NHS
The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Annual Report and Accounts

2017/18

The Rotherham NHS Foundation Trust
40
Caring for our Community

70 YEARS OF THE NHS 1948 - 2018

Ambitious Caring Together

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2017/18

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

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We want 2018/19 to be a year of real progress, embracing the 70th anniversary of the NHS and 40 years of our hospital, and putting patients, their families and our staff at the heart of what we do.

Martin Havenhand
Chairman


NHS NHS NHS

Welcome from the Chairman

Welcome to The Rotherham NHS Foundation Trust's Annual Report and Accounts for 2017/18. This document sets out how the Trust performed over the year including key achievements and challenges. Thank you all for your continued support.

Like many Trusts across the country it has been a challenging year both operationally and financially. Recognising the challenges we are facing, the opportunities we have and the need to become more sustainable, we have refreshed our strategy to encapsulate the collaborative work we are doing in the Trust as well as with our partners across Rotherham and the wider South Yorkshire and Bassetlaw region.

Over the year we have seen this collaboration progressing. The Rotherham Place Plan has been updated and we will soon begin the roll-out of the integrated locality model, following a successful pilot. Regionally, the Integrated Care System (ICS) continues to bring health and social care providers and commissioners together to look at how we can deliver sustainable services for everyone in the future.

Our performance across a number of key targets remains positive, particularly for diagnostics and the 18-week target. However, the four-hour access target for patients attending the Emergency Department, and, during the latter half of the year, cancer performance, have proved challenging.

In July 2017, we opened our new Urgent and Emergency Care Centre at Rotherham Hospital which gives patients an improved and simpler way to access urgent and emergency care whilst providing our colleagues with a modern, purpose built working environment. Since opening we have seen improvements in our performance against the four-hour access target and at times we have been among the best performing Trusts in the country, which is a significant achievement. The Trust is still not consistently delivering 95% against the A&E four-hour access standard, but together with our dedicated colleagues, we continue to focus on steady improvement.

We recognise that without our workforce we wouldn't be able to provide our patients with the care they need. We have introduced further health and welfare initiatives which provide our workforce with the support that they need to provide that care, and to ensure that the Trust continues to be a really great place to work.

The Trust's financial position continues to be a significant challenge. We set out to end the year with a £13.6M deficit, excluding the impairment of the Urgent and Emergency Care Centre. Disappointingly, we finished the year £8.7M off plan with a £22.3M deficit excluding impairments. We are focussed on improving our financial foundations which is needed for us to have a sustainable future.

Among the highlights of the year, we've seen colleagues from across the Trust being recognised as part of national award programmes. Our Ear Care and Audiology Service won the Nursing Times Award for Care of Older People, for their innovative work in improving the care available for older people. Another award winner was Gail Miles, Respiratory Nurse Consultant who received The Queen Elizabeth the Queen Mother Award for Outstanding Service from the Queen's Nursing Institute.

Our Governors have once again provided valuable insight and contribution throughout the year and I'd like to thank them all for their work. I'd like to make a particular mention of thanks to Dennis Wray, our Lead Governor, who will be stepping down at the end of May 2018 after 10 years as a Governor at the Trust.

Our vision remains to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital. The work we are doing within the Trust, with our partners in Rotherham and those across the region is a key focus for us to further sustain quality services for the people of Rotherham.

Martin Havenhand
Chairman

Performance Report

Introduction to The Rotherham NHS Foundation Trust

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

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

The Trust serves a population of around 261,000 of which almost a fifth (19%) are aged 65 and over and just over a fifth (22%) are aged 17 or under.[1]

The Black and Minority Ethnic (BME) population in Rotherham constitutes a relatively small percentage although it has become increasingly diverse and more than doubled between 2001 and 2011. In 2011 (the date of the last census) 8% (20,842) of the population belonged to Black and Minority Ethnic (BME) groups, which was significantly below the English average of 20%.[1]

Within the BME groups, the largest included those identifying themselves as Pakistani & Kashmiri at 3% of total population. The second largest BME group was 'Other White' at just over 1%, the largest community within this being Slovak and Czech Roma. 92% of Rotherham residents were White British.[2]

The number of people in Rotherham with a limiting long-term illness in 2011 was around 56,600 (22% of the population) meaning that the borough had a higher rate than the national average of 17.6%.

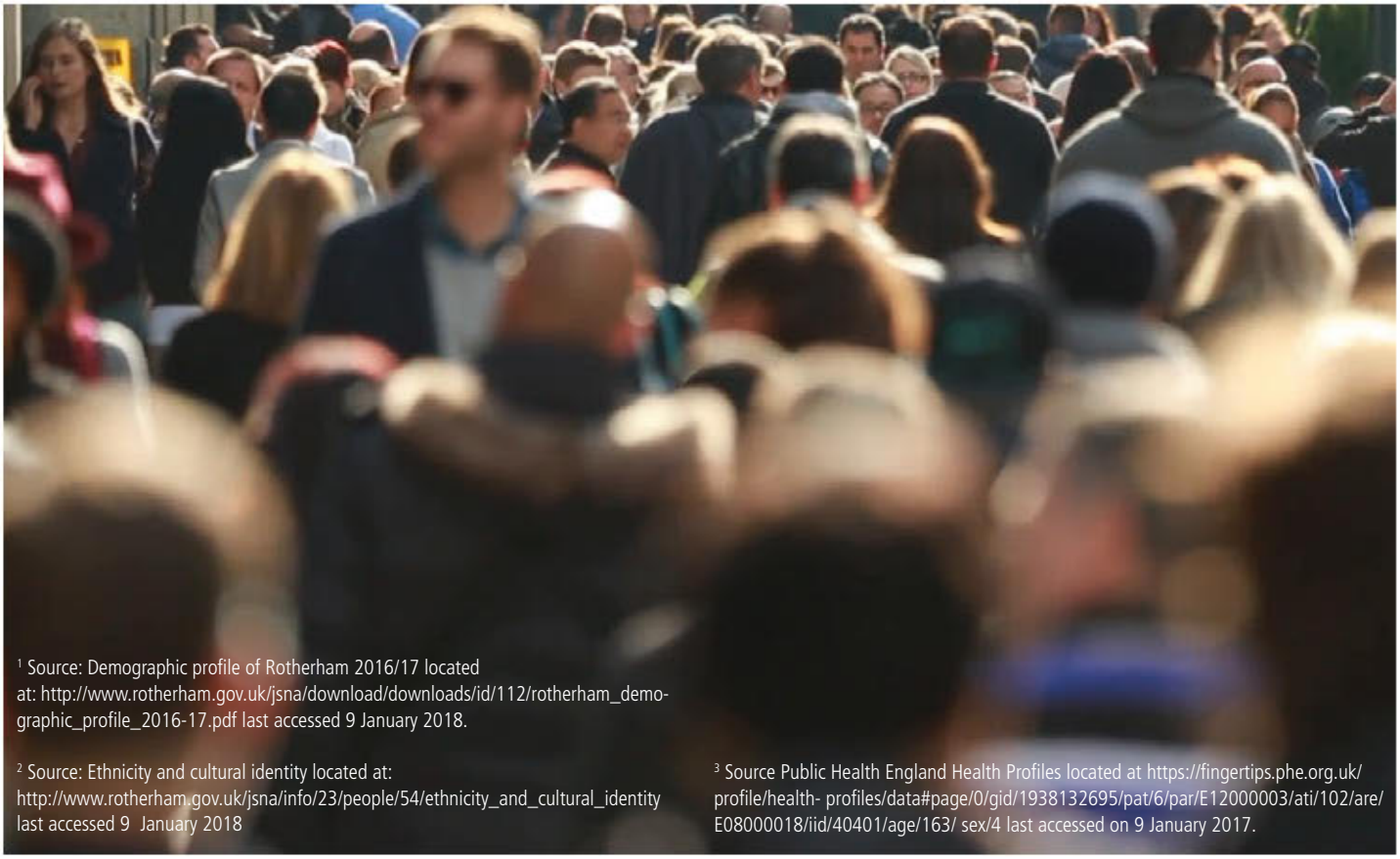
In the 2011 census, 12% of the population were carers who provided unpaid care, compared to 10% for England. In fact, 3% of Rotherham's population provided 50 hours or more of unpaid care per week, a figure higher than the English average of 2.4%.

Deprivation is also higher than average (28.3 compared to England average of 21.8) with Rotherham being in the most deprived quintile (20%) within the Index of Multiple Deprivation. Around 25% (12,340) of children in Rotherham live in low income families compared to the England average of 20%.

Life expectancy for both men and women is also lower than the England average. It is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham compared to the least deprived areas.[3]

The Trust has 449 beds inpatient beds including critical care and paediatric beds as well as 26 inpatient beds at Oakwood Community Unit and 20 inpatient beds at Breathing Space. In addition, therapy input is provided into the Intermediate Care beds across Rotherham at two principal facilities.

Around 4,000 members of staff provide a comprehensive range of services to the population of Rotherham, as well as specialist services across the South Yorkshire region and nationally.



[1] Source: Demographic profile of Rotherham 2016/17 located at: http://www.rotherham.gov.uk/jsna/download/downloads/id/112/rotherham_demographic_profile_2016-17.pdf last accessed 9 January 2018.

[2] Source: Ethnicity and cultural identity located at: http://www.rotherham.gov.uk/jsna/info/23/people/54/ethnicity_and_cultural_identity last accessed 9 January 2018

[3] Source Public Health England Health Profiles located at https://fingertips.phe.org.uk/profile/health- profiles/data#page/0/gid/1938132695/pat/6/par/E12000003/ati/102/are/E08000018/iid/40401/age/163/ sex/4 last accessed on 9 January 2017.

Overview of Performance

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

During 2017/18 the Trust consistently achieved the 18-week Referral to Treatment performance indicator. And whilst the Trust experienced excellent performance against cancer targets for the first half of the financial year, disappointingly, performance deteriorated in quarter three. However, the Trust has a detailed action plan in place, with a view to recovering this performance in Q2 2018/19.

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

The principal area of concern operationally during the year was the continued challenges in meeting the 4-hour access target. Whilst the Trust was not alone in this and the national picture was one where performance remained significantly below the 95% standard, during 2017/18 the organisation experienced difficulties which were linked in a large part to the development of the new Urgent & Emergency Care Centre.

To bring context to this, the changes and the move saw new teams come together from secondary care, primary care and the Trust's partner, Care UK, a significantly increased department in terms of layout and size, a new IT system to accommodate the interface with the hospital and community systems and new patient cohorts presenting as a result of the Walk-In-Centre moving into the new facility as well. All of this meant a period of 'bedding-in' which took longer than originally anticipated.

However, improvements were seen through the end of Q3 and into Q4 which saw the Trust ranked 25th out of 138 providers for type 1 A&E performance in January 2018 and 24th of 138 in February 2018. (Type 1 is a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients). Both Trust and system wide plans involving work undertaken with partners was crucial in delivering this change. However, the improving performance was not able to be sustained through to year end, and work continues on recovering the position in order to sustain high levels of performance for our patients during 2018/19.

Other highlights include overall Length of Stay, which was also within the top 10 of providers nationally and the Trust has nationally-recognised strong performance in the Friends and Family Test and saw the recovery of complaint response times from a relatively weak position to achievement of 100% of complaints responded to within the agreed time frame.

The harm-free care performance remained very strong during the year, and in terms of Hospital Acquired Infections, whilst there were a number of cases of MRSA, the numbers of C-Difficile were at a record low.

Performance against the sickness absence target was good in year, and 2017/18 saw achievements within the 3.95% standard set for seven months of the year.

Mortality performance against HSMR (Hospital Standardised Mortality Ratio) was an area of focus for much of the year. However, following a significant amount of work, improvements have been seen with performance in January 2018 at 96.3 (against a standard of 100) this will remain an area of focus for 2018/19 to ensure that such performance is sustained.

The Trust did not achieve the financial plan in 2017/18, which resulted in a forecast deficit of £22.3M, excluding the impairment, and the associated cash requirements needed to support this. The Trust set a Cost Improvement Programme (CIP) target of £8.5M and achieved £8.4M in year (99% of the target). This is equated to £9.2M full year effect.

Purpose and Activities of The Rotherham NHS Foundation Trust

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

- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures
- Family planning services
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

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

During 2017, the Trust took on new services previously provided by Care UK within Rotherham, which were a range of diagnostic services at Rotherham Community Health Centre and the out-of-hours services for Primary Care across Rotherham. The new Urgent and Emergency Care Centre was opened in 2017 at the hospital site, bringing together primary and secondary care clinicians within a new centre providing urgent and emergency care services for Rotherham.

The Rotherham NHS Foundation Trust has a divisional management structure to co-ordinate and deliver healthcare services. This is done through 4 clinical Divisions: Integrated Medicine, Family Health, Surgery and Clinical Support Services. Additional services covering Health informatics, Estates and Facilities, Workforce and Finance functions are considered to be provided through a corporate divisional structure.

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

The Trust sits within a sub-regional strategic context which continues to change. The development of the South Yorkshire and Bassetlaw

Integrated Care System (ICS) is likely to have a significant impact on the way the organisation delivers services. Similarly, the Rotherham Integrated Care Partnership (ICP) will be a key driver of integration across health and social care. The Trust is committed to partnership working across both the ICS and the ICP and this features strongly in the priorities for next year.

National Healthcare Strategies

National Healthcare strategy continues to be developed and shaped by NHS England's Five Year Forward View (FYFV)[4], and the Next Steps on the NHS Five Year Forward View[5] published in March 2017; and highlights the importance of managing systems rather than organisations.

The Trust recognises the importance of both physical and mental health especially the impact that mental health has on physical health outcomes. Consequently, a key part of the organisation's strategy is working with partners across Rotherham and beyond to ensure that services are appropriately delivered to meet the mental health needs of the local population. Rotherham has a high prevalence of learning disability, added to which is the national recognition and need to support patients with dementia, and as such, the Trust's services need to be configured with this in mind. The Trust is working with Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) towards implementing the principles of 'Core 24' which states that by 2020/21, all acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum.[6]

Against this environment, the Trust has continued to strive towards its vision to *be an outstanding Trust, delivering excellent care at home, in our community and in hospital.* Our Mission is to *improve the health and wellbeing of the population we serve, building a healthier future together.*

The Trust's Vision and Mission reflect the Trust's ambition to develop as a thriving district general hospital with a fully integrated community health service, with closer integration with social care partners.

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

The Trust has established close working relationships with key health partners across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS), building upon historical programmes such as the Working Together Programme. The ICS brings together Health & Social Care partners across Rotherham as well as across South Yorkshire & Bassetlaw. Shared pathways are in place for a number of specialties with partner organisations and it is anticipated that this will continue.

Over the next year, progress on the development of the ICS is likely to accelerate. It is important that the Trust plays a key role in influencing the direction of travel of the ICS. The Hospital Services Review report was published in May 2018 and centres around two key principles: firstly, that the hospitals in SYB (Mid Yorkshire and North Derbyshire (MYND)) need to work together; and, secondly that SYB (MYND) needs to continue to provide care as close to home as possible.

The Rotherham Integrated Health and Social Care (RIHSC) Place Plan sets out a local vision for the integration of health and social care services. The Plan has been jointly produced by the Rotherham Clinical Commissioning Group (RCCG), Rotherham Metropolitan Borough Council (RMBC), The Rotherham NHS Foundation Trust, (TRFT), Rotherham, Doncaster & South Humber NHS Foundation Trust, (RDaSH) and Voluntary Action Rotherham (VAR) and demonstrates the commitment across partners in Rotherham to partnership working and to improve the access, quality, affordability and sustainability of services for the population we serve.

In order to oversee the delivery of the RIHSC Place Plan, new governance arrangements have been created. The work stream most relevant to the Trust is that relating to urgent and community care transformation.

Work streams which form part of the RIHSC Place Plan are eligible for support from the ICS Development Fund. By aligning the Trust Operational Plan to the RIHSC Place Plan we will be better able to access this funding for projects that are consistent with our Five Year Strategy.

[4] https://www.england.nhs.uk/publication/nhs-five-year-forward-view/

[5] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR- FORWARD-VIEW.pdf

[6] Implementing the Five Health Forward View of Mental health https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/07/5.-Adult-mental- health-community-acute-and-crisis-care.pdf last accessed 15/03/18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Suspect a stroke?
Act FAST.
FAST
stroke

Chief Executive's Statement

During the year there were a number of key challenges facing the Trust.

Although the Trust is meeting many national operating standards, the 4-hour access target and, very recently, cancer performance are a particular challenge. Whilst work has begun to streamline services within the Trust and through partnership working across Rotherham, through the Rotherham Integrated Health and Social Care Place Plan, there remains a degree of fragmentation and duplication of services across health and care settings. We have identified steps in the 'Place Plan' to redesign and streamline services further with partner organisations, commensurate with the direction outlined in the Five Year Forward View.

These plans, together with internal Trust actions, aim to ensure the achievement of the 4-hour access standard by March 2019. In addition, we will drive improvements in cancer pathways to ensure that we consistently meet these national standards for our cancer patients.

The Trust's financial challenge remains significant and despite having surfaced and tackled a number of financial issues in previous years, the Trust did not deliver its financial plan in 2017/18. The effective and efficient use of resources remains critical and central to our planning for 2018/19 and future years.

The Trust's Operational Plan for 2018/19 therefore confirms actions to strengthen the performance framework to support improved delivery, alongside an increased focus on the identification and implementation of cash releasing efficiency schemes and the development of a long term plan.

As well as reporting good operational delivery across a range of indicators, we have also delivered against our transformational change agenda, of which some of the highlights include:

- The successful opening of the new Urgent & Emergency Care Centre (UECC), on time and with a smooth transition of services
- The relocation of the Rotherham Walk-In-Centre into the new UECC and the fully operational primary care stream
- The transfer of the GP Out-Of-Hours service from Care UK to the Trust, whilst implementing a new IT platform (SystemOne)
- Securing support from the Ambulatory Emergency Care Network to support our ambulatory care pathways
- The opening of a new Dementia ward in partnership with Rotherham, Doncaster and South Humber Mental Health Trust (RDaSH)
- Enhancement of the Care Coordination Centre with Mental Health nurses also in partnership with RDaSH
- Reconfiguration of the Children's Community Services to support community based care and further integration
- Successfully winning both the Integrated Sexual Health and 0-19 contracts
- The transfer of the Community Diagnostic services into the Trust at Rotherham Community Health Centre
- Successful launch of the Band 7 development programme to focus on promoting and developing leadership skills through the Trust
- The evaluation of the integrated locality pilot with partners, demonstrating early benefits of the integrated approach to care
- The integration of the Trust Transfer of Care team with the RMBC hospital social work team to move towards an Integrated Hospital Discharge Service
- Successful launch of a service improvement approach with >90 individuals trained in service / quality improvement methodology

All in all, with the developments already implemented, this will have been a very exciting year for the Trust and will set us up in good stead for the next stages of transformation in 2018/19.

2018/19 is also particularly important as it marks not only the 70th anniversary of the NHS, but also the 40th anniversary of the Trust, both of which are significant milestones. In addition, given the current context in which the Trust is working, in terms of the demands and challenges facing health and social care and the political and economic challenges, another reason why 2018/19 should be a year to celebrate, underpinned by making the ambitious progress we aspire to deliver.

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

Finance:

The Trust set an Income and Expenditure deficit plan for 2017/18 of £13.6M (excluding impairments). However, the year-end position, shows an actual year end position of a £22.3M deficit (excluding impairments), £8.7M adverse to Plan. The adverse performance was as a consequence of a number of factors including:

- The delivery of insufficient levels of efficiency improvements to compensate for the increased costs associated with a number of service changes
- Difficulties in recruiting to key medical positions that led to higher than expected staff agency costs
- Unexpected financial consequences of moving to the new payment system (HRG4+)

In addition to the Income and Expenditure Plan, the Trust also had a capital programme of £3.6M to support investment in its Estate, IT infrastructure and medical equipment. In particular, the Trust invested capital in:

- Urgent and Emergency Care Centre (which was completed in July 2017)
- Theatre Refurbishment
- Medical equipment; and
- Maintaining environmental standards

Looking ahead to 2018/19:

We have reviewed and agreed service requirements, activity targets and operational performance metrics with our commissioners. In addition, we have developed an ambitious efficiency improvement plan that will deliver £9.7m of recurrent savings in 2018/19. This represents 3.6% of the Trust's total cost base which compares well against the targets set by the other NHS Trusts in the South Yorkshire and Bassetlaw Integrated Care System.

