham NHS Foundation Trust only

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of The Rotherham NHS Foundation Trust for the year ended 31 March 2016 set out on pages 200 to 250. In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Valuation of land and buildings - £89 million (2014/15 £89 million) → Risk is the same as last year

Refer to page 51 (Audit Committee Report), page 272 to 284 (accounting policy) and pages 233 to 236 (financial disclosures).

The risk: Land and buildings are initially recognised at cost, but are subsequently recognised at current value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. A review is carried out each year to test assets for potential impairment, with an interim desk-top valuation carried out every three years and a full valuation every five years.

There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to its degree of specialisation, as well as over the assumptions made in arriving at the valuation of the asset. In particular the DRC basis of valuation requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site. Further, DRC is decreased if VAT on replacement costs is deemed to be recoverable. Both of these assumptions can have potentially significant effects on the valuation.

Following a full revaluation of land and buildings as at 31 March 2015, management have undertaken a review for indicators of impairment as at 31 March 2016.

Our response: In this area our audit procedures included:

- Assessing the basis of the assumptions used by management to determine the risk that assets are impaired by comparing to known benchmarks and indices;
- Undertaking physical verification of a sample of four buildings to confirm existence and to identify any indications of obsolescence or physical damage;
- Determining whether disclosures in relation to land and buildings complied with the requirements of the ARM;
- Considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

Recognition of NHS and non-NHS income - £222 million (2014/15 £222 million) → Risk is the same as last year

Refer to page 51 (Audit Committee Report), page 272 to 284 (accounting policy) and pages 233 to 236 (financial disclosures)

The risk: The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 95% of income from activities. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between income, expenditure, receivable balances and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements. Mis-matches can occur for a number of reasons, but the most significant arise where:

- the Trust and commissioners record different accruals for healthcare activities which have not yet been invoiced ;
- income relating to partially completed healthcare spells is apportioned across the financial years and the commissioners and the Trust make different apportionment assumptions;
- accruals for inter-trust agreements are not matched by the amounts invoiced; or
- there is a lack of agreement over proposed contract penalties for sub-standard performance.

Where there is a lack of agreement, mis-matches can also be classified as formal disputes and referred to NHS England Area Teams for resolution.

Our response: In this area our audit procedures included:

- Using the results of the AoB exercise to match the Trust's NHS income with counterparty expenditure. We investigated differences by reconciling the initial contract value with the counterparty to the final income reported in the financial statements, determining the reasons for any differences and critically assessing the validity of recognising reconciling income items in the Trust's financial statements.
- For estimated accruals relating to completed periods of healthcare or in relation to inter-trust agreements, reviewing the Trust's calculation of the accrual, critically assessing the Trust's and the counterparty's correspondence in relation to disputed items and forming a view as to the accuracy of the balance recorded in the Trust's accounts.
- Checking the validity of accruals for partially completed spells by reconciling to counterparty balances and, for disputed balances, checking evidence of acceptance after the year end.
- For a sample of invoices raised immediately before and after the balance sheet date, checking that income had been recognised in the correct financial period.
- Considering the adequacy of the disclosures about the key judgements and degree of estimation involved in arriving at the estimate of revenue receivable and the related sensitivities.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole, NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

3 Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £4 million (2014/15 £4.5 million), determined with reference to a benchmark of income from operations, of which it represents 1.75% (2014/15 1.9%). We consider income from operations to be more stable than a surplus-related benchmark.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £200,000 (2014/15 £225,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Rotherham.

4 Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the following matters on which we are required to report by exception

Under ISAs (UK&I) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or
- the Audit Committee section of the part of the Annual Report which addresses Governance and Organisational Structure does not appropriately address matters communicated by us to the audit committee.

Under the Code of Audit Practice we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

6 Other matters on which we report by exception - adequacy of arrangements to secure value for money

Under the Code of Audit Practice we are required to report by exception if we conclude that we are not satisfied that the Trust has put in place proper arrangements to secure value for money in the use of resources for the relevant period.

In April 2013, Monitor issued enforcement undertakings to the Trust in respect of breaches relating to financial planning, governance and Electronic Patient Records (EPR). Monitor issued compliance certificates in relation to the Electronic Patient Record and governance breaches in July 2014 and January 2015 respectively. As at 31 March 2016 the Trust remains subject to enforcement action in relation to the financial planning breaches and had a red governance risk rating throughout 2015/16 as a result of the Trust's financial performance. The enforcement actions require that the Trust take such additional steps as are necessary to ensure that it is able to return to a Financial Risk Rating (FRR) of at least 2 in the first two years of the Recovery Plan and at least 3 in the third year of the recovery plan (2015/16). The Trust has reported a deficit of £8.8m in 2015/16 and has had a FRR of 1 throughout the year.

Except for the matters referred to above we are satisfied that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate of audit completion

We certify that we have completed the audit of the accounts of The Rotherham NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 202 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

Respective responsibilities of the Trust and auditor in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), 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. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.



Clare Partridge
for and on behalf of KPMG LLP, Statutory Auditor
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26 May 2016

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.