Our performance management framework has been strengthened to further improve the mechanisms that drive performance delivery, and we will also continue to work very closely with our health system partners, both across Rotherham and across the South Yorkshire and Bassetlaw Integrated Care System, to identify opportunities to improve the financial performance of the Trust (and the wider health system) in future years.

We have committed to produce a long term plan in 2018/19 in partnership with our main commissioner, Rotherham Clinical Commissioning Group, that will outline specific initiatives to be implemented over the next five years. The capital programme for 2018/19 is £5.8M to invest in our Estate, IT infrastructure and medical equipment. We continue to receive cash investment to support the deficit.

Workforce:

Three factors that influence the ability to achieve a fully staffed substantive workforce are availability of staff in the market, flexible employment opportunities which make the Trust an attractive place to apply to and a wide range of support when in post such as development opportunities. The Trust continues to work hard to recruit and retain nursing staff, however, faces workforce challenges in a number of areas with governmental policies, such as Brexit, having an impact on the availability of appropriately qualified nursing staff. Insufficient new entrants into the nursing profession, coupled with the decrease in overseas nurses contributing to the workforce, is continuing to create challenges in terms of ensuring a fully staffed, substantive local workforce.

The 2017/18 year has seen some key appointments of senior medical staff which has significantly helped in a number of clinical areas, with a total of 13 new consultants having been appointed. Nevertheless, several key vacancies remain. There has been a small increase in medical locum costs although this did not reflect an increased demand, but instead resulted from improved fill rates for locum vacancies due to improvements in the working relationships with our Master Vendor Agency Locum Provider.

Operational Delivery:

The achievement of the A&E 4-hour access standard was a particular challenge during 2017/18 with excellent performance on some days but low performance on others. During quarters 3 and 4 the improvements began to be seen on previous performance, with the Trust ranked 25th out of 138 providers for type 1 performance in January 2018 and 24th of 138 in February 2018. However, this performance was not sustained in March and April 2018 and the Trust is taking further actions to improve performance and sustain this during 2018/19.

The 6 week-wait diagnostic target, which aims to support patients receiving their diagnostic test within 6 weeks, has traditionally been a standard the Trust has achieved strongly. However, at the beginning of 2017/18 the organisation experienced specific challenges within endoscopy, which saw the target not met. Following the implementation of a series of actions, performance significantly improved from July 2017 onwards and the Trust ended the year as one of the best performing in the country against this particular standard.

The Delayed Transfers of Care standard received significant focus on a national basis during 2017/18, and at the beginning of the year, the Trust was not performing well. This is an outcome measure which benefits from strong partnership working with the local authority. Therefore, together with Rotherham Metropolitan Borough Council, a joint approach and action plan was agreed drawing upon Local Government Authority and external NHS expertise. As a result, performance falls well within national target thresholds, ranking amongst the strongest performance regionally.


Rotherham
Simulation Suite

Quality of Care:

The Trust will continue to focus on improving the quality of the care it delivers by concentrating on delivering safe, clinically effective services which provide a positive experience. The Trust will do this by ensuring that it has a robust quality governance framework which provides assurance about how effective the services are that it provides. It will also continue to improve its services by continuing to train staff in quality improvement techniques which can be applied to the services provided. The Trust expects to be inspected by the CQC during 2018/19.

Failure to deliver high quality patient care, leading to poor patient experience and avoidable harm, failure to deliver clinical sustainability, eventually leading to financial penalties and regulatory action.

External Environment:

In January 2018, it was announced that the then Secretary of State for Health would become the Secretary of State for Health and Social Care. This reflects the wider changes taking place in terms of health and care. The Rotherham Integrated Healthcare and Social Care Place Plan sets out our ambitious integration plans, which include closer working relationships with stakeholders including Rotherham Metropolitan Borough Council (RMBC). This was demonstrated through joint discussions around allocation of funding (via the Better Care Fund) and the joint provision of health and social care services, the establishment of joint commissioning roles between Rotherham Clinical Commissioning Group and RMBC and the emergence of joint provider roles, which are expected to take shape during 2018/19.

The South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) has continued to develop over the last 2 years, and it is intended that the system will go 'live' during 2018/19.

The SYB ICS plan sets out the vision, ambition and priorities for the future of health and care in the region, with the goal that everyone in South Yorkshire and Bassetlaw has a great start in life, with support to stay healthier and live longer. As a Trust, we actively engage with the ICS and work together with partners to improve the sustainability of services across South Yorkshire and Bassetlaw.

Preparation of Accounts and Going Concern

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

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

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

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

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

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

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future, subject to additional central funding being provided by the Department of Health and Social Care to help manage working capital and maintain liquidity. For this reason, and as there is no indication from the regulators that the Trust will cease any part of its trading activities, they will continue to adopt the going concern basis in preparing the accounts. However, the Trust recognises the challenges ahead including the existence of a material uncertainty in relation to the 2018/19 finances of the Trust, the need to take steps regarding its underlying deficit and to continue to work with partners and stakeholders to improve sustainability. The Trust has a strategic commitment to working with partners to achieve this.

Also, see note 1 of the financial statements on page 219 and the report from the Audit Committee detailing the significant issues considered by the Committee in relation to the financial statements as required by the Foundation Trust FT Code of Governance (provision C.3.9) in the Governance and Organisational Structure section of this Annual Report.

Performance Analysis

Development and Performance of the Trust during the Year

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

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

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

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

Clinical teams have timely, relevant information to inform them of progress against their performance objectives, and there are appropriate feedback loops in place to see that any data quality issues are addressed.

In addition, during 2017/18, the preparations began for the roll-out of Service Line Management (SLM). It is planned that SLM will be rolled-out to 10 service lines during 2018/19.

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

Emergency Access

The Rotherham NHS Foundation Trust did not meet the national standard for transferring 95% of patients from its Emergency Department (ED) within 4-hours of their arrival (85.0% was achieved). Regrettably, 5 patients waited for longer than 12- hours following a decision to admit into the hospital compared to 0 such waits in 2016/17.

Throughout 2017/18 the executive and operational teams have ensured close scrutiny of a range of indicators relating to the safety and outcomes within emergency care so that assurance is available that the Trust is delivering safe and quality care during the busiest winter months. This has included the completion of detailed reviews of all ED waits over 8-hours so that full learning can be gained from each significant wait. The CQC Report, published March 2017, assessed Urgent and Emergency Services as 'requires improvement'.

The Trust's executive team recognise that there is more that can and must be done to develop the ways in which the Trust improves this performance.

Part of the organisation's journey of development this year has been to better embed more effective ward rounds and discharge planning by ward teams. Recent assessments show that the organisation is yet to achieve the necessary levels of 'bed flow'. Through 2018/19 there will be a re-focus on the importance of improving flow through the Emergency Department, hospital and community services. This will include strengthening the tools used and overseeing the effective use of them to help in this endeavour. This includes attention on increasing the proportion of morning discharges, the number of discharges at weekends, and the timely availability of medication and transport for patients leaving hospital.

Following successful trials, GPs regularly work in the Rotherham Urgent and Emergency Care Centre 'at the front door' to help triage patients to be seen as quickly as possible.

In response to the increased demands placed on our health service over the winter period, the Trust led the development of a system-wide Winter Plan. This consisted of detailed modelling of the anticipated demand that would be placed upon the Trust and the actions that needed to be taken to meet this demand. All partners across the borough were engaged with the plan and contributed to specific actions. This resulted in an additional 26 beds being opened within the hospital site as well as additional beds being provided by the CCG within the nursing home sector. Other actions included joint assessments for long term care needs for patients being undertaken outside of the hospital setting as well as a reduction in the Trust's elective care activity during the busiest periods for emergency admissions. All of these actions resulted in positive external stakeholder feedback for the construct, implementation and delivery of the plan.

The Trust placed significant focus on these internal challenges and the executive and operational teams continued to work with partner organisations to improve the quality and timeliness of transfer of patients from the acute settings when they are medically ready to be transferred.

During 2017/18 there was a 7.5% increase in Emergency Department attendances compared to the previous year. This was directly as a result of the integration of the Walk In Centre, previously based in Rotherham town centre, into the new Urgent & Emergency Care Centre.

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

18 Week Referral to Treatment Waiting Times

The Rotherham NHS Foundation Trust is proud of the consistent whole Trust delivery of the 18-week referral-to-treatment incomplete waiting time target. The Trust remains among the strongest performers in the country against this standard.

Cancer Waiting Times

Timely management of those patients referred onto the cancer pathway is an important focus for the Trust. The organisation has performed strongly against the cancer standards in previous years and was pleased that performance against 5 of the 9 standards during 2017/18 was in the top 20% in the country.

However, during the last 6 months of the year, the Trust was not compliant with the 62-day standard of patients being treated following referral from a GP. This was due to a number of factors which included a significant increase in referrals into the Trust coupled with workforce challenges in a number of key areas. As would be expected for such a priority group of patients, recovery plans were put in place and enhanced oversight provided to instigate an improvement in performance. Whilst this did not see improved performance for 2017/18, a return to compliant standards is anticipated by Q2 2018/19.

Diagnostic Waiting Times

The performance average for 2017/18 indicates that 0.5% of patients waited no longer than six weeks for their diagnostic test. The national standard requires that no more than 1% of patients wait longer than the designated six weeks and therefore this was a positive achievement for the teams involved in ensuring the timeliness of these tests.

Workforce, Equality and Human Rights

The Trust continues to strengthen its performance on equality and increased engagement in order to meet its requirements with regard to the Equality Act 2010 and Public Sector Equality Duty (PSED). During 2017/18 the Trust reported on the Workforce Race Equality Standard (WRES) and Public Sector Equality Duty (PSED) data, staff survey data, plus data from NHS jobs and census data all provide assurance in this area. These reports are available to view via the equality and engagement pages of the Trust's website.

Following government consultation, it became mandatory for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG); the Trust published their first GPG report in March 2018. During the financial year 2018/19 the Trust will commence work on the implementation of the Workforce Disability Equality Standard (WDES); the Trust's first report will be published in the summer of 2019. This will strengthen the Trust's approach to equality; ensuring that the organisation remains a fully inclusive one which offers opportunity for all colleagues and the community as a whole.

Furthermore, the Trust has a suite of policies and procedures in relation to the workforce in order to support colleagues in their roles which bring together the Trust's approach to equality, across all the protected interests, and to respecting the basic human rights of colleagues, patients and public. An equality impact assessment is required to be undertaken for each new or reviewed policy to help the Trust assess any potential impacts across its workforce or community. All policies are reviewed and scrutinised via the Document Ratification Group which is a key part of the Trust's internal governance arrangements.

Social, Community and Anti-Bribery Issues

In 2017/18 The Rotherham NHS Foundation Trust was recognised by several organisations for its work in the community and in improving services for patients and colleagues. These included:

- The Trust's Ear Care and Audiology Service was recognised as part of the Nursing Times Awards, winning the 'Care of Older People' category for improving services for the over 55s
- The Baby Box company, in conjunction with the Trust's midwives, launched their baby box scheme in Rotherham to emphasise the importance of safe sleep for babies
- RoSPA[7] awarded the Trust a Gold Award in their Occupational Health and Safety Awards 2017 for the fourth consecutive year
- Patients praised the quality of care they received at the Trust as part of the National Cancer Patient Experience Survey

The Trust's Chief Executive and Director of Finance are responsible for ensuring adherence to the NHS Counter Fraud Authority (NHSCFA) Anti-Crime Strategy for countering fraud, bribery and corruption. The Trust is obliged to safeguard NHS funds and resources through compliance with 24 standards for countering fraud, bribery and corruption.

The Trust has a nominated Counter Fraud Specialist (CFS) in place. The CFS is responsible for carrying out a range of activities in compliance with the 24 standards overseen by the Director of Finance and the Audit Committee. The CFS undertakes fraud, bribery and corruption risk assessments throughout the year which are used to inform the annual programme of activities that are undertaken.

During 2017/18, counter fraud activity focussed on activities to ensure compliance with NHSCFA standards and to address areas of heightened risk such as cyber-crime; bank and agency staff; declarations of interests and overseas visitors.

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

Where fraud is identified or reported, it is formally investigated in accordance with the Trust's Fraud, Bribery and Corruption policy. During 2017/18, a small number of referrals of suspected fraud, bribery or corruption were made to the CFS, demonstrating a good awareness and understanding of the Fraud, Bribery and Corruption policy.

[7] The Royal Society for the Prevention of Accidents

Within the entrance to Rotherham Hospital there is an area for health enquiries and promotions known as 'Community Corner'. The Community Corner hosted 206 promotions from local and national organisations during 2017/18 including South Yorkshire Fire and Rescue, Freedom to Speak Up Guardians and a range of health awareness events.

A number of events held in Community Corner during the year raised £9,600 for The Rotherham Hospital and Community Charity.

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

The Charity has continued to work with fundraisers, volunteers, local businesses, schools and organisations to raise money to fund equipment, resources and facilities which benefit patients, their families and carers.

As well as enthusiastic support from colleagues and Trust volunteers, Charity supporters during the year have included the Rotherham Lions, Rotherham College, Wath-on-Dearne Mother's Union, the Stag Medical Centre's Patient and Public Group, Rotherham United Football Club, Wingfield Academy and St Bernard's Catholic High School.

The Charity has funded a host of resources and equipment during 2017/18, including:

- £22,000 to fund a Changing Places facility in the reception area at Rotherham General Hospital – one of only two such facilities available in Rotherham. The facility provides dignity, privacy and extra space for patients and visitors with physical and learning disabilities.
- Physiotherapy equipment for the Oakwood Community Unit, including dumbbells and ankle and wrist weights, to help patients regain their strength and mobility more quickly. The equipment is also being used for group physiotherapy sessions, which encourage patients to socialise and boost their mental wellbeing.
- Dementia dolls and a 'retro' record player to enhance the care provided to patients living with dementia on Ward A6. In addition, a touch screen TV, iPads and specialist software plus reminiscence activities, textured pictures and images were also funded by the Charity for patients living with dementia.
- Three 'Biliblankets' worth £8,350 for Wharncliffe Ward. These portable phototherapy devices help treat babies with neonatal jaundice.
- £3,300 for the Speech and Language Therapy Service to invest in iPads pre-loaded with specialist therapy 'apps' to help treat patients who have suffered a stroke or have neurological conditions.
- £6,500 to refurbish 'Maria's room' on the Special Care Baby Unit. This family room enables parents to stay closer to their babies while they are being treated on the unit.

Fundraisers continued to raise money for the Charity throughout the year by organising events, including charity darts and football matches, a casino night, coffee mornings, a cycle ride, book and cake sales. A 10-strong team of fundraisers took part in the Run for All Sheffield 10K, raising more than £2,000.

Volunteers joined forces with the local growers' organisation 'Rotherham In Root' as part of the appeal to provide a fourth Purple Butterfly room at Rotherham Hospital by selling sunflowers. £800 was raised. Volunteers also helped the Charity to organise and run the annual Christmas Fair in December, which raised over £800.

Overseas Operations

The Trust does not have any overseas operations.

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

Since the summer of 2017, the seven healthcare organisations making up the South Yorkshire and Bassetlaw Integrated Care System, have been taking part in a Hospital Services Review to identify the ways in which five services could be improved across the region. Reporting on the review in May 2018, three main themes emerged from this work: changing the ways that organisations work together, transforming the way that services work, and reconfiguring services where necessary to ensure sustainability of healthcare services across the region, for the future. Whilst this initial report made no site specific recommendations as to the configuration of services in the future, the Report did reflect that more work needs to be completed over the next 12 – 18 months. More information can be found on page 156.

The second important event since the end of the financial year was the appointment of George Briggs as substantive Chief Operating Officer from the 1 April 2018.

Progress against the Sustainable Development Plan

Introduction

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

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

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

The SDMP will embed opportunities to:

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

Policies

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

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

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

One of the ways in which the impact of the organisation on corporate social responsibility is measured is through the use of the Good Corporate Citizenship (GCC) tool. As an organisation that acknowledges its responsibility towards creating a sustainable future, the running of awareness campaigns that promote the benefits of sustainability to colleagues aids in achievement of this goal.

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

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

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

Partnerships

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

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

Organisation Name	SDMP	GCC	SD Reporting score

No commissioners identified

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

Performance

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

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

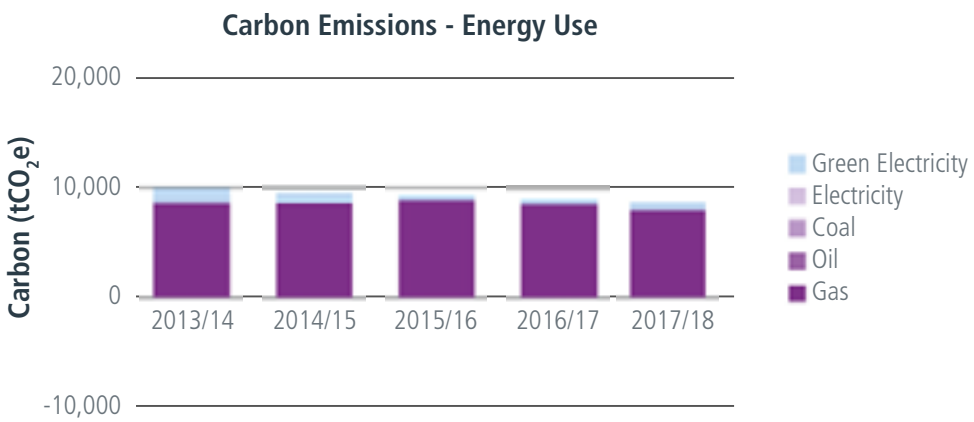
In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. The Trust has supported this ambition as follows:

Energy

TRFT has spent £1,492,854 on energy in 2017/18, which is a £405,225 (3.7%) increase on energy spend from the previous year.

Information relating to energy usage that has been previously reported can and has changed, this is for a number of different reasons including:
- Climate targets set by external authorities
- Energy changes occurring throughout the year
- Review by energy companies including meter reviews, rebates and additional expenditure

Resource		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	37,433,799	36,553,450	40,575,468	37,312,553	37,940,410
	tCO_2e	6,925	6,762	7,484	6,852	6,974
Oil	Use (kWh)	175,350	0	0	194,400	0
	tCO_2e	56	0	0	618	0
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	4,043,915	3,482,394	1,459,102	3,027,769	5,192,968
	tCO_2e	2,204	1,898	730	1360	1,892
Green Electricity	Use (kWh)	0	348,377	1,037,104	2,306,501	4,412,514
	tCO_2e	0	0	378	841	1609
Total Energy CO_2e		9,185	8,660	8,214	9,212	10,475
Total Energy Spend		£1,643,442	£ 1,462,708	£ 1,073,928	£1,087,629	£1,492,854



Performance

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

However, over the last 12 months the CHP has undergone a total refurbishment (60,000 hours' service) which resulted in it being unavailable for 14 weeks which has impacted upon both the electricity and gas consumption on site. This had an adverse effect upon the finances of the Trust as it resulted in more electricity being purchased from the supply grid, as well as more gas to provide heating and hot water from the site boilers. The CHP would normally generate approximately 65% of the hospital base load electricity and supplement the heating and hot water infrastructure via the waste heat that the CHP engine produces.

Over the past 4 years there has been a consistent reduction in energy consumption and, even accounting for increasing tariffs and supply charges the overall spend has remained at a similar level. These past 9 months has seen the Urgent & Emergency Care Centre (UECC) come on line, which has resulted in an increase in all utilities. Total energy (gas and electricity) consumption has increased by 2.8% overall. When taking into consideration the downtime of the CHP and site growth, then there has been a reduction in real terms.

Commentary

Over the past 3 years there has been very little capital expenditure available to improve the energy performance on site and so the decision has been taken to work with a third party provider to identify and implement energy saving solutions under an Energy Performance Contract (EPC). A selection of potential partners is currently preparing proposals and a preferred bidder will be selected in late 2018.

All the projects identified will be funded by the energy savings made and these savings will be guaranteed. Should the targets not be met the shortfall will be made up by the partner. Schemes may include boiler / CHP upgrades, improvements to building heating controls, installation of low energy lighting and building fabric improvements such as insulation and window replacement.

Travel

The organisation recognises that colleague and visitor travel impacts greatly upon the local air quality. This is an area that the Trust is actively working on to reduce vehicle emissions. Air pollution and accidents are a major cause of health issues in the locality, whether that is through respiratory problems or attendance at our new Urgent and Emergency Care Centre on the hospital site which opened in July 2017. It is the aim of the Trust to reduce the number of cars on site and the amount of staff travel.

Performance

A Green Travel Plan has been developed and the Trust is committed to encouraging active and low carbon travel in order to reduce vehicle carbon emissions, reduce the demand for car parking spaces and promote health and well-being. The organisation has a long standing relationship with local bus operators, RMBC and South Yorkshire

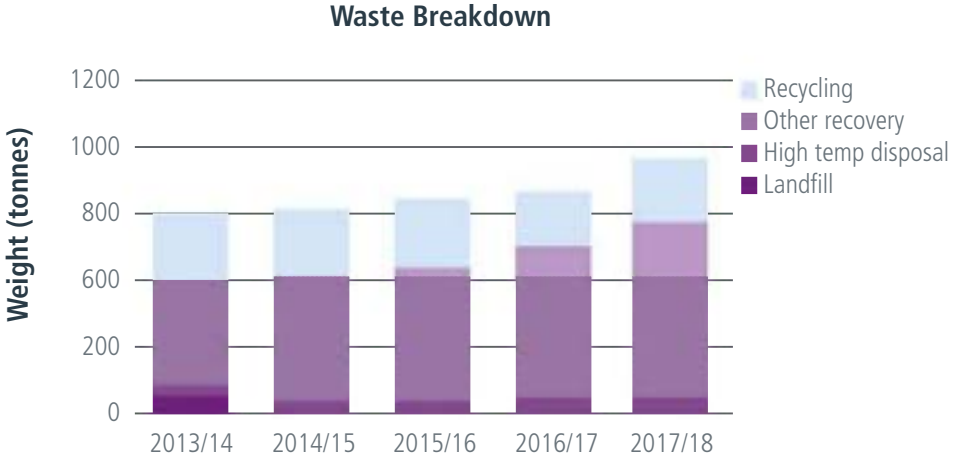
Passenger Transport Executive (SYPTE) to maintain and possibly improve access to Rotherham Hospital by bus. Public transport incentive schemes are popular with colleagues and are aimed at encouraging bus use rather than car use. Cycle to Work schemes and car share initiatives are already in place, whilst other initiatives such as the Dr Bike free cycle maintenance and health check have proved very popular with colleagues.

Resource		2013/14	2014/15	2015/16	2016/17	2017/18
Business travel	miles	1,009,287	942,142	894,015	825,198	732,937
	tCO_2e	547	346	265	246	209
Fleet travel	miles	387,678	411,019	403,186	423,531	No data available
	tCO_2e	120	124	104	108	
Patient travel	miles	410,333	Data not collected	Data not collected	Data not collected	No data available
	tCO_2e	137				
Staff travel	miles	106,722	161,748	263,356	370,552	483,618
	tCO_2e	32	52	68	95	124

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

Waste

Waste		2013/14	2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	197.00	195.00	216.00	187.00	197.00
	tCO_2e	4.14	4.10	4.32	4.07	4.29
Other recovery	(tonnes)	476.00	574.00	573.00	642.00	700.35
	tCO_2e	10.00	12.05	11.46	14.74	16.08
High Temp disposal	(tonnes)	54.00	64.00	63.00	61.00	67.68
	tCO_2e	11.88	14.08	13.80	15.51	17.21
Landfill	(tonnes)	81.00	0.00	0.00	0.00	0.00
	tCO_2e	19.80	0.00	0.00	0.00	0.00
Total Waste (tonnes)		808.00	833.00	852.00	890.00	970.45
% Recycled or Re-used		24%	23%	25%	21%	20%
Total Waste tCO_2e		45.81	30.23	29.58	34.33	37.58

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GENERAL WASTE

Performance

In line with legislative requirements, none of the waste from the Trust is sent to landfill. Other recovery tonnage has continued to increase with the further 5% increase in the 'tiger stripe' waste stream and improved segregation. Plastic bottle recycling continues to increase with a further 8% increase on 2016/17 tonnages. A further initiative for plastic recycling is the introduction of the Unisan bottle crusher system, the Trust has purchased two of these machines which will further increase the volume of the plastic recycling stream.

Continuation of the initiatives set in place previously with the 'recycling family', means that general waste is set to reduce by a further 1.3% and the orange bag waste stream is expected to reduce by 11%, ahead of the key performance indicator (KPI) previously set for 2%.

Commentary

A number of initiatives are currently in place, with the implementation of the 'Recycling Family' to segregate Plastic, Cans and General Waste, to improve recycling rates and reduce black bag waste tonnage. Three characters have been created to improve this recycling:

- BART an acronym for Be A Recycler Today, BART is the recycling character for Plastic,
- BART's girlfriend GRACE (Go Recycle A Can Everyday) is the Can recycling character
- Grandpa SETH (Segregate Everyday Trash Here) deals with the black bag waste stream.

The recycling of anaesthetic masks is continuing which means that the masks are sent for shredding and re-use, this has produced 0.05 of a tonne, although this is a small weight, this improves the Trust's segregation and disposal by general waste.

Due to improved waste segregation and Trust initiatives, orange bag waste has further reduced and improved segregation of paper waste has seen a reduction in the amount of confidential waste produced.

Performance

Due to the UECC coming into use consumption has risen along with the associated legal requirements to carry out Legionella flushing, there has been a marked increase in water consumption (16%).

Commentary

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

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC (Estates Return Information Collection) returns as its data source.

However, this does not reflect the organisation's entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx

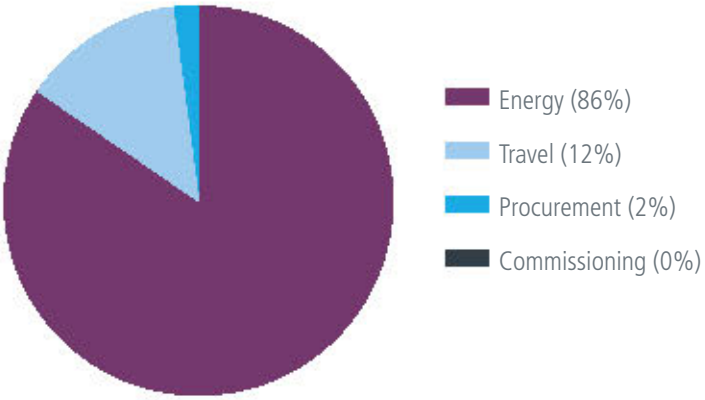
Resulting in an estimated total carbon footprint of 3,634 tonnes of carbon dioxide equivalent emissions (tCO2e), the Trust's carbon intensity per pound is 0 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£). Average emissions for service mix is 190 grams per pound.

Category	% CO_2e
Energy	94.8%
Waste	0.4%
Travel	13%
Water & Sewage	1.1%
Procurement	2%
Commissioning	0%

Finite resource use - Water

Water		2013/14	2014/15	2015/16	2016/17	2017/18
Water	m^3	106,325	104,971	97,450	90,224	104,822
	tCO_2e	43	42	34	31	36
Sewage	Disposal (m^3)	103,417	83,977	77,966	92,085	94,340
	tCO_2e	72	59	55	65	67

Proportions of Carbon Footprint



Modelled trajectory

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

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

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

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

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

Adaptation

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

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

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

Louise Barnett
Accounting Officer
May 2018

Quality Report 2017/18

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Forward the Chairman

Welcome to The Rotherham NHS Foundation Trust's Quality Report for 2017/18 which describes the Trust's performance against a range of national and local quality priorities. Our quality priorities are agreed each year with local organisations representing the patients and members of the public we serve, our commissioners (NHS Rotherham Clinical Commissioning Group), our Governors and Trust colleagues.

Our vision is to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital. Whilst 2017/18 has been another very challenging year across the organisation, it has also been one filled with many highlights and areas of improvement which are helping us get closer to achieving our objectives. We recognise that we can't achieve our vision working alone, and we need to continue forging our collaborative relationships with health and social care partners in Rotherham and across the region. By continuing to work this way together, particularly with partners in the Rotherham Place and the Integrated Care System (ICS), we are striving to provide sustainable quality services for our patients that are delivered where people need them.

The ICS is bringing partners, across South Yorkshire and Bassetlaw, together with the ambition of providing better co-ordinated working by GPs, hospitals and community health services, physical and mental healthcare, social care and the NHS to give patients access to seamless care. A key piece of work being undertaken by the ICS is the Hospital Services Review. The Trust is playing an active role in this review which has the overall aim of ensuring patients and local communities have access to appropriate, safe, high quality care and that improved ways of working are developed.

Within the Trust, a refreshed strategy was launched during the year which is aligned to the Five Year Forward View, and sets the direction of the Trust to 2021. This sets out our strategic objectives over the coming years and how we will ensure we provide a sustainable District General Hospital, with effective community services, providing a range of services from birth to end-of-life care for the people of Rotherham.

During the year the Trust has continued to build on its reputation for adopting new ways of working and in particular the use of digital technology to enhance patient care and experience. The Trust's award winning SEPIA clinical portal has continued to be a valuable asset to colleagues across our hospital and community services and a visit to a Parliamentary event during the year provided us with the opportunity to showcase this and other digital projects on a national stage.

2017/18 also saw the official opening of Rotherham's Urgent and Emergency Care Centre by HRH Duke of Kent. The centre, which after several years in the planning and building, has provided patients with a simpler way to access urgent and emergency care in a purpose built environment. Whilst meeting the four-hour access target has continued to be challenging, since the opening of the new centre, improvements have continued to be made and at times throughout the year performance was amongst the best in the country. We ended the year with 84.99% of patients being admitted, treated or discharged against the target of 95%.

Winter pressures were once again felt right across the NHS this year. Within the Trust we built on our experiences of previous years, and our colleagues worked extremely hard to implement our annual winter plan. This work, which has been supported by our partners across Rotherham saw the Trust responding positively to the challenges of winter, which enabled the Trust to continue to provide a full range of services and deliver a high standard of urgent care. This was really positive news for our patients and meant that we were able to continue delivering the quality care and services they needed.

Thanks to the hard work and dedication of our colleagues we have made some really encouraging progress throughout the year. I know as we enter what will be another challenging year, we will all continue to work together to make a truly positive difference to our patients.

Martin Havenhand
Chairman
May 2018

Part One: Statement on Quality from the Chief Executive

Across the country, NHS organisations are continuing to transform the services they provide to ensure that they can meet the changing needs of their population, in a high quality and sustainable way.

This Quality Report outlines a number of areas where, over the course of 2017/18, our teams have transformed some of our services and made good progress in a number of areas which is making a real difference to our patients.

A key priority for the Trust is ensuring our patients have a positive experience whilst being cared for by the Trust, that they receive the care they need when they need it, and that this is provided in the most appropriate setting, whether this is at home, in our community or in hospital.

One area of focus this year has been in relation to ambulatory care. Part of this work has involved piloting a frailty team as part of a six-month pilot over the winter period. The team helped support patients with multiple health needs with rapid intervention and support from specialists to get them back home as quickly and as safely as possible.

Work is also underway to reconfigure children's community health services. Similar to our locality based approach in adult community care, which is being further rolled out in the coming year, our teams are looking at how we can develop hubs with multi-disciplinary teams which are co-located to support joint, closer, integrated working between staff working for different organisations to provide a more seamless quality service for patients.

Performance across our key target areas has on the whole been positive throughout the year, particularly in relation to seeing and treating patients within18-weeks and providing timely diagnostics, where we have consistently been among the best performing Trusts in the country. The four-hour Accident & Emergency target has remained a challenge, however significant progress has been made, particularly since the opening of our Urgent and Emergency Care Centre. Disappointingly, we did have two mixed-sex breaches in the year which we investigated fully and we will continue to work hard to prevent this in the future.

Over the course of the year we have continued to implement our strong and effective infection, prevention and control practices. Our performance has remained strong in reducing the number of cases of hospital acquired clostridium difficile and during 2017/18 we had fifteen cases, below the trajectory of twenty-six. Unfortunately, we did have three confirmed cases of MRSA bacteraemia during the year. Lessons have been learned from these cases and actions to prevent further cases have been implemented by clinical teams.

Following our Care Quality Commission (CQC) re-inspection in September 2016, our teams have continued to engage in progressing the actions from this inspection. The introduction of a new Chief Nurse, Chris Morley, in October 2017 has given the Trust a fresh perspective on our approach to this process and this work will continue throughout 2018/19.

Understanding the views of our patients, colleagues and members of the public is essential if we are to continue providing high quality services. We always encourage patients to provide their feedback, and there are several channels that we use to capture this information.

Nationally, the Friends and Family Test is used to seek views from patients about the care that they receive in different settings within Trusts. I am really pleased to report that our Friends and Family Test results continue to be extremely positive, with many areas scoring much higher than the national average.

The timeliness of our response to complaints have also greatly improved over the year with recent changes in the process helping us achieve almost 100% of complaints being responded to within 30 days.

Unfortunately, the results from the national Maternity Survey facilitated by the CQC were disappointing despite very positive friends and family feedback throughout the year. However, this provides the opportunity to focus on improving some specific areas identified by the survey, by developing an action plan to implement changes to help us ensure our patients receive high quality care.

All of the information we gather from patient feedback is now being used to produce a new patient experience report which allows themes from feedback, both positive and negative, to be reviewed and shared with colleagues, stakeholders, patients and families to support learning, highlight particular areas for improvement and take actions to drive quality improvement for patients.

I am incredibly grateful to our colleagues, volunteers, governors and partners, patients and families from across Rotherham and the wider region for their continued dedication and support which is helping us move forward on our journey to achieve our vision of becoming an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital. Thank you to everyone for their engagement during the year.

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

Louise Barnett
Chief Executive
23 May 2018

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

2.1 Priorities for improvement during 2018/19

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

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

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

For 2018/19, the focus will be on the quality priorities outlined below. These have been agreed following a consultation process culminating in a public 'showcase' where more than 50 colleagues, governors, patients and members of public were able to comment on the draft proposals and shape how these priorities were delivered.

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

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

The quality priorities for 2018/19 are:
Patient Experience
1. End of Life Care
2. Discharge
3. Learning from the views of Inpatients

Patient Safety
1. Missed or Delayed Diagnosis
2. Deteriorating Patient (including Sepsis)
3. Medication Safety

Clinical Effectiveness
1. Improving the quality of services provided through preparing for the Care Quality Commission (CQC) Inspection
2. Improvement of Compliance with the Mental Capacity Act (Increasing staff knowledge and awareness)
3. Effective outcomes for women and babies

Domain: Patient Experience

1. End of Life Care

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

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

Acute – End of Life Care
Ensure all "do not attempt cardio-pulmonary resuscitation" (DNACPR) decisions are always documented in line with national guidance and legislation.

Ensure there is evidence that patients' capacity has been assessed in line with the requirements of the Mental Capacity Act (2005).

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

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

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

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

This priority continues from 2017/18.

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

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 is to embed improvements in the care of patients on the End of Life Care Pathway through progressing the improvements achieved on wards A2 and Fitzwilliam following their participation in the NHS Improvement End of Life Care Collaborative.

The objectives for 2018/19 are to:

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

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

The planned activity to achieve this
A plan to roll out the training of staff will be devised during Quarter 4 2017/18 following a similar approach to that used on the End of Life Care Collaborative facilitated by NHS Improvement.

Roll out Plan 2018/2019:

Quarter 1 : Ward A1 and Ward A4
Quarter 2 : Medical Assessment Unit and Ward A5
Quarter 3 : Stroke Ward and Ward A7
Quarter 4 : Ward B4 and Ward B5

How will progress be monitored and reported?
The work will be managed through the Trust End of Life Care Operational Group and reported through the Clinical Governance Committee. A quarterly report will be submitted to the Quality Assurance Committee.

The areas will be audited prior to the quarter when the initiatives are being implemented to establish baseline data.

Plan to re-audit 3-4 months after the quarter during which the initiatives were implemented to ensure compliance and confirm practice is embedded.

2. Discharge

Executive Lead: Chief Operating Officer
Operational Lead: Assistant Chief Nurse (Operations)

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

This priority continues from 2017/18.

In 2018/19 the Trust aims to continue to improve the management of hospital discharge ensuring people leave hospital in a safe, timely, way.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 is to increase the proportion of discharges that take place in the morning as part of implementing the SAFER patient flow care bundle.

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

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

The planned activity to achieve this
The Trust is currently participating in an NHS Improvement Collaborative on Nurse Led Discharge. As part of this the Trust will engage in a range of quality improvement techniques which will help to redesign processes involving the discharge of patients. This is currently in use on one ward in the Trust and it is hoped that we can roll out to another ward during this time.

How will progress be monitored and reported?
An improvement project group will be established to drive this work forward, which will ultimately be time limited, but during 2018/19 will report to the Clinical Governance Committee. A quarterly report will be submitted to the Quality Assurance Committee.

3. Learning from the Views of Inpatients

Executive Lead: Chief Nurse
Operational Lead: Deputy Chief Nurse

Current position and why is it important?

The most recent annual national inpatient survey Care Quality Commission (2017), shows 5 areas where the Trust are performing worse than the majority of Trusts in the country and more than 40 areas (out of 65) where our performance is lower compared to our score the previous year. One of the questions on the survey relates to whether patients were asked to give their opinion on the quality of care they received during their stay. Although the Trust benchmarked as 'about the same' in this category, the scores were poor across all Trusts.

This is a new priority for 2018/19

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

The aim for 2018/19 is to improve our patient's experience, which will then be reflected in our scores reported in the annual national inpatient survey. The data is currently being collected for the 2017 survey so the Trust is unable to affect this but we aim to improve the score for 2018 survey. The comparison of current performance and planned improvement is shown below based on benchmarking the Care Quality Commission scores against other Trusts (Table 1) and comparing the Trust data with data from the previous year (Table 2).

Table 1 – Performance against other Trusts

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

(Source: Care Quality Commission)

Table 2 – Internal performance against previous years

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

(Source: Care Quality Commission)

Specific objectives are:

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

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

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

The planned activity to achieve this

An action plan has been produced to address all areas that have shown a deterioration internally. This also encompasses all areas that are worse than the national average.

Monthly ward visits have commenced to conduct interviews with individual patients based upon the questions included in the national inpatient survey. Results will be collated at both ward and Trust level to identify emerging trends and themes. This will enable local action plans to be developed to reflect more accurately any required areas for improvement as it is recognised that the national survey gives an aggregate position for the Trust and will not reflect the situation on individual wards.

How will progress be monitored and reported?

Progress against the response to the national survey action plan and the monthly interviews (and subsequent action plans) will be monitored monthly via the Patient Experience Group and reported through the Clinical Governance Committee.

Once the Key Performance Indicator metrics have been agreed (as shown in the tables above) the data from the monthly interviews will be used to provide assurance of progress.

A quarterly report will be submitted to the Quality Assurance Committee.

Domain: Patient Safety

1. Missed or Delayed Diagnosis
Executive Lead: Medical Director
Operational Lead: Associate Medical Director

Current position and why is it important?
The current systems of acknowledging the results of radiology investigations is a hybrid of electronic and paper based systems. By introducing a single electronic system, the Trust can reduce the risk of a result being either missed or there being a delay in it being reviewed.

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

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

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

The planned activity to achieve this
There is a dedicated Informatics project, the Results Acknowledgement Project which is driving this work forward, led by a senior clinician and supported by the Director of Health Informatics.

How will progress be monitored and reported?
The project will be progressed via the Results Acknowledgement Project Group which reports to the Clinical Health Informatics Development Group. Quarterly reports will also be provided for the Clinical Governance Committee and the Quality Assurance Committee.

2. Deteriorating Patient focusing on the Management of Sepsis
Executive Lead: Medical Director
Operational Lead: Consultant – Integrated Medicine

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

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

This priority continues from 2017/18.

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

The objectives for 2018/19 are:

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

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

The planned activity to achieve this
A Sepsis group has been formed, this is multidisciplinary and is looking at improving the knowledge of the importance of administering antibiotics in a timely manner, availability of appropriate antibiotics in a timely manner and facilitating accurate recording of both the identification of sepsis and the time of administration of an appropriate antibiotic.

How will progress be monitored and reported?
The Sepsis group reports to the Patient Safety Group which ultimately reports to the Clinical Governance Committee. A quarterly report will be submitted to the Quality Assurance Committee.

3. Medication Safety
Executive Lead: Medical Director
Operational Lead: Chief Pharmacist

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

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

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

This priority continues from 2017/18.

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

The objectives for 2018/19 are to:

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

The planned activity to achieve this
This will be delivered through a programme of education and training and by reviewing processes and documentation. Alongside this the quarterly medication omissions audit will track the number of medication administrations signed or, reasons for non-administration clearly recorded. Separately a process for establishing whether patients being discharged have received their discharge letter and medication and have received information from the discharging ward/nurse on their medication will be established.

How will progress be monitored and reported?
The Medication Safety Group reports to the Patient Safety Group which ultimately reports to the Clinical Governance Committee. A quarterly report will be submitted to the Quality Assurance Committee.

Domain: Clinical Effectiveness

1. Improving the quality of services provided through preparing for the Care Quality Commission (CQC) Inspection

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

Current position and why is it important?

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

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

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

This is a new priority for 2018/19.

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

The aim for 2018/19 is to use the opportunity of the CQC inspection cycle to promote better quality of care. This includes:

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

The planned activity to achieve this

Use the CQC template Provider Information Request to ensure that relevant information can be provided, to confirm how the Trust will manage the process and to identify any concerns that need addressing.

Prepare the organisation for the unannounced inspections of core services, through;

- Undertaking a wide range of activities including mock inspection reviews, seminars, staff awareness sessions, produce leaflets etc.

- Developing a Standard Operating Procedure (based on the success of last times factually accuracy process) to be able to respond in an appropriate and timely way and ensure relevant staff are aware of their responsibilities as part of this process.

How will progress be monitored and reported?

Through regular meetings with the Chief Nurse and Medical Director.

Regular reports to the Clinical Governance Committee, with quarterly reports to the Quality Assurance Committee and Trust Management Committee, increased to monthly once the inspection cycle starts.

2. Improvement of Compliance with the Mental Capacity Act (Increasing staff knowledge and awareness)

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

Current position and why is it important?

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

This priority continues from 2017/18.

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

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

The objectives for 2018/19 are to improve:

- The percentage compliance with the Mental Capacity Act based on three assessment criteria being:
  - (A) Is there evidence of a capacity assessment in the patient's record
  - (B) Is there evidence of a best interest decision in the patient's records
  - (C) Has a Deprivation of Liberty (DoL) request been completed (where appropriate) (Acute Adult Services only)

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

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

The planned activity to achieve this

Work to achieve this objective will include, continuing ongoing support for operational areas from the Safeguarding Team, agreement of a support process when non-compliance is observed, and by continuing to embed the MCA form.

This work will be monitored via a quarterly audit undertaken by the Safeguarding Team to check compliance.

How will progress be monitored and reported?

The work will be managed through the Safeguarding Leads Group and reported through the Clinical Governance Committee. A quarterly report will be submitted to the Quality Assurance Committee.

3. Effective outcomes for women and baby

Executive Lead: Chief Nurse
Operational Lead: Head of Maternity

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

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

This is a new priority for 2018/19.

The aim and objective(s) (including the measures/metrics)
The aim for 2018/19 is to continue to increase the detection rate and to continue to improve detection by more than 1% per quarter, beginning with a 44.5% detection rate for Q1 of next year. This would represent a significant improvement in the first year of the programme, with a clear trajectory for year 2.

The objective for 2018/19 is to improve the percentage of small for gestational age babies detected from 43.4% to 50% by 31 March 2019.

The planned activity to achieve this
The education and further development of midwives' skills in Symphysis Fundal Height measurement and accurate plotting has been a focus in quarters 1 and 2 of 2017/18 with external educational provision provided to upskill and increase staff confidence. For 2018/19 further work will include measures to align with the national Growth Assessment Protocol (GAP) Accreditation programme and include skills in midwifery, ultrasonography and medical measurement, plotting and also the underpinning cultural change work to encourage a 'hearts and minds' adoption of these goals as a collective service.

How will progress be monitored and reported?
The work will be managed through a project group within the Family Health Division and will be reported through the Clinical Governance Committee. A quarterly report will be submitted to the Quality Assurance Committee.

Keeping our stakeholders Informed
The Trust will continue to share information on progress throughout the year with NHS Rotherham Clinical Commissioning Group and provide a mid-year update to Rotherham Health Select Commission.

A quarterly report on progress against the indicators will be provided to the Council of Governors.

2.2: Statements of Assurance from the Board of Directors

Subcontracted services

During 2017/18 The Rotherham NHS Foundation Trust provided and/or subcontracted 65 relevant health services, both community and acute services. The Rotherham NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 65 of these relevant health services. The income generated by the relevant health services reviewed in 2017/18 represented 83% of the total income generated from the provision of relevant health services by The Rotherham NHS Foundation Trust for 2017/18.

Clinical Audit and Research

During 2017/18, 47 national clinical audits and 7 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation provides. During that period The Rotherham NHS Foundation Trust participated in 41 (87%) of national clinical audits and 6 (86%) of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Rotherham NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Participation yes/no?	Reason for non-participation	% Cases submitted
BAUS Urology Audits- Female stress urinary incontinence	Yes	Not applicable	100%
BAUS Urology Audits- Nephrectomy audit	Yes	Not applicable	100%
BAUS Urology Audits- Percutaneous Nephrolithotomy (PCNL)	Yes	Not applicable	100%
Cardiac Rhythm Management (CRM)	Yes	Not applicable	100%
Case Mix Programme (CMP)	Yes	Not applicable	100%
Elective Surgery (National PROMs Programme)	Yes	Not applicable	100%
Endocrine and Thyroid National Audit	No	Local audit (S1416) On-going, not expected to complete until 2019 due to cost of participating in national audit	NA
Falls and Fragility Fractures Audit programme (FFFAP)- Fracture Liaison Service Database	Yes	NA	100%
Falls and Fragility Fractures Audit programme (FFFAP)-Inpatient Falls	Yes	NA	100%
Falls and Fragility Fractures Audit programme (FFFAP)- National Hip Fracture Database	Yes	NA	100%
Fractured Neck of Femur (care in emergency departments)	Yes	NA	100%
Head and Neck Cancer Audit	No	Audit on hold due to: i) changes in Audit Provider with decision pending on confirmation of dataset and ii) limited resource availability in Clinical Effectiveness Department for resource intensive data collection.	NA
Inflammatory Bowel Disease (IBD) programme / IBD Registry	No	Subscription required for participation	NA
Learning Disability Mortality Review Programme (LeDeR)	Yes	NA	100%

National Audit	Participation yes/no?	Reason for non-participation	% Cases submitted
Major Trauma Audit	Yes	NA	78-96% figure provided by TARN. It is an estimate given by TARN 'A range is derived based on the expected variation of the HES dataset'.
Myocardial Ischaemia National Audit Project (MINAP)	Yes	NA	100%
National Audit of Dementia	Yes	NA	100%
National Audit of Intermediate Care (NAIC)	Yes	NA	Information submitted regarding service provision, waiting times, length of stay, no patient information was submitted.
National Bowel Cancer (NBOCA)	Yes	NA	100%
National Cardiac Arrest Audit (NCAA)	Yes	NA	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit - Pulmonary rehabilitation	Yes	NA	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit - Secondary Care	Yes	NA	777 COPD related admissions between April 2017 – March 2018 Of these, 395 have been reviewed (50.8%). 282 (71.4%) included and submitted 113 (28.6%) not included as not appropriate
National Clinical Audit of Care at the End of Life (NACEL)	No	Audit did not collect data in 2017-18	NA
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	No	Audit did not collect data in 2017-18	NA
National Comparative Audit of Blood Transfusion programme-Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	NA	100%
National Comparative Audit of Blood Transfusion programme-2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	NA	100%
National Comparative Audit of Blood Transfusion programme- Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016	Yes	NA	100%
Audit of the use of blood in Lower GI bleeding	No	Audit did not collect data in 2017-18	NA
National Diabetes Audit – Adults- National Diabetes Foot Care Audit	Yes	NA	100%
National Diabetes Audit – Adults-National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	Yes	NA	100%
National Diabetes Audit – Adults- National Pregnancy in Diabetes Audit	Yes	NA	100%
National Diabetes Audit – Adults-National Core Diabetes Audit Diabetes Audit	Yes	NA	100%

National Audit	Participation yes/no?	Reason for non-participation	% Cases submitted
National Emergency Laparotomy Audit (NELA)	Yes	NA	60% (recognising that nationally, in the majority of instances, less than 100% of cases are submitted)
National Heart Failure Audit	Yes	NA	85% (clinical notes could not be obtained for the remainder of the sample)
National Joint Registry (NJR)	Yes	NA	99% (due to time and resource)
National Lung Cancer Audit (NLCA)	Yes	NA	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) 2017	Yes	NA	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) 2016	Yes	NA	100%
National Oesophago-gastric Cancer (NAOGC)	Yes	NA	100%
National Ophthalmology Audit	Yes	NA	48% (774/1293 – aimed for 100 cases per surgeon)
National Paediatric Diabetes Audit (NPDA)	Yes	NA	100%
National Prostate Cancer Audit	Yes	NA	100%
Pain in Children (care in emergency departments)	Yes	NA	100%
Procedural Sedation in Adults (care in emergency departments)	Yes	NA	100%
Sentinel Stroke National Audit programme (SSNAP)	Yes	NA	Band A 90%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme)	Yes	NA	100%
UK Parkinson's Audit	Yes	NA	100%

(Source Respective audit provider website)

National Confidential Enquires	Participation yes/no?	Reason for non-participation	% Cases submitted
Child Health Clinical Outcome Review Programme - Chronic neurodisability	Yes	NA	100%
Child Health Clinical Outcome Review Programme - Young People's Mental Health	Yes	NA	100%
Medical and Surgical Clinical Outcome Review Programme - Non-invasive Ventilation	Yes	NA	100%
Medical and Surgical Clinical Outcome Review Programme - Acute Heart Failure	Yes	NA	100%
Medical and Surgical Clinical Outcome Review Programme - Pulmonary Embolism	No	NA	NA - Study not yet started at national level
Medical and Surgical Clinical Outcome Review Programme - Perioperative diabetes	Yes	NA	Still in progress at national level
Medical and Surgical Clinical Outcome Review Programme - Cancer in Children, Teens and Young Adults	Yes	NA	100%

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

The reports of 35 national audits were reviewed by the provider in 2017-18 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (where appropriate):

Title	Report published 2017 (calendar year)	Report Reviewed	Action(s) to improve quality of care
BAUS Urology Audits- Female stress urinary incontinence	Yes	Yes	A process has been implemented to ensure detailed counselling is provided in recurrent Stress Urinary Incontinence (UTI) cases
BAUS Urology Audits- Nephrectomy audit	Yes	Yes	No actions identified
BAUS Urology Audits- Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	No actions identified
Cardiac Rhythm Management (CRM)	Yes	Yes	No actions identified
Case Mix Programme (CMP)	Yes	Site specific reports reviewed on quarterly basis	No actions identified
Child Health Clinical Outcome Review Programme-Chronic neurodisability	Yes	In Progress	Report published 8th March 2018 - further time for review required
Elective Surgery (National PROMs Programme)	No – no report published	NA	NA
Endocrine and Thyroid National Audit	Yes	Yes	No actions identified

Title	Report published 2017 (calendar year)	Report Reviewed	Action(s) to improve quality of care
Falls and Fragility Fractures Audit programme (FFFAP)- Fracture Liaison Service Database	Yes	Yes	The Fracture Liaison Nurse is responsible for ensuring the following actions are completed during 2018/19. A virtual clinic to be developed to allow for monitoring of long- term treatment adherence and extra clinics to be introduced to allow for assessment of more patients within 90 days. To have discussions with the lead clinician and at local governance meeting regarding the inclusion of hip fractures into the audit. To discuss the inclusion into the audit of patients over 75 years seen by the falls team, with the falls team and also at the local governance meeting. Review the results in relation to inappropriate anti-osteoporosis medication decisions and the current clinical pathway with the lead clinician.
Falls and Fragility Fractures Audit programme (FFFAP)- Inpatient Falls	Yes	Yes	The Chair of the Trust Falls group is responsible for ensuring the following actions are completed during 2018/19. By May 2018 to audit at patient level against NICE Quality Standard 86 falls in older people, quality statements 4 – 6, to identify how patients are managed following a fall and address areas of weakness to improve the care of these patients. By September 2018, roll out the Royal College of Physicians bedside vision checks for falls prevention assessment tool and lying and standing blood pressure guide to ward staff. Audits to be undertaken on these two elements once staff training is complete. To discuss the review of the dementia and delirium policies with the Trust dementia lead to ensure the policies include related clinical issues such as falls. An annual audit of clinical appropriateness of bed rail use to be carried out across ward areas.
Falls and Fragility Fractures Audit programme (FFFAP)- National Hip Fracture Database	Yes	Yes	A Quality Improvement meeting was held in December 2017, led by a lead orthopaedic consultant, to review the 30-day mortality for hip fractures at TRFT and to brainstorm what changes could be made to the service provided. A number of improvements have been implemented including; updated guidelines for decision making with anticoagulated patients; a standard approach to anaesthesia; Availability of guidelines for bone cement implantation syndrome; delirium score included as part of the Hip Fracture document. A number of additional actions will be implemented in 2018/19 including revision of the admission document to include commonly missed items, such as bone health and a discharge checklist.
Learning Disability Mortality Review Programme (LeDeR)	No – no report published	NA	NA
Major Trauma Audit	Yes	Yes	A review was undertaken by the Trauma Lead of patients with an injury severity score (ISS) >15 included in the clinical reports, to provide further information in relation to type of injuries sustained, delivery of care and outcome at discharge. The findings were discussed at the Trust Trauma Group meeting February 2018 and it was confirmed all cases were appropriately managed. The Clinical Effectiveness Manager and the Medical Director plan to develop a business case for additional staff to complete Trauma Audit and Research Network (TARN) data collection to enable an improvement of submission of data to increase case ascertainment during 18/19.

Title	Report published 2017 (calendar year)	Report Reviewed	Action(s) to improve quality of care
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births from January to December 2015	Yes	Yes	A continued focus on neonatal deaths is required in order to achieve an improvement in neonatal mortality rates from the position seen over the past three years, including close monitoring of foetal growth during pregnancy and implementing the new National Perinatal Mortality Review Tool. Rotherham is in 'Wave 1' for implementing the national learning set, as part of the NHSI improvement programme. The focused areas in Rotherham being reviewed are: • To reduce term admissions to Special Care Baby Unit (SCBU) – by reviewing top 5 admission reasons • Identify Small for Gestational Age Babies – optimising time for delivery, improved scan referrals, implementing Ultrasound scans to term for high risk women as per perinatal institute guidance. • Reduced Foetal movements – planned learning event for women and midwifery staff on the importance of seeking early advice, and identifying barriers stopping women contacting the unit. • Cardiotocography (CTG) establish "fresh eyes / ears" training and audit completion of data. • Smoking – Carbon Monoxide (CO) monitoring, change in way referrals to smoking cessation service are made and reviewed.
Maternal, Newborn and Infant Clinical Outcome Review Programme- Maternal morbidity confidential enquiries: Saving Lives, Improving Mothers' Care.	Yes	Yes	Establish regular training program in Emergency Dept., for postnatal cases especially focusing on stroke, sepsis and mental health.
Maternal, Newborn and Infant Clinical Outcome Review Programme- Perinatal Mortality Surveillance Enquiry	Yes	Yes	Sands-Post Mortem Training packs for doctors and midwives introduced as a result of the report. Perinatal Institute: Growth Assessment Protocol (GAP) training to be completed by all Midwives and Medical staff annually. Annual Perinatal Mortality Event to be held to review all Maternal Deaths, Stillbirths and Neonatal deaths. Set up midwife training "Fresh Ears" to ensure hourly review for low risk women having intermittent auscultation is under review. Conduct Survey of 'Why women delay visiting / contacting the Hospital when the pattern of Foetal movement changes'. Revise guideline and introduce in community midwifery and on Labour ward to increase surveillance of CO monitoring to every contact.
Medical and Surgical Clinical Outcome Review Programme- Non-Invasive Ventilation	Yes	Yes	The Clinical Director of the Medical Division to assess whether a dedicated Non- Invasive Ventilation (NIV) bay will facilitate meeting the recommendations in the report and British Thoracic Society guideline which states that all areas providing acute NIV ensure a minimum staffing ratio of one nurse to two acute NIV patients. Further recommendations are under review.
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	An assessment of the efficiency of acute coronary syndrome (ACS) management by undertaking an audit of ACS cases in 2018/19 supervisedby Consultant Cardiologist.

Title	Report published 2017 (calendar year)	Report Reviewed	Action(s) to improve quality of care
National Audit of Dementia	Yes	Yes	Actions to be taken in 2018/19 include adding Delirium screening to dementia screening forms and/or look at a new delirium screening forms as a separate entity. Introduce a dementia care support plan to implement Person Centre Care with a dementia champion on every ward and improved risk assessment during ward rounds. "This is Me" document reviewed and added to a new service model of care. Increase awareness of finger food options and consider blue plates to increase nutritional intake. Review dementia support care plans to include extension of out of hours' mental health services and appropriate Mental Capacity Act (MCA) assessments forms. In January, our dementia lead (and Admiral nurse) left the Trust. At present there is no one in post although there are plans to review how this post might be re-envisaged as part of the frailty/dementia/person- centred care team, focusing on the providing of clinical care, maintenance of quality and standards and provision of training. We are working with the community matrons to review admissions and determine alternative treatment and care pathways for people living with dementia.
National Audit of Intermediate Care (NAIC)	Yes	Yes	No actions required
National Bowel Cancer (NBOCA)	Yes	Yes	No actions identified
National Comparative Audit of Blood Transfusion programme- Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	In progress	Report published 19th March 2018 - further time for review required
National Comparative Audit of Blood Transfusion programme- 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	No – no report published	NA	NA
National Comparative Audit of Blood Transfusion programme- Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016	Yes	Yes	A number of actions were completed including a review of current elective preoperative anaemia management pathways to confirm standards are being met. NHS Blood and Transplant (NHSBT) materials regarding National Blood Transfusion Committee (NBTC) indication codes for Transfusion being used at education sessions i.e. for Junior Doctors and Non-Medical Authorisers. NHSBT materials are being used in clinical areas for display and to increase Trust awareness of 'Don't give unit two without review'. Work to further increase use of Tranexamic Acid where appropriate, has continued by raising with the Hospital Transfusion Team (HTT). Ensure staff adequately trained in use of cell salvage and widen scope of use. A laboratory action card/algorithm has been introduced to help improve patient blood management (PBM) within the organisation.
National Diabetes Audit – Adults-National Diabetes Foot Care Audit	Yes	NA	Report published 14th March 2018 - further time for review required.
National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	No – no report published	NA	NA

Title	Report published 2017 (calendar year)	Report Reviewed	Action(s) to improve quality of care
National Diabetes Audit – Adults-National Pregnancy in Diabetes Audit	Yes	Yes	Alongside preconception management training, a "To be fit for Pregnancy" information leaflet was developed and distributed to GPs to be used at Annual Reviews to increase pre-conception Folic Acid uptake and improve preconception Glycaemic control. A further action being taken forward in 2018/19 by the consultant Obstetrician to identify resource for diabetes preconception care by the hospital Multidisciplinary Team.
National Diabetes Audit – Adults-National Core Diabetes Audit	Yes	In progress	Report published 14th March 2018 - further time for review required
National Emergency Laparotomy Audit (NELA)	Yes	Yes	A Multidisciplinary Emergency Laparotomy Proforma (MELP) has been developed to improve compliance to MELP pathway to facilitate improvements in NELA data quality. A service evaluation on the use of MELP pathway will be undertaken during 2018/19. The NELA Lead will discuss provision of care of elderly preoperative management with the lead from the Medical Division.
National Heart Failure Audit	Yes	Yes	To facilitate the management of heart failure patients under specialised care a number of actions will be undertaken during 2018/19 led by the Consultant Cardiologist and Heart Failure Specialist nurses. Actions include implementing systems to ensure that heart failure patients admitted under other specialist care i.e. care of the elderly, Acute Medical Unit are referred to the heart failure service for their specialist input and to ensure that patients with heart failure are placed onto a cardiology ward at admission, where possible. Further review of recommendations on how to improve cardiology follow up at discharge to improve outcomes for patients are to be reviewed.
National Joint Registry (NJR)	Yes	Yes	No actions identified.
National Lung Cancer Audit (NLCA)	Yes	Yes	During 2018/19 the Trust Lung Cancer Lead will undertake a review of patients with no performance status (PS) recorded to ascertain the reasons why. Patient with a PS 0 to 2 with non-small-cell lung cancer (NSCLC) who did not have treatment with curative intent will be reviewed to determine the appropriateness of receiving neither surgery or radical radiotherapy. Any issues identified will be further investigated.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) 2016	Yes	Yes	Special Care Baby Unit (SCBU) has now identified a group of staff to act as breast feeding champions to promote breastfeeding. The appropriate use of antenatal steroids and magnesium sulphate is on the perinatal meeting as a regular agenda item. Further actions to be taken forward by a neonatal consultant during 2018/19 is to establish a robust system for 2 years neurodevelopmental follow up which requires a process to identify preterm babies which meet the criteria and a business case to be written and submitted to set up a neurodevelopmental multidisciplinary follow up clinic.
National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	No actions identified.
National Ophthalmology Audit	Yes	Yes	No actions required.

Title	Report published 2017 (calendar year)	Report Reviewed	Action(s) to improve quality of care
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	A number of actions were undertaken to ensure that the care process submission continues to improve including: increasing discharges to young adult clinics to improve transitional care flow; updating clinical guidelines and delivery of teaching to trainee doctors; submission of a business plan for purchase of 'safe use of insulin' e-learning package to improve structured education for staff; improve clinical outcomes by changing the operational policy on new Glycated Haemoglobin (a measure of blood sugar levels over time) targets, provision of blood ketone meters for children's wards and making Continuous Glucose Monitors available for eligible patients as per National Institute for Health and Care Excellence (NICE) Guidance. Further work towards approval/funding of new technologies like Flash Libre sensors (Advanced Glucose Monitoring System) continues.
National Prostate Cancer Audit	Yes	Yes	No actions required.
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	SSNAP action plan developed and monitored through the Stroke Business and Governance meetings. Specific actions to implement include: facilitating early transfer of stroke patients to the unit, improving thrombolysis figures and monitoring uptake of early supportive discharge (ESD) / speech and language therapy.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme)	Yes	Yes	No actions required.

(Source: Trust Audit Database)

Review of Local Clinical Audits

The reports of 109 local clinical audits were reviewed by the provider in 2017-18 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table at Appendix 1).

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2017/18 that were recruited to participate in research approved by a research ethics committee was 988 compared to 540 in 2016/17. A significant number of recruits (372) are the result of participation in the Yorkshire Health Study, which is a questionnaire study available to staff, patients and public.

To be consistent with previous submissions, this data includes all participants (patients and staff) recruited to NIHR Portfolio research studies actively recruiting at The Rotherham NHS Foundation Trust i.e. included all studies that received Trust confirmation of "Capacity and Capability" as per Health Research Authority requirements. This includes studies that require research ethics approval and those that have no legal requirement to do so as per Governance Arrangements for Research Ethics Committees GAfREC (Department of Health, 2011).

The table below shows the total number of studies that have been actively recruiting during 2017/18

Study Type (as at 05 April 2018)	Number of studies
NIHR Portfolio Commercially sponsored	3
NIHR Portfolio Non-commercial	42
Studies where The Rotherham NHSFT is a Participant Identification Centre (PIC)	8
Non-portfolio The Rotherham NHSFT Sponsored	3
Other Non-portfolio (supporting academic qualifications)	4

(Source: TRFT Research Database)


NHS
NHS
NHS
NHS
NHS

The increase seen in research activity is testament to the changes implemented in the Research and Development Department, including the development of the team of centrally located Trust employed Research and Development generic research nurses. The implementation of this team:

- Provides a team of generic research nurses to work across all departments of the Trust wherever support is needed.
- Ensures that as a group, the professional research nurses are given specialised senior research nurse management, specialised training, career development opportunities and peer support.
- Ensures the appropriate and flexible allocation of resource according to the intensity of the research activity and value for money by ensuring that individuals worked to capacity.
- Provides an assurance of the quality and standardisation of the working practices with appropriate management oversight.

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

CQUINs (Commissioning for Quality and Innovation)

A proportion of The Rotherham NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between The Rotherham NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

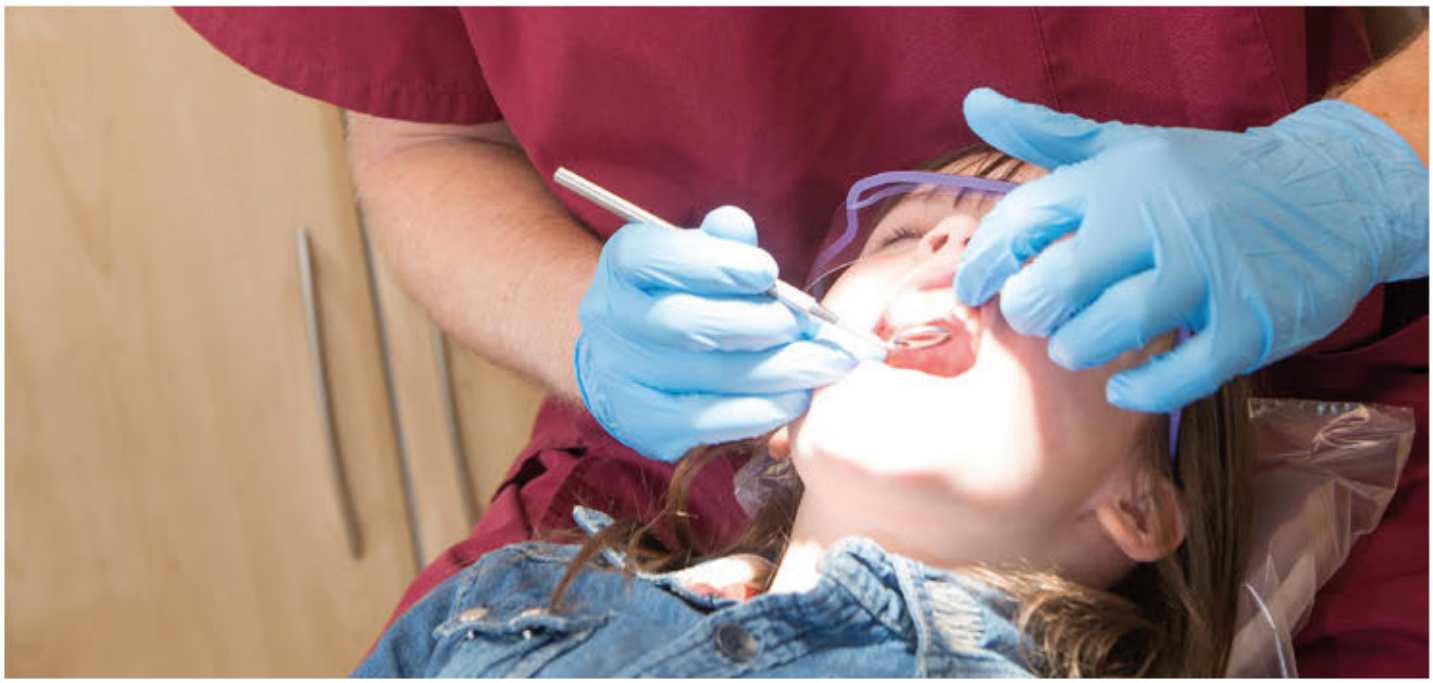
In 2017/18 £4.2M of Trust income for all applicable Commissioners was conditional upon achieving the CQUIN goals compared with £4.4 million in 2015/16.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically from the Trust Website at: http://www.therotherhamft.nhs.uk/CQUINqualityindicatorframework/

CQUIN goals continue to form part of the National NHS Standard contract for 2018-2019. All schemes agreed are national indicators. A high level summary of the indicators applicable in 2018/19 is provided below:

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

(Source: NHS England)



CQC Registration and Periodic Reviews/Specialist Reviews

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Registered without Conditions'. The Care Quality Commission has not taken enforcement action against The Rotherham NHS Foundation Trust during 2017/18.

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

At the September 2016 inspection, the overall key question of well-led was reviewed and was rated as Requires Improvement. This remains as the previous inspection in 2015. The remainder of the five key questions (Safe, Effective, Caring and Responsive) were not re-rated at that time.

The tables below show the detailed ratings by key question and by core service for the re-inspection conducted in September 2016.

CQC ratings for Trust Hospital services after 2016 re-inspection:

	Safe	Effective	Caring	Responsive	Well led
Urgent & Emergency Services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Good
Surgery	Good	●	●	Good	●
Critical Care	Good	Good	●	●	Requires Improvement
Maternity and gynaecology	Requires Improvement	Good	Good	Good	Requires Improvement
Children and young people	Good	Requires Improvement	Good	Good	Requires Improvement
End of life care	●	Requires Improvement	●	●	●
Outpatients and diagnostic imaging	Good	●	●	●	●

CQC ratings for Trust Community services after 2016 re-inspection:

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

● not rated during this inspection visit

(Source: Care Quality Commission)

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

The Trust is currently preparing for an inspection which it is believed will be undertaken in 2018/19 and the actions to be undertaken are located on page 40.

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

A comprehensive action plan was created as a result of the inspection findings for the regulation breaches which was approved at the Quality Assurance Committee on 13 April 2017, prior to the requirement for submission to the CQC on 15 April 2017. It was then retrospectively approved by Board on 25 April 2017. The plan aims for all actions to be in place within 12 months.

Together, the Annual Quality Report priorities and the CQC requirements, made up the Trust's Quality Improvement Plan. A newly developed Quality Improvement Board reviewed and monitored achievement against the Quality Priorities. These arrangements have been the subject of a further refinement during 2017/18, with the monitoring of progress with the CQC requirements being undertaken by the Clinical Governance Committee.

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

The Medical Director was the nominated individual during 2017/18, however this will change to the Chief Nurse in 2018/19.

Amendments were made to the Trust's CQC registration during 2017/18 which included adding the Urgent and Emergency Care Centre to the Trust's Statement of Purpose.

A copy of the Trust's registration certificate can be viewed at http://www.cqc.org.uk/provider/RFR/registration-info or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec Company Secretary
General Management Department, Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

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

The Trust is also required to report any breaches of the Ionising Radiation Regulations to the CQC. Below is a summary of the radiation incidents which have been reported to the CQC from 1 April 2017 to 31 March 2018.

Month	Details of radiation incident reported to CQC April 2017- April2018
July 2017	The incorrect patient had an unnecessary chest x-ray on ITU taken in error. Closed by CQC on 20.7.17
July 2017	Radiation dose greater than intended, due to incorrect selection of exposure factors. Closed by CQC 25.7.17
September 2017	Doctor requested CT head scan on the incorrect patient. Cancelled on Electronic Patient Record but did not phone x-ray department to cancel so patient was scanned. Closed by CQC 16.3.2018
November 2017	Incorrect abdominal x-ray, this was due to operator error. Closed by CQC 21.11.17
December 2017	Electronic referral for a patient, when patient on table it was recognised that referral indications did not match the patient. Patient had a Topogram of their Chest, abdomen and pelvis before this was realised. The referrer had requested the scan on the wrong patient and not cancelled the procedure with the Imaging department. Closed by CQC 26.3.2018
February 2018	Incorrect chest x-ray, this was due to referral error. The incorrect patient was referred for a mobile chest x-ray. Closed By CQC 27.3.18 (awaiting official email of closure).
February 2018	Transcription error of voice recognition software on an ultrasound report. This led to the referrer wrongly requesting an unnecessary CT Urogram examination. CQC closed 16.3.18
February 2018	Electronic request for the wrong patient, cancelled on Meditech but no phone call to cancel on Radiology Information System. Repeat of base of skull due to movement. Incident still open with CQC.

(Source: Datix and Radiation Protection Advisors Report)

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

Special Reviews and Investigations

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

Data Quality

The Rotherham NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data April 2017 – January 2018.

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

99.8% (99.9% for 2016/17) for admitted patient care
99.9% (99.9% for 2016/17) for outpatient care
97.1% (88.5% for 2016/17) for accident and emergency care

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

100% (99.9% for 2016/17) for admitted patient care
100% (99.8% for 2016/17) for outpatient care
100% (98.9% for 2016/17) for accident and emergency care

Please note: 2017-18 data in this section is based on a refreshed data position from NHS Digital submissions. The 2016/17 data is based on the published data April 2016 – January 2017.

Information Governance

The Rotherham NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 74% and was graded Green (Satisfactory). (See details in the Annual Report)

Payment by Results

The Rotherham NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission. (Note: NHSI Comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHS Improvement. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'costing audit'.)

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

The Trust engaged in implementing the NHS Spine to our clinical information system MediTech in January 2018 and we are the first Trust using our Electronic Patient Record (EPR) (Meditech) to transition to Patient Demographics Service in the country. It was anticipated that additional improvements would be seen, in particular in our Emergency Care data which had recently migrated from our legacy system Symphony onto MediTech. Initial investigations have found that some significant improvements have been made, this will over the following year make positive improvements in the quality of the Emergency Department Data bringing it more in line with the high standards we have set in our Inpatient and Outpatient data.

The Rotherham NHS Foundation Trust was subject to the mandatory

clinical coding Information Governance audit during the reporting period as required by NHS Digital.

In addition, TRFT have also had external audits of the following specialities; Haematology and Urology, Maxillofacial Surgery and General and Breast Surgery. Feedback was very good for both diagnosis and depth of coding.

Data Quality Index (HRG4+ based)

CHKS continues to be the source of information for the Data Quality Index and at the time of reporting data for the period April 2017 to December 2017 is available. There has again been a marginal increase from the previous year; the Trust continues to outperform peer averages with an index of 96.09 compared to a peer average of 95.0.

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

The Trust position for unaccepted diagnosis codes in the period up to December 2017 has worsened, achieving 1.17% against a previous measurement of 0.18% for 2016/17 – this has occurred due to a significant change in the system following the migration of our Emergency Department onto our primary Acute System MediTech, action plans have been put in place and in the last quarter we were seeing signs of these actions making improvements on the quality of that data – we are continuing to take steps to reduce the impact of this change on our data. Our depth of coding (average number of diagnoses per coded episode) continues to increase from 5.1 in January of 2017 to 6.8 in December 2017, this is an improvement of 25% in year.

Clinical Coding

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

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	95.5	96	95.3	98.2

(Source: The Rotherham NHS FT Information Governance Audit Report 2017/2018)

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

In 2016/17 the Trust took the following actions to improve clinical coding data quality and these continued throughout 2017/18:

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

Improvements and actions to further improve clinical coding during 2017/18 included:

- Reviewing coding processes across the organisation to benefit from coding at source and in near-real time wherever practicable.
- Implement and review coding performance indicators.
- An objective was put in place to recruit Accredited Clinical Coder (ACC) Qualified Clinical Coders, to reduce the Trust reliance on using Contract Coders to meet deadlines, within the financial year 2017/18. We have been successful in recruiting these staff and these steps have aided the Trust in significantly improving the depth of coding.

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

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 -16	96	Increase	96	96	97	96	96	→
		2017 - 18	96	Increase	96.12%	95.38%	96.82%	Data not yet available	96.09%	↑
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 -16	0.46%	Decrease	0.15%	0.13%	0.24%	0.22%	0.18%	↓
		2017 - 18	0.18%	Decrease	1.23%	1.39%	0.86%	Data not yet available	1.17%	↑
	IDQ-3 Sign and symptom as primary diagnosis (R codes) at first episode (CHKS Live)	2015 -16	8.84%	Decrease	10.30%	11.80%	10.80%	10.43%	10.85%	↑
		2017 - 18	10.85%	Decrease	12.07%	12.15%	9.96%	Data not yet available	11.43%	↑
	IDQ-4 Sign and Symptom as primary diagnosis (R codes) at second episode (CHKS Live)	2015 -16	11.99%	Decrease	12.90%	17.50%	12.80%	14.18%	14.83%	↑
		2017 - 18	14.83%	Decrease	16.99%	17.59%	15.12%	Data not yet available	16.64%	↑
	IDQ-5 SUS Data Quality - Admitted Patient Care: NHS number validity (NHS Digital Dashboard)	2015 -16	99.80%	Increase	99.80%	99.80%	99.80%	99.80%	99.90%	↑
		2017 - 18	99.90%	Increase	99.90%	99.90%	99.80%	Data not yet available	99.80%	↓
	IDQ-6 SUS Data Quality - Admitted Patient Care: Postcode validity (NHS Digital Dashboard)	2015 -16	100.00%	Increase	100.00%	100.00%	100.00%	100.00%	100.00%	→
		2017 - 18	100.00%	Maintain	100.00%	100.00%	100.00%	Data not yet available	100.00%	→
	IDQ-7 SUS Data Quality - Outpatients: NHS number validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	99.90%	99.90%	99.90%	99.90%	99.90%	→
		2017 -18	99.90%	Increase	100.00%	99.90%	99.90%	Data not yet available	99.90%	→
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	100.00%	100.00%	100.00%	100.00%	100.00%	↑
		2017 - 18	100.00%	Maintain	100.00%	100.00%	100.00%	Data not yet available	100.00%	→
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 -16	86.60%	Increase	83.70%	83.70%	86.90%	89.70%	89.70%	↑
		2017 - 18	89.70%	Increase	99.20%	98.40%	98.80%	Data not yet available	98.80%	↑
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.10%	Increase	98.10%	98.30%	98.70%	99.00%	98.80%	↓
		2017 - 18	98.80%	Increase	100.00%	100.00%	100.00%	Data not yet available	100.00%	↑

(Source: NHS Digital and CHKS Live)

The baseline was established in 2015-16 and the Trust uses that baseline to compare against. The data for Q4 is not available until the end of May 2018 which is after the deadline of the report and so not included.

Learning from Deaths

During 2017/18 1008 of TRFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 253 in the first quarter;
- 199 in the second quarter;
- 264 in the third quarter;
- 292 in the fourth quarter.

By 6 April 2018, 313 case record reviews and 14 investigations have been carried out in relation to 1008 of the deaths included in above. In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 84 in the first quarter;
- 50 in the second quarter;
- 132 in the third quarter
- 47 in the fourth quarter

13 representing 1.3% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 5 representing 2% for the first quarter;
- 7 representing 3.5% for the second quarter;
- 0 representing 0% for the third quarter;
- 1 representing 0.34% for the fourth quarter.

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

What the provider has learnt from case record reviews

The Trust has been conducting case record reviews on selected patients within the Trust at random and following specific diagnosis codes that have been identified through the data. The specific diagnosis codes reviewed were pneumonia, myocardial infarction, hip fracture, and intestinal hernia without obstruction.

There were specific themes that arose from these case note reviews such as poor communication, failure to recognise a deteriorating patient, lack of advance care planning and delayed/missed diagnoses. There was also a theme of incorrectly coded incidents where the patient's disease profile was not captured accurately through the coding process.

Description and assessment (including actions)

There has therefore been extensive work with the coding department to ensure that the depth of coding has increased and that the actual cause of death or comorbidities are accurately captured. This has significantly improved the mortality picture. The palliative care team have worked extremely hard with the introduction of advance care pathways and this has reduced the number of patients who have inappropriately been admitted to hospital and reduced the number of deaths within 24 hours of admission.

There has been focus on the patients who had prolonged length of stay and should have been discharged significantly earlier in the admission as these patients were more likely to succumb to hospital acquired infections. This has made a significant impact on the quality of care for patients.

The introduction of the pneumonia bundle has vastly improved the risk stratification of pneumonia patients allowing earlier critical care intervention. The theme of sepsis has been targeted with improvements made throughout the Trust.

The restructuring of the deteriorating patient pathway with earlier intervention by senior medical staff and highlighting the Modified Early Warning System (MEWS) scores has reduced the number of unexpected admissions to critical care and dramatically reduced the number of cardiac arrests within the ward based areas. The introduction of a Hospital at Night Service has improved patient safety by supporting the medical workforce and the results of this have not been systematically analysed but anecdotally has made a significant difference. The Trust has introduced the acute kidney injury bundle which has reduced the number of patients who have had their injury worsened by suboptimal care on the wards.

In relation to the theme of poor communication handover has been given a higher focus and electronic handover and strict adherence to policy has made communication tighter throughout the Trust.

66 case record reviews and 0 investigations completed after 1 April 2017 which related to deaths which took place before the start of the reporting period.

2 representing 0.2% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Preventable Incidents Survival and Mortality (PRISM) methodology.

6 representing 0.6% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.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2.3: Reporting against core indicators

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

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

	Indicator name	Latest & previous reporting periods	TRFT value Oct 16 - Sept 17	TRFT previous value April 16 - March 17	Acute Trust average Oct 16 - Sept 17	Acute Trust previous average April 16 - March 17	TRFT previous value April 16 - March 17	TRFT previous value April 16 - March 17
Domain 1 - Preventing people from dying prematurely	Summary Hospital Mortality Indicator – Value	April 16 - March 17 Oct 16 - Sept - 17	106.67	111.81	100.5	100.50	107.26	121.23
	Summary Hospital Mortality Indicator – Banding	July 16 - June 17 Oct 16 - Sept - 17	2	2	2	2	3	1
	SHMI: Percentage of patient deaths with palliative care coding at diagnosis level	July 16 - June 17 Oct 16 - Sept - 17	30.64%	30%	29.56%	29.07%	66.92%	56.90%

(Source: NHS Digital)
Hospital Episode Statistics (HES) data linked to Office for National Statistics (ONS) death registrations data

Patient Related Outcome Measures (PROMS)								
DOMAIN	Indicator Title	Modelled records	Average Pre-Op Q Score	Average Post-Op Q Score	Health Gain	Improved	Unchanged	Worsened
Domain 3 - Helping people to recover from episodes of ill health or following injury	**Primary hip replacement surgery (EQ-5D Index) - health gain**							
	1st April 2016 - 31st December 2016	56	0.279	0.824	0.545	51 (91.1%)	2 (3.6%)	3 (5.4%)
	1st April 2016 - 30th March 2017	121	0.292	0.798	0.506	106 (87.6%)	9 (7.4%)	6 (5.0%)
	Groin hernia surgery (EQ-5D Index) - health gain							
	1st April 2016 - 31st December 2016	78	0.751	0.875	0.124	48 (61.5%)	20 (25.6%)	10 (12.8%)
	1st April 2017 - 30th September 2017	19	0.651	0.898	0.247	14 (73.7%)	2 (10.5%)	3 (15.8%)
	Primary knee replacement surgery (EQ-5D Index) - health gain							
	1st April 2016 - 31st December 2016	77	0.353	0.734	0.381	67 (87%)	5 (6.5%)	5 (6.5%)
	1st April 2016 - 30th March 2017	148	0.372	0.726	0.353	125 (84.5%)	13 (8.8%)	10 (6.8%)
	Varicose vein surgery (EQ-5D Index) - health gain							
	1st April 2016 - 31st December 2016	No Data	No Data	No Data	No Data	No Data	No Data	No Data
	1st April 2017 - 30th September 2017	No Data	No Data	No Data	No Data	No Data	No Data	No Data

(Source: NHS Digital)

Note – Primary hip replacement surgery and primary knee replacement surgery for April 2016 to March 2017 was published February 2018. This is the most up to date data available. For groin hernia surgery and varicose vein surgery, the data ceased being collected from October 2017 following consultation.

Re admissions within 28 days of discharge from Hospital:

Please note that this indicator was last updated in December 2013 and future releases have been suspended pending a methodology review.

	NHSD ref	Indicator name	Latest & previous reporting periods	Trust value	Acute Trust average	Acute Trust highest	Acute Trust lowest
Domain 4: ensuring that people have a positive experience of care	PO1533	CQUIN: Responsiveness to patients personal needs	2015	68.1	68.9	86.1	59.1
			2016	65.1	68.1	85.2	60
	PO1533	Staff who would recommend their Trust to family or friends (Acute Trusts for comparison)	Qtr 4 Jan - March 2016/17	65%	63%	85%	20%
			Qtr 2 July - Sept 2017/18	45%	62%	96%	25%

Source of all data, NHS Digital.

NHS England do not publish a full year end position therefore the tables include the last quarter results for 16/17 and the latest publication for 17/18.

	NHS DIGITAL Indicator	Indicator name	Latest & previous reporting periods	Trust value	Acute Trust average	Acute Trust highest value	Acute Trust lowest value
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. NHS DIGITAL Indicator	PO1556	Percentage of patients admitted to hospital and risk assessed for VTE	Oct 15 - Dec 15	95.90%	95.50%	96%	61.5%
			Jan 17 - March 17	96.28%	95.54%	100%	63%
	PO1557	Rate per 100,000 bed days of cases of C.diff amongst patients aged 2 or over	Apr 15- Mar 16	19	14.5	17.4	0
			Apr 16- Mar 17	17	11.7	75.9	0
	PO1394	Patient safety incidents: rate per 1000 bed days (acute non-specialist for comparison)	Oct 14 - Mar 15	40.5	37.15	82.2	0.2
			Apr 17 – Sept 17	48.14	42.84	111.69	23.47
	PO1395	Patient safety Incidents: % resulting in severe harm or death (medium acute Trusts for comparison)	Oct 14 - Mar 15	0.08%	0%	0.17%	0%
			Apr 17 – Sept 17	0.61%	0.40%	1.9%	0%

Source of all data, NHS Digital.

The blank boxes are where there is no data published for this period on either the NHS Digital (NHSD) or National Reporting and Learning System (NRLS) websites.

Please note that the data reported for previous financial years in the tables above has been refreshed.

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

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:
12a. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period	Data validated and published by NHS Digital. The Trust has experienced a rise in mortality indicators after the number of deaths increased between April and July 2016. There has been a subsequent fall in deaths and the review process continues. The SHMI reported rose until the most recent result in April 2018 when it has started to come down as the reporting period no longer includes the rise in deaths in 2016.	The Trust holds regular meetings of the Mortality Review Group which reports to the Clinical Governance Committee. Data (SHMI and HSMR) and incidents are reviewed to help identify trends and areas of concern. A summary of the Trust's performance and mitigating actions taken is shared in Board reports. Deaths are reviewed and reported quarterly in the Learning from Deaths Report to the Board.
12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	The Trust's Consultant-led Specialist Palliative Care Team identifies and assesses all patients receiving palliative care. Only patients receiving care from the team are included in the data.	Latest Score 30.64% To improve the percentage score the Trust's Consultantled Specialist Palliative Care Team will continue to identify and assesses all patients receiving palliative care.
18. Patient Reported Outcome Measures scores for— (i) groin hernia surgery; (ii) varicose vein surgery; (iii) hip replacement surgery; and (iv) knee replacement surgery during the reporting period.	The data is considered to be accurate based on the number of returns received and the data validated and published by NHS Digital. The latest reporting periods vary between the type of surgery performed. The Trust performs too few Varicose Vein procedures to reach the threshold for data analysis. Since October 2017 the outcome measures for Groin Hernia and Varicose veins are no longer a national requirement.	Post Op Score (i) 0.898 (ii) / (iii) 0.798 (iv) 0.726 PROMS are measures recorded pre- and post-operatively by patients. They measure changes in quality of life and health outcomes. The Trust will continue to collect PROMs data to help inform future service provision.
19. Percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, Readmitted to a hospital which forms part of the trust within 28 days of discharge.	This indicator is not presently being updated by NHS Digital; as yet there is no date available for the next data release. Data shown for the period 2016/17 for elective and nonelective patients is drawn from internal sources – Readmissions report from the TRFT Data Warehouse.	The Indicator continues to be monitored through the Board Integrated Performance Report based on the Trust's own data. The Transfer of Care Team works to reduce readmission rates through better planning of discharge. The Care Home Team identifies factors leading to admission and readmission of Care Home Patients and works with the sector to improve effectiveness.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's position is drawn from 5 key questions asked in the national in-patient survey (administered by the CQC). The most recent data is from the survey conductedbetween August 2016 and January 2017. Full results are available later in this report.	CQC will publish 2017 patient survey results in June 2018
21. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	Department of Health conduct an annual independent survey of staff opinion	For staff survey data and staff Friends and Family data see page 102. The Trust's **Together We Can** programme will continue in 2018/19 (See Part 3)

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:
21.1 Friends and Family Test – " How likely are you to recommend our hospital to friends and family if they need similar care or treatment" Services covered: - Inpatients - Day cases - Accident and Emergency - Outpatients - Maternity - Community	The data is considered to be accurate based on the number of forms inputted into the system received for each area. The data is submitted to NHS Digital monthly for publication. The published data relates to the positive and negative scores for each area derived from the number of patients who would or would not recommend our services. Since March 2017 the Trust has run the Friends and Family test in house, previously it was out sourced to an external contractor. Due to the large number of outpatient clinics there is a rota system in operation which ensures all clinics are captured at certain months throughout the year.	The target for the positive score is 95% for all areas except Accident and Emergency where it is 85%. The Trust continues to over perform in relation to positive response scores across the Trust and remains in a strong position going forward. The February positive scores: - Inpatients 96.31% - Day cases 97.1% - Accident and Emergency 99.1% - Outpatients 97% - Maternity 98.39% - Community 98.12% The Trust will continue to collect FFT data to help to improve the experiences of our patients and to triangulate the data with the national patient survey results.
23. Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	Data is validated and published by NHS DIGITAL	The Trust will continue to monitor VTE rates, and report through local clinical governance structures to the Clinical Governance Committee.
24. The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	Data is validated and published by NHS Digital. Trust data quality is also subject to external audit. Data validated and published by NHS Digital (NRLS); latest data is for the period April – September 2017. This was the latest reporting period where TRFT has submitted its data. The results were published 21st March 2018.	The Trust will continue to monitor rates through root cause analysis and audits and report through local clinical governance structures to the Clinical Governance Committee; for further actions to reduce rate of c-diff see Part 3
25. The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Number of incidents occurring in this period - 3,749 Bed days – 77,873 Apr 17 – Sep 17 Rate per 1,000 bed days - 48.14 The next reporting period will be October 2017 to March 2018 a deadline for this has not been released yet. Organisation patient safety incident reports: 21 March 2018: data based on incidents that occurred from 1 April to 30 September 2017	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures.

(Source: Trust Information System)

Her Majesty's Coroner's Inquests 2017/18

There have been 38 inquests held in total for 2017/18 in comparison to 44 in total for 2016/17. At the time of producing this report the Trust has not received any "Reports to Prevent Future Deaths"; the power that comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

Learning from inquests continues to be a priority for the Divisions to include in their governance processes to ensure we do not see a repetition of incidents.

The Chief Coroner, recently published the fourth annual report which covers the period 1 July 2016 to 30 June 2017. For 2018/19 he has identified that:

- there will be continued focus on nationalisation of the service to assist with standardisation and consistency.
- a decision is still awaited about the national introduction of the medical examiner scheme. Since the pilot started, there has been an increase of 35% in inquest work in that area.

There may be further changes considered during 2018/19 which may affect the Trust but these would require a change in the law. They include:

- the possibility of merging of coroner areas - smaller areas into one to assist with flexibility
- the discontinuance of investigations by the coroner where the cause of death is identified through another source other than a post mortem
- inquests without a hearing where the facts are not contentious and there is no need for oral evidence, consideration should be given to an inquest on paper
- amending the guidance for legal aid at an inquest where the state has agreed to provide representation for another interested person

Part Three: Other Information

3.1 Overview of quality of care based on performance in 2017/18

A summary of the Trust's quality priorities for 2017/18 is provided below with an indication as to whether the priority was achieved or not by the year end.

Reference	Metric	Outcome
Patient Experience 1 - Safe Management of Discharge from Hospital	Continue each month to monitor telephone calls with 6 patients'about their experience of discharge planning, sharing themes and feedback with Divisions through the Patient Experience Group.	Green
	See a 10% reduction in IAF (incident alert forms) with failed discharge completed from Community and Social Care settings.	Green
	Continue to work and align data to reduce re- admissions by 5%, once baseline is established for patient numbers in quarter one.	Green
	Reduce formal discharge related complaints by 10% in year from 2016/17 baseline (from 21 reported in 2016/17)	Green
	Streamline the individualised care management plans for patients with repeated attendance at the Emergency Department	Green
Patient Experience 2 and 3 - End of Life Care – acute and community services	Fully embed its End of Life Care (EOLC) 5-year strategy that describes and sets out the requirements for complying with guidance from One Chance to Get it Right – Leadership Alliance for the Care of Dying People. This provides a focus for improving care for people who are dying and for their families, ensuring all patients at the end of life receive the best possible care for a peaceful, pain free and dignified death.	Amber
	Use NICE Guidance and other National EOLC Guidance to inform Trust processes and systems.	Green
	Provide focused leadership and the best End of Life and Palliative Care across the Trust by a Task and Finish Group.	Green
	Have effective monitoring, accountability and governance arrangements for End of Life Care which is via the EOLC Operational Group, relevant Divisional Governance Groups and the Quality Assurance Committee.	Amber
	Work in collaboration with Local Authorities, the Hospice and other partners to provide joined up services.	Green
	To ensure full compliance with the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Policy and the Mental Capacity Act.	Amber
	To ensure all actions that are identified via the End of Life Care Operational Group and other Partnership Groups (Hospice, Local Authority and Clinical Commissioning Group) are progressed.	Green

Reference	Metric	Outcome
Patient Safety 1 - Improving Medication Safety and Efficiency	Reduce the level of harm caused by medication errors by 10%	Green
	Ensure 100% of medication administration is signed for (or a reason for non-administration recorded)	Amber
	Ensure systems of communication are embedded by October 2017 to share learning from incidents	Green
	Achieve a rate of 85% on AMU for medicines reconciliation within 24 hours of admission	Green
	Use benchmarking data for Pharmacy to develop pharmacy workforce and business plans	Green
Patient Safety 2 - The Deteriorating Patient	We will use a recognised early warning score, implement an escalation process and act in a timely manner as soon as it is recognised that patients are deteriorating.	Amber
Patient Safety 3 - Increasing the Rate of Harm Free Care	To understand performance variation within the organisation, to set improvement goals and measure progress.	Green
Clinical Effectiveness 1 - Compliance with the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy	Patients are appropriately assessed to identify the correct level of care	Amber
	Management plans are agreed and accurately documented in the patient record, using the correct DNACPR form.	Amber
	Undertake regular ward reviews of documentation and patient assessments	Green
	Medical and Nursing colleagues take full ownership for compliance with DNACPR policy	Amber
	To undertake a benchmark review to assess current position	Green
	To undertake spot audits that demonstrate compliance of all areas at least quarterly	Green
	To undertake a formal audit of compliance	Green
	To evaluate the effectiveness of training from audits	Green

Reference	Metric	Outcome
Clinical Effectiveness 2 - Compliance with the Mental Capacity Act (2005)	To ensure Trust colleagues have the relevant training in relation to the Mental Capacity Act and are able to assess patients in accordance with the Policy	Green
	To audit compliance with the requirements of the Mental Capacity Act	Green
	Identify issues or learning in order to develop an action plan to improve compliance	Green
	Celebrate areas demonstrating good practice and compliance to share learning	Green
	To ensure full ownership from Medical and Nursing colleagues of compliance and follow up action accordingly	Amber
	To undertake a benchmark full review to assess current position by the end of April 2017	Green
	To evaluate the effectiveness of training	Green
Clinical Effectiveness 3 - National Quality Requirements and Clinical Audit	To complete the annual audit plan within the year time frame and ensure that recommendations from the audits are implemented within the specific department.	Green

3.1.2 Performance against the 2017/18 Priorities

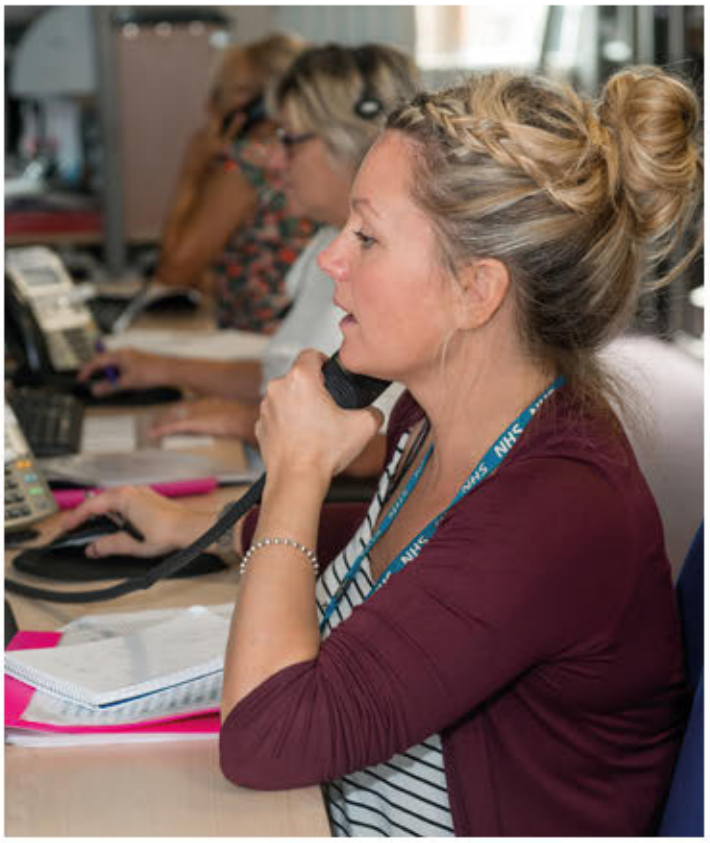
There were nine quality priorities for 2017/18, as follows;

- Patient Experience
  - Safe Management of Discharge from Hospital
  - End of Life Care – acute
  - End of Life Care - community services

- Patient Safety
  - Improving Medication Safety and Efficiency
  - The Deteriorating Patient
  - Increasing the Rate of Harm Free Care

- Clinical Effectiveness
  - Compliance with the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
  - Compliance with the Mental Capacity Act (2005)
  - National Quality Requirements and Clinical Audit

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



Domain: Patient Experience

1. The safe management of discharge from hospital
Lead: Director of Operations
Operational Lead: Head of Nursing – Operations
CQC domain: Responsive

Rationale
Discharge remains a fundamental part of our patient's journey and ongoing care across the healthcare economy. An effective, safe, timely and well planned discharge can ensure the ongoing provision of an effective patient pathway across services. As an organisation, we are aware that we need to continue to enhance, develop and refine our discharge process to ensure a positive and safe experience for our patients.

We need to improve both our internal and external processes to plan ahead for discharge and work with other agencies.

There is also a CQUIN indicator for 2017-19 – supporting proactive and safe discharge.

In 2017/18 the Trust aims were to continue to improve the management of hospital discharge ensuring people leave hospital in a safe, timely, way. Enabling patients to get back to their usual place of residence in a timely and safe way.

Our objectives for 2017/18 were:

- Continue each month to monitor telephone calls with 6 patients about their experience of discharge planning, sharing themes and feedback with Divisions through the Patient Experience Group.
- See a 10% reduction in IAF (incident alert forms) completed from Community and Social Care settings.
- Continue to work and align data to reduce re-admissions by 5%, once baseline is established for patient numbers in quarter one.
- Reduce formal discharge related complaints by 10% in year from 2016/17 baseline (from 21 reported in 2016/17)
- Streamline the individualised care management plans for patients with repeated attendance at the ED department

This priority continued from 2016/17 and into 2018/19.

What did we achieve?
Update on service changes
The Trust is developing an Integrated Discharge Team which will consist of a group of professionals from both Social Care and the Transfer of Care Team, who are co-located within the Hospital, and collaboratively work together to ensure the safe and timely discharge and transfer of patients with complex needs from hospital back home or to another care setting. The Integrated Discharge Team will use a single assessment process for patients.
Work has started to clarify the discharge pathways. These will be:

1. Home First pathway
2. Further assessment – discharge to assess
3. Long term care placement

However, we have identified that we have more to do around the management of 'routine' or 'simple' patient discharges from our ward areas, that fall into pathway 1 and 2.

Feedback has been obtained from junior doctors to understand their challenges, which include prescribing take home medication or writing discharge letters on their wards in a proactive and timely fashion.

We launched the red bag scheme in December 2017 with the Care Home team. Care home colleagues who may need to send patients to hospital for admission will send relevant information about the patients' medical condition, medication or other significant information with the patient in the red bag. Once the patient is discharged colleagues from the hospital site will return the paperwork with any further information relevant to their hospital stay in the same red bag.

Additionally, in December a small team commenced the NHS Improvement (NHSI) collaborative on criteria led discharge. We are working through this programme on Fitzwilliam ward (Trauma and Orthopaedics). All patients who sustain a fractured neck of femur are discharged using a criteria led discharge pathway using a multi-disciplinary approach.

The Trust is still however seeing a picture of delays for patients being discharged out of hospital. Current data is showing that our practice is still challenged around take home medication (TTOs), prescribing and take home letters. On average only 10% of patients are discharged before midday which includes the Acute Medical Unit and short stay facility, despite patients being told they can go home very early on ward rounds. There is an average of 6 hours between TTOs being discussed as required for the patient to take home, to final completion of prescription.

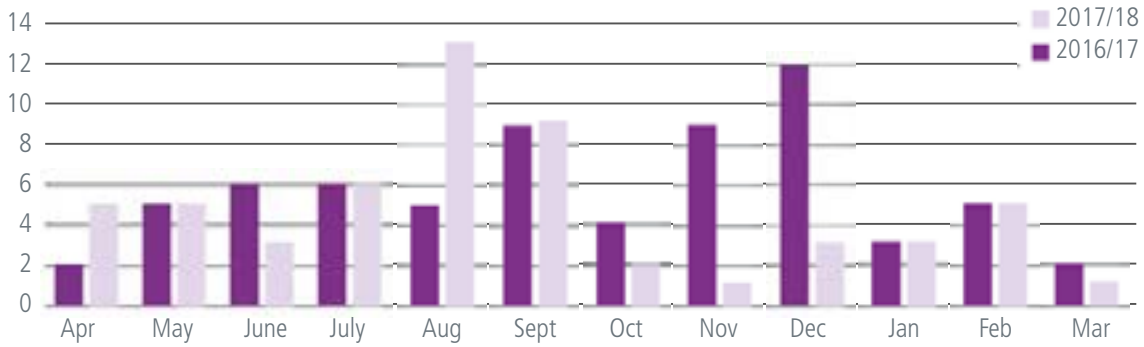
79% of all TTOs requests are made after mid-day to pharmacy, with TTO requests being on the day and not pre-planned. 90% of patient discharges take place after mid- day, often late afternoon and can be later. (Note – data for previous years is not available).

The Division of Medicine is leading a piece of work around the Urgent and Emergency Care Improvement Board, which address the problems with TTOs and discharge letters. This will also be progressed towards our target of 25% of all patients discharged before midday. This includes a potential pilot of transcribing TTOs differently at ward level, which in another trust has made significant difference to pre noon discharge and redirection in tasks for nurses and medical teams.

In addition, we have seen a reduction of formal complaints about purely discharge. Last year we had 10 formal complaints, this year we have seen 5 formal complaints.

Incident alert forms (IAF) are used to log concerns from partner agencies about discharge. The Patient Experience Group receives reports of changes made across wards and departments as a result of feedback. There were 68 for 2016/17 and 56

for 2017/18, which shows a reduction of 18%. This is demonstrated in the table below;



(Source: Trust Information System)
Note: the data for 2016/17 has changed due to a data cleansing exercise.

How was progress monitored and reported?

Progress was monitored through monthly data from Datix incident reports and by the Operation Division and Patient Experience Group. Assurance was also given through the Clinical Governance Committee and Quality Improvement Board.

What further actions need to be undertaken?

Whilst improvements have been made over the last 12 months, there is a need to undertake further work alongside simple/routine discharge management from ward areas. This work continues and will be further supported and embedded into practice by aligning and restructuring the quality priority for discharge planning as part of the 2018/19 quality priorities.

Further discussions/agreements will take place about the challenges that junior doctors face around the prescribing and writing of discharge letters and take home medication. Support to launch a "message in a bottle" scheme for use between hospital and carers in the patient's home is being sought.

Further updates and educational/ resource information is being planned to continue to support our teams at ward level to manage simple/ routine discharge from our wards.

2 and 3. End of Life Care
Executive Lead: Chief Nurse
Operational Lead: Assistant Chief Nurse (Vulnerabilities)
CQC Domain: Effective

Rationale

The Trust aims to ensure all patients that are coming to the end of life have the best possible support and care to provide a peaceful and pain free death. In addition, that the relatives and loved ones of patients who die in the Trust's care have a positive albeit extremely sad and emotionally distressing experience of the care provision for patients at the end of their life.

The CQC Trust inspection in 2015 and more recently the CQC Trust re-inspection in 2016 identified a number of excellent examples of systems and process and care provision. However, the re-inspection also identified the following areas that required improvement:

Acute – End of life care

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

Community – End of life care

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

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

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

This priority was a new priority for 2017/18.

In 2017/18 the Trust aimed to ensure that patients requiring palliative or end of life care receive care consistent with the Leadership Alliance for the Care of Dying People best practice standards published in One Chance to Get it Right (Leadership Alliance for the Care of Dying People, 2014)

Our objectives for 2017/18 were:

- To fully embed its End of Life Care 5-year strategy that describes and sets out the requirements for complying with guidance from One Chance to Get it Right. This provides a focus for improving care for people who are dying and for their families, ensuring all patients at the end of life receive the best possible care for a peaceful, pain free and dignified death.


Sarah Tomlinson
Transfer of Care Sister
NHS
NHS
NHS
STAFF
NHS

- To provide focused leadership and the best End of Life and Palliative Care across the Trust through a specific Task and Finish Group.
- To ensure 100% compliance with the DNACPR Policy and the Mental Capacity Act (see Clinical Effectiveness 1 and 2, below)
- To ensure 100% of actions that are identified via the End of Life Care Operational Group and other Partnership Groups (Hospice, Local Authority and Clinical Commissioning Group) are progressed.
- Use Key Performance Indictors (KPI's) agreed to End of Life Care (EOLC) and Palliative Care Services.

What did we achieve?

The Trust End of Life Care (EOLC) Operational Group continued to meet on a monthly basis and membership included Hospice colleagues. A Standard agenda item was a 'hot topic of the month' so that the Group could also focus on a quality and improvement plan for areas of service requiring a review or further development. The EOLC Lead Commissioner received the minutes of the meetings and attended as required. Key Performance Indicators and Metrics were a standard agenda item in order to review and use to improve the service on this group.

The End of Life Care Strategy Group led by the Clinical Commissioning Group and chaired by the Deputy Chief Executive met monthly and The Rotherham NHS Foundation Trust (TRFT) was represented.

A robust work plan provided the on-going actions that were required to support delivery of the 5 year EOLC Strategy. For 2017/18, the Trust was in year three of a five-year Strategy.

TRFT had an opportunity to take part in an NHS Improvement, End of Life Care – Collaborative where the Trust was one of 15 healthcare organisations which took part. The Improvement Collaborative was a 6-month project that commenced on 2 May 2017 and completed at the end of October 2017. The Trust improvement initiative was in relation to two aims on Ward A2 (Elderly Care) and Fitzwilliam Ward (Trauma and Orthopaedics) which were:

- To ensure that the EOLC Individualised Care Plan for adults was embedded on Wards A2 and Fitzwilliam Ward for all end of life care patients
- To improve education and training for staff on Ward A2 and Fitzwilliam Ward to improve confidence, knowledge and understanding of palliative and end of life care and completion of the individualised care plan

The Hospice, Community and GPs were involved in the project team in order to continue to develop our shared and joint working around seamless care for this patient group.

The TRFT Project Team presented all the improvement work alongside all the other teams at an NHS Improvement event at the Law Society in London in October 2017. Prior to this the TRFT Project Team presented the EOLC Improvement Journey to the Nursing, Midwifery and Allied Health Care Professionals Board. The findings were as follows:

- At the beginning of the collaboration 0% EOLC Individualised Care Plans were being utilised and now due to all the improvements and raising awareness via training the utilisation has improved to 100% on A2 and 66% on Fitzwilliam Ward.

  Training and awareness has been provided to colleagues in these two areas including medical colleagues. From this and on-going support from the Palliative Care Team colleagues are more confident and competent in caring for patients who are at the end of their life and in relation to providing support for families and friends. Out of 32 Registered Nurses (RN) & Health Care Support Workers (HCSW) on ward A2, 24 were trained on the Individualised Care Plan for Adults (4 Staff out of 32 were on maternity/sick leave). Out of 34 staff (RN & HCSW) on Fitzwilliam Ward, 9 were trained on the individualised care plan
- Testimonies provided in the patient and family books in the Purple Butterfly Rooms are extremely heart felt in relation to the positive feedback of the care and support provided. The Purple Butterfly Rooms provide privacy, dignity, space and a home-from-home for patients, their families, friends and carers as they reach the end of life.
- Greater awareness of EOLC is apparent as a result of the EOLC documentation including the EOLC Plan. Patients need to have commenced an EOLC Plan prior to admission to the Purple Butterfly Room.

Following the National Care of the Dying Audit, a new process has been put into place to obtain patient and relative feedback on the care and support they have received. The outcome report from the survey will be reported via the End of Life Care Operational Group and relevant findings will be incorporated into an action plan.

Initially Community Services were using the end of life care plan as appropriate. This was challenging as the majority of records used in the community are electronic. Further work is being undertaken to explore this issue. SystmOne (electronic patient record in the community) has a section aligned to the patient to identify the patient's preferred place of care and preferred place of death. This is part of the electronic palliative care co-ordination system (EPACCS) support end of life care documentation.

How was progress monitored and reported?

A summary report regarding the work of the EOLC Operational Group was provided to the Patient Experience Group that reported to the Clinical Governance Committee and a 6 monthly update report was provided to the Quality Assurance Committee.

The Improvement Collaborative Project reported regular updates on progress have been provided via the relevant governance groups and to the Board of Directors by the Executive Lead.

What further actions need to be undertaken?

To progress the improvements following the NHS Improvement End of Life Care Collaborative. This includes roll out of training for colleagues in relation to the use of the End of Life Care Plan and compliance with use of the Care Plan, which will be in a number of Wards that have higher incidence of deaths with a plan to achieve 80% compliance with training and 100% compliance with the use of the plan by the end of June 2018 on 2 wards. For the remaining identified Wards to roll out by the end of March 2019. The time period will enable a similar approach to be taken to that undertaken via the NHS Improvement Collaborative. This use of a consistent methodology should achieve the desired results and embed and sustain improvement in a coordinated and structured way. For Community Services, actions to improve the embedding of the plan are already in place but more focused work will have commenced

from the end of January 2018. An EOLC Workshop has been planned for 12 April 2018 to progress improvements that have been identified from the EOLC Operational Group.

To further support teams that have taken part in the End of Life Care Collaborative, NHS Improvement have:

- Started developing a website to host and share all the materials produced throughout this programme. The link for this will be sent out once completed.
- Scheduled a follow up event to be held in June 2018 in London to support the roll out of learning, TRTF will be represented at this event.

A True for us review is planned to be undertaken following an End of Life Care presentation by the CQC Deputy Chief Inspector at the NHS Improvement event in October 2017. The presentation included all the CQC domains and national findings to enable Trust comparisons. The TRFT True for Us Review will provide a benchmark in relation to what we are doing well and areas that we want to develop or improve. The Trust True for Us Review will be managed via the Trust End of Life Care Operational Group and shared with the End of Life Care Strategic Group at the April 2018 Meeting.

With the full support of the Medical Director, the Trust is progressing support in relation to the implementation of The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). This is a planned implementation of a national form which will incorporate ceilings of care, the level of treatment a patient should appropriately receive, and resuscitation decisions and which will replace all existing DNACPR forms. The Recommended Summary Plan was released in February 2017 and although its use is to be encouraged, there is no mandate for organisations to use it. However, it has the support, in principle, of many healthcare providers including ambulance services across the country. Following further discussions at the Trust Resuscitation Committee and the End of Life Care Strategic Group this approach is supported but will be included in the Strategy over the next two years to build on all the improvement work associated with the DNACPR documentation which has taken place.

Following discussion at the EOLC Operational Group in September 2017 and also following review of an audit of patients who were admitted and died within 24 hours there was agreement that there is further work to do to improve enabling individuals to be cared for in their preferred place of care and also preferred place of death.

The Group acknowledged that in order for any developments to be successful there must be a Trust and wider partnership approach with the Clinical Commissioning Group, Local Authority and Hospice colleagues working collaboratively to support any actions and possibly investment to provide the care for the individual in the preferred place rather than in a hospital setting. To progress such discussions, the Assistant Chief Nurse will be writing to key colleagues offering an invitation to a summit to fully explore how to improve the care of patents in the last days of life and ultimately providing the best possible experience and support for the individual and their families. The summit will be planned to take place during the summer of 2018.

End of Life Care will also remain as one of nine Quality Priorities for 2018/2019.

Domain: Patient Safety

1. Improving medication safety and efficiency
Executive Lead: Medical Director
Operational Lead: Chief Pharmacist
CQC Domain: Safe

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

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

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

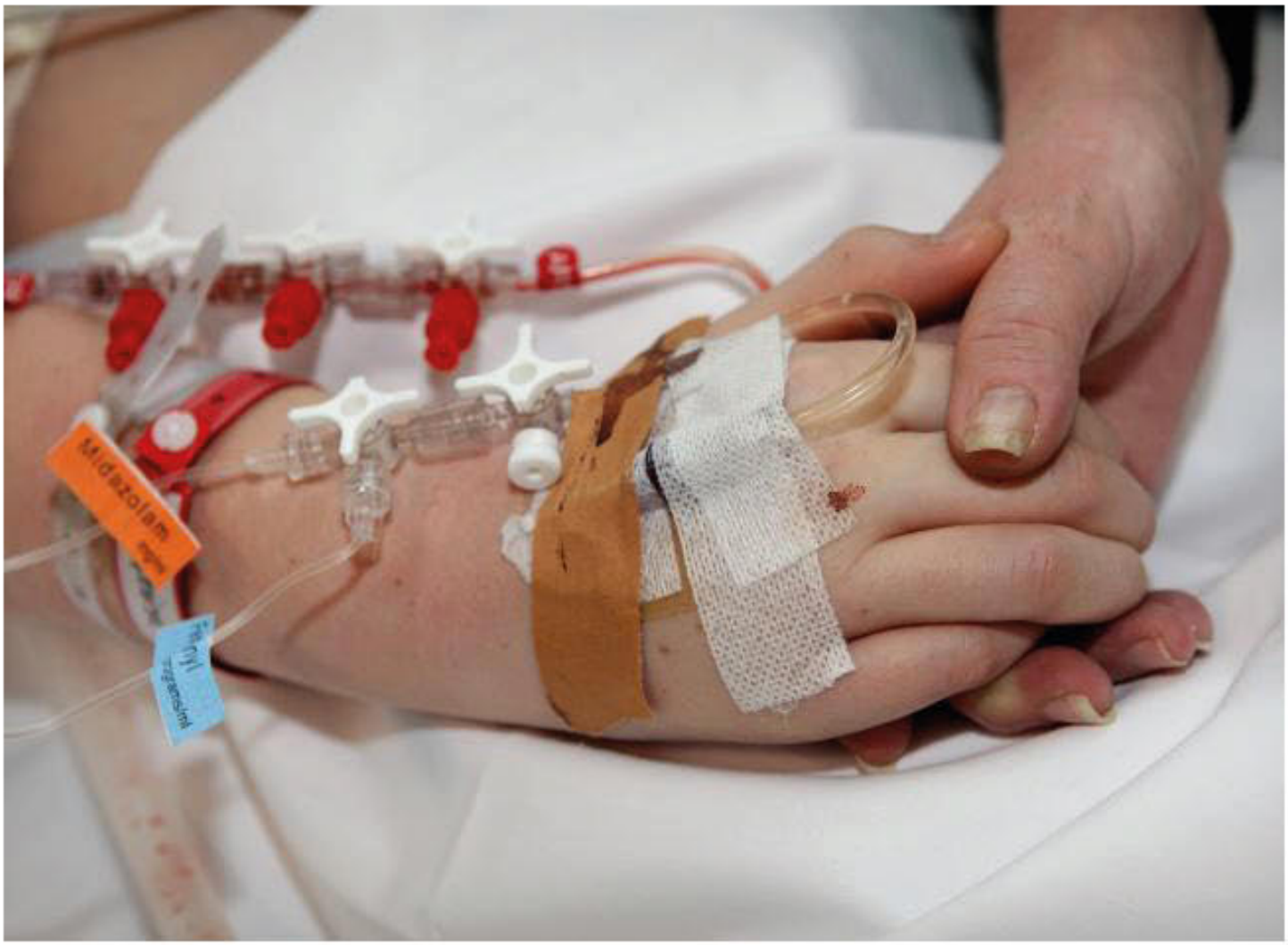
This priority continued from 2016/17 into 2017/18, with the objectives for 2017/18 being:
- Reduce the level of harm caused by medication errors by 10% over 2017/18.
- Ensure 100% of medication administration is signed for (or a reason for non-administration recorded) on drugs kardex.
- Ensure systems of communication are embedded by October 2017 to share learning from incidents.
- Achieve a rate of 85% on AMU for medicines reconciliation within 24 hours of admission by quarter 4 with at least 65% by end of quarter 2.
- Use benchmarking data for Pharmacy to develop pharmacy workforce and business plans

What did we achieve?
- Reduce overall omissions rate and reduce to zero the omissions where nothing is recorded
  - Overall omissions rate has fluctuated during the year with the end of year position at 10.2% compared to the start of year position of 11.2%. The lowest omission rate mid-year was 7.7%.
  - Approximately a third of omissions were due to blanks appearing on the administration record at the start of the year and remained the case mid-year. This proportion has changed at year end audit and now two thirds of all omissions are due to blanks.
- Use benchmarking data for Pharmacy to develop pharmacy workforce and business plans
  - Benchmarking data has been used to develop pharmacy workforce and business plans. Pharmacy inputted on and used NHS Benchmarking data and Model Hospital data to produce a business case for improving pharmacy staffing.
- Ensure systems of communication are embedded by October 2017 to share learning from incidents.
  - The Medication Safety Group look at reported incidents on a monthly basis and any required actions to reduce risk are identified.
  - A newsletter to share learning from incidents has been developed and went live in November 2017. The intention is for this to be produced monthly.
- Achieve a rate of 85% on AMU for medicines reconciliation within 24 hours of admission.
  - The position at the start of the year was 75%. This has improved and the year-end position is 86%.
- Reduce the level of harm caused by medication errors by 10%
  - TRFT now sits in the best 25% of Trusts for reporting of incidents with the National Reporting and Learning System (NRLS), this is the first time ever and shows a very good reporting culture.
  - Of the incidents reported, approx. 13% are medication incidents (in line with national levels).
  - Of the medication incidents that resulted in moderate or severe harm, this is a very small portion of the overall number of medication incidents (0.008%).
  - The number of medication incidents that resulted in moderate or severe harm in 2016/17 was 17. The number of medication incidents that caused moderate or severe harm in 2017/18 was 15, a reduction of 11.7%. It must be noted that the level of harm caused is not always a result of an error but rather the fact that an incident involving a medicine occurred. Further work is required to establish systems that can describe medication errors that result in harm.

How was progress monitored and reported?
Regular reports were provided to and discussion at the following groups;
- Quality Assurance Committee
- Clinical Governance Committee
- Patient Safety Group
- Medication Safety Group

What further actions need to be undertaken?
A focus needs to remain on omissions to ensure 100% of medication administrations are signed for (or a reason for non-administration recorded) on administration records. This will be an ongoing priority for 2018/19 and emphasised as a key measure of quality and safety in supporting any e-prescribing and medicines administration (EPMA) developments.

This is also a 2018/19 priority. For further details, see page 40.



2. The Deteriorating Patient
Executive Lead: Medical Director
Operational Lead: Associate Medical Director
CQC Domain: Safe

Rationale

The new system of Modified Early Warning Scores (MEWS) was introduced last year in response to concerns regarding the identification and treatment of deteriorating patients. This had led to extensive work undertaken across the Trust in reviewing the process and implementing an altered "code red" system of review so that patients were getting reviewed and managed in a more timely manner to prevent patient harm.

Our aim was to ensure that deteriorating patients are managed appropriately and in a timely manner to avoid patient harm.

This priority continued from 2016/17 and for 2017/18 the objective was;

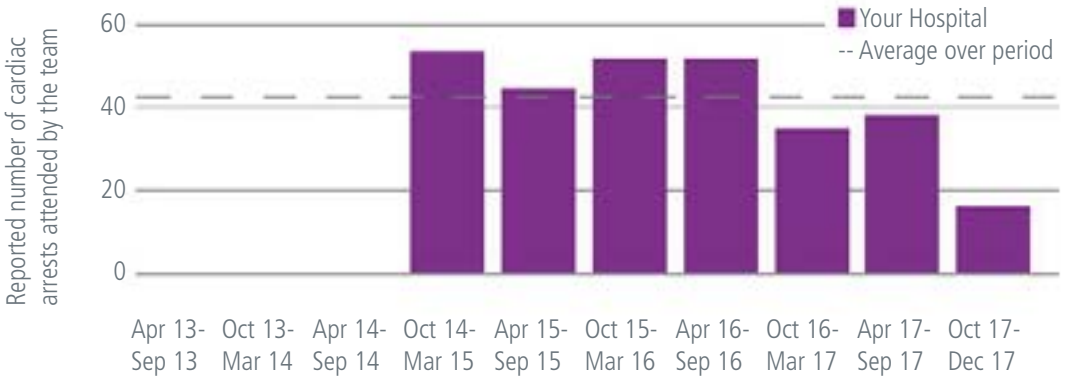
- We will use a recognised early warning score, implement an escalation process and act in a timely manner as soon as it is recognised that patients are deteriorating.

What did we achieve?

- Almost 100% of calls are being reviewed but there have been issues with reviewing every call at times of high levels of activity. There is no evidence in a reduction in the quality of the response at busy times from the calls that have been reviewed. There have not been any issues with unnecessary calls. There is scope to improve the collection of data by making the process simple but robust. (for 2016/17 there was no robust process to capture this information)
- 100% of cardiac arrest calls reviewed (for further information see graph opposite)
- MEWS scoring embedded, training completed and in use. Electronic observations trial commenced.
- 100% of Datix's and Serious Incidents investigated and themes tracked. (this was the same as in 2016/17)

The graph opposite shows the number of inpatient cardiac arrest calls in each period of time in The Rotherham NHS Foundation Trust. This shows a marked reduction for which the implied cause is that earlier treatment for these patients has been instigated. The last box on the right is a shorter period of time but if extrapolated still shows a reducing trend.

Reported number of cardiac arrests attended by the team - trended



(Source: National Cardiac Arrest Audit Report, January 2018)

How was progress monitored and reported?

- Numbers of code red calls, unplanned Intensive Care Unit/High Dependency Unit admissions, incidents and complaints monitored at weekly Harm Free Meetings and any exceptional incidents reported to weekly Executive Team Meetings.
- Review of Serious Incidents, Complaints, Inquests reported to Patient Safety Group. Overseen by Clinical Governance Committee. Quarterly trend report to Quality Assurance Committee.

What further actions need to be undertaken?

- We will need to move to the national early warning scoring system (NEWS2) as this has become national policy.
- Evaluation and roll out to other areas of electronic observations.
- Development of an easier recording process for code red calls.

3. Increasing the rate of Harm Free Care
Executive Lead: Chief Nurse
Operational Lead: Assistant Chief Nurse
CQC Domain: Safe

The NHS Safety Thermometer is a tool for assessing the safety of services based on data relating to avoidable harm. The NHS Safety Thermometer is a measurement tool for a programme of work to support patient safety and improvement. It is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. The NHS Safety Thermometer records the presence or absence of four harms:

- Pressure ulcers
- Falls
- Urinary Tract Infections (UTIs) in patients with a catheter
- New venous thromboembolisms (VTEs)

The definition of 'Harm Free Care' is the absence of all four harms. These four harms were selected as the focus by the Department of Health's Safe Care programme because they are common, and because there is a clinical consensus that they are largely preventable through appropriate patient care. The concept of Harm Free Care was designed to bring focus to the patient's overall experience.

By converting complex data to a simple score it enables Trusts to compare performance over time and with other similar Trusts. By extending the use of this methodology to Children's and Maternity services, the Trust can gather evidence of current performance, identify priorities for improvement and provide assurance to patients regarding the quality and safety of services

The 'Classic' Safety Thermometer data continues to be collected and this enables the Trust to take a 'temperature check' on safety on one day each month by measuring common harms at the point of care, both within acute areas and the community.

The Trust has used the opportunity of collecting this data monthly to collect additional metrics which will only be reported internally to provide additional assurance of compliance with safety standards to prevent harm to adults and children in our care.

The Paediatric Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in children and young people's services. The Safety Thermometer collects data on Deterioration, Extravasation (leakage of intravenous fluids into the soft tissue), 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.

'Harmfree'care

What did we achieve?

Classic Safety Thermometer:

The Trust has seen and sustained improvement during 2017/18 with an average monthly harm free care score for the Trust of 93.62% compared to 92.16% in 2016/17. The breakdown on monthly scores is shown in the table.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
TRFT (HFC)	94.17%	92.22%	90.77%	92.70%	94.37%	94.42%	94.83%	94.22%	94.23%	94.02%	92.85%	94.63%
National (HFC)	94.12%	94.29%	94.19%	94.22%	94.21%	94.38%	94.32%	94.35%	94.49%	94.20%	94.17%	94.00%

(Source: E Health Survey and SystmOne)

Maternity Safety Thermometer:

The Trust began participating in data collection for the Maternity Safety Thermometer in 2015 and the process is now well embedded within the community and acute maternity areas. For the maternity safety thermometer, the Trust scored an average monthly harm free care score of 88.44% during 2017/18 compared to 84.70% in 2016/17. The breakdown on monthly scores are shown in the table. This compares favourably against the national average score of 72% at February 2018.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Combined 'Harm Free' Care - TRFT	80.56%	91.43%	81.82%	78.26%	67.44%	87.23%	77.50%	84.62%	72.22%	83.33%	94.29%	90.63%
Combined 'Harm Free' Care - National	76.83%	75.02%	74.25%	73.39%	74.75%	74.37%	74.89%	73.87%	72.76%	74.12%	72.38%	73.58%

(Source: Safety Thermometer System)

The maternity unit continue to work closely with their patients around their perception of safety during and after labour which has affected the score at times throughout the year. Specifically, they continue to review post-partum haemorrhages which had increased during September and October 2017/18.

Paediatric Safety Thermometer:

The Trust continues to perform well achieving 100% for the majority of 2017/18. There are no specific areas of concern identified for this area. Due to the low number of surveys carried out in paediatrics, one adverse result can significantly impact on percentages as shown in February 2018. The paediatric scores for the Trust compare favourably against the national average score of 85.9% at February 2018.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Harm Free Care Rotherham	100%	94.12%	95.0%	100%	100%	100%	85.71%	100%	100%	100%	100%	100%
Harm Free Care Rotherham	83.98%	85.31%	84.62%	82.71%	86.46%	83.31%	82.95%	85.75%	87.30%	87.60%	86.07%	86.35

(Source: Safety Thermometer System)

There is excellent engagement with all clinical teams for collection of this data. The data is used alongside other data sources to review the quality of care provided to our patients and provide support to clinical areas that need support to improve standards of care.

How was progress monitored and reported?

NHS Safety Thermometer data is validated by the Trust prior to being submitted each month for the national data collection. Progress on this work is monitored through the Trusts Patient Safety Group, Clinical Governance Committee and Quality Assurance Committee.

What further actions need to be undertaken?

The Trust will continue to monitor the data collected and triangulate this with other data sources to ensure we reduce these 4 avoidable harms for the benefit of our patients.

A Root Cause Analysis should be completed for all patient falls and pressure ulcers within 3 weeks of reporting.

During 2018/19 there will be specific quality improvement work being undertaken with some of the wards and the issues identified as part of the harm free care data collection will be addressed to support reducing harm. This quality improvement work will be led by the Assistant Chief Nurse and supported by the Practice Development team working closely with the Divisional teams.

Domain: Clinical Effectiveness

1: Compliance with the Trust's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
Executive Lead: Chief Nurse
Operational Lead: Assistant Chief Nurse (Vulnerabilities)/ Associate Medical Director
CQC Domain: Effective

Rationale
We aim to safeguard vulnerable adults through achieving full compliance with statutory regulations and Trust Policy in relation to DNACPR.

At present there are inconsistencies across the organisation in relation to assessment of individual needs and requirements of patients in relation to the completion of DNACPR documentation. The CQC Trust inspection in 2015 and more recently, the CQC Trust re-inspection in 2016, identified this as an area that required improvement and should be subject to a 'must do' action.

There has been significant improvement in the completion of the DNACPR documentation with Trust wide engagement. Although improvements have been made in the adherence to the Mental Capacity Act 2005 this remains a challenge and has only seen slow changes.

This was a new priority for 2017/18.

The Trust aimed to safeguard vulnerable adults through achieving full compliance with statutory regulation and Trust Policy in relation to DNACPR. Our objectives for 2017/18 were:

- Patients will be appropriately assessed to identify the correct level of care
- Management plans are agreed and accurately documented in the patient record, using the correct DNACPR form.
- Undertake regular ward reviews of documentation and patient assessments
- Medical and Nursing colleagues take full ownership for compliance with DNACPR policy

What did we achieve?
See Compliance with the Mental Capacity Act (2005) priority opposite

How was progress monitored and reported?
See Compliance with the Mental Capacity Act (2005) priority opposite

What further actions need to be undertaken?
See Compliance with the Mental Capacity Act (2005) priority opposite

2. Compliance with the Mental Capacity Act (2005)
Executive Lead: Chief Nurse
Operational Lead: Assistant Chief Nurse (Vulnerabilities) and Associate Medical Director
CQC Domain: Effective

Rationale
The CQC Trust inspection in 2015 and more recently at the CQC Trust re-inspection in September 2016 identified compliance with the Mental Capacity Act as an area that required improvement and was identified as a 'Must Do' and regulatory action. Although a significant amount of work to improve has been undertaken, this remains an important area of focus. As of late April 2017 there was significantly improved compliance on audit and work was focused on sustaining and improving compliance. This priority was a new priority for 2017/18 and had been chosen by Governors as an area of particular concern.

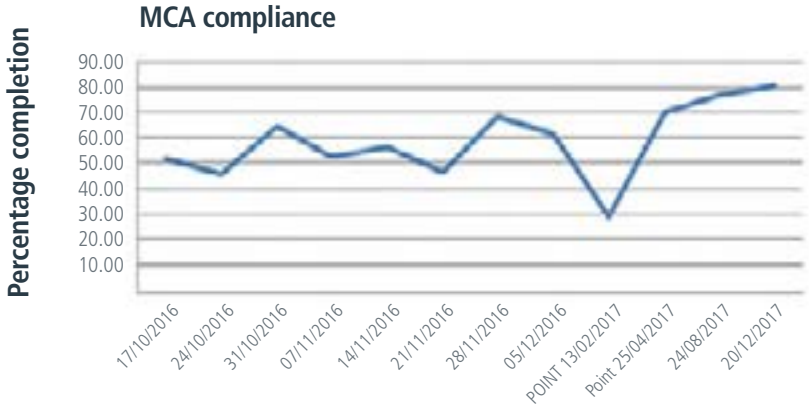
During 2017/18, the Trust aimed:

- To ensure Trust colleagues have the relevant training in relation to the Mental Capacity Act and are able to assess patients in accordance with the Policy
- To audit compliance with the requirements of the Mental Capacity Act
- Identify issues or learning in order to develop an action plan to improve compliance
- Celebrate areas demonstrating good practice and compliance to share learning
- To ensure full ownership from Medical and Nursing colleagues of compliance and follow up action accordingly
- To undertake a benchmark full review to assess current position
- To evaluate the effectiveness of training

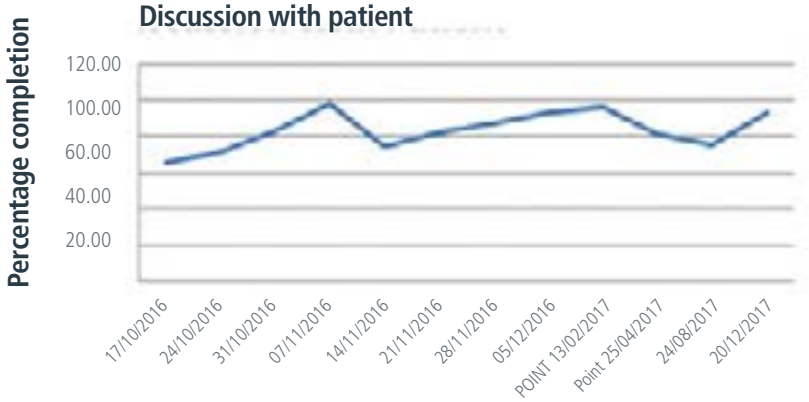
What did we achieve?
A Together We Can Group was established and met monthly to ensure improvements were embedded and compliance was sustained. A number of actions were monitored via the new Group and audits carried out across the Trust. The latest audit carried out by the Associate Medical Director saw significant improvements in compliance.

Trust wide completion rates

(Source: DNACPR Audit Results Database)



(Source: DNACPR Audit Results Database)



(Source: DNACPR Audit Results Database)

Week Commencing	Trust Wide DNACPR Compliance	MCA Compliance	Discussion with Patients
17/10/2016	85.27	51.82	65.91
24/10/2016	83.40	46.00	72.00
31/10/2016	90.32	64.55	83.10
07/11/2016	90.92	52.73	98.18
14/11/2016	84.66	56	75
21/11/2016	89.27	46.59	82.09
28/11/2016	89.99	68.7	86.98
05/12/2016	90.7	61.33	93.67
13/02/2017	87.41	29	96.3
25/04/2017	88.97	69.87	81.73
24/08/2017	91.94	76.6	75.85
20/12/2017	92.5	80.5	93.6

(Source: DNACPR Audit Results Database)

Significant support has been provided by the Safeguarding Team to Urgent and Emergency Care colleagues in relation to working alongside them to support and develop confidence in the assessment of capacity, documentation and relevant action planning.

Deprivation of Liberty Safeguards (DoLS) applications continues to rise and this information is shared at the weekly Harmfree Care Meeting. This demonstrates colleagues increased understanding of DoLS and confidence to complete the relevant documentation following assessment of capacity to safeguard the patient.

For Community Services, following the introduction of the MCA Form as a template in SystmOne and an innovative approach using scenario based training for community staff, again significant improvements have been made in compliance. This is evidenced and supported from audits and from review of Pressure Ulcer Root Cause Analysis where evidence of an assessment of capacity is part of the review proforma.

How was progress monitored and reported?

Progress was monitored by the Task and Finish Group and through the relevant Governance Groups. Reporting was to the Clinical Governance Committee and Quality Improvement Board.

What further actions need to be undertaken?

Following a meeting between the Deputy Chief Inspector CQC and the Assistant Chief Nurse (Vulnerabilities) a number of actions were identified including requesting a peer review from colleagues from a Mental Health Trust and continuing to provide colleagues support on a one to one basis to improve confidence and compliance.

Recognising both the importance of compliance with the MCA for our patients and that there are further improvements to be made, MCA will again be a quality priority for the Trust in 2018/19, see page 40.

The Trust approach is to aim to achieve 100% compliance of correctly completed DNACPR forms that have been completed by TRFT colleagues. There may be mitigations in not achieving 100% if completed via a General Practitioner (see below for further information). This will be identified via the audit process and for any area identified to be incorrectly completed then a Datix will be completed. In relation to compliance with the Mental Capacity Act, again the on-going audits will provide updated information of how well embedded compliance of the Act is and for any area that is identified as not being compliant a support process will be in place with the Divisional Management Team and appropriate actions will be put in place and monitored. This will ensure that ownership and accountability remains with the appropriate team.

DNACPR Forms that are completed in the Community will be completed by General Practitioners and Specialist Nurses who have been trained to undertake this process. If a patient who has a DNACPR in place is on a District Nursing caseload, the quality of the completion of the DNACPR can be audited via the quarterly Community Nursing Quality Audits. We are not able to undertake the audit of General Practitioner patients that are not on caseload as we will be unable to establish this information. If following admission, it has been identified that a General Practitioner has incorrectly completed the DNACPR, timely feedback will be provided in order to facilitate learning and improvement.

3. National quality requirements and clinical audit
Executive Lead: Medical Director
Operational Lead: Associate Medical Director
CQC Domain: Well led

The CQC, as part of the September 2016 Inspection, identified that services should carry out appropriate and timely clinical and nursing audits. CQC stated that the services must ensure that a regular and effective audit schedule is developed.

This was a new priority for 2017/18. The aim was that the Trust had an Annual Audit plan which was produced and managed by individual departments led by the departmental Clinical Effectiveness Lead and facilitated by the Clinical Effectiveness department. The aim was to complete all proposed audits within the year time frame unless there is a valid reason for not being able to do so. The audit proposals will be aligned to national, Trust and departmental priorities and will be clearly identified within the CQC domains.

Our objectives for 2017/18 were to complete the annual audit plan within the year time frame and ensure that recommendations from the audits are implemented within the specific department.

What did we achieve?

It is a national requirement to undertake the national quality audits and we are compliant with the completion of these. The annual audit plan is published to the organisation after it has been signed off at Clinical Effectiveness Group (CEG) in May.

During 2017-18, 47 national clinical audits and 7 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation provides. During that period The Rotherham NHS Foundation Trust participated in 41 (87%) of national clinical audits and 6 (86%) of national confidential enquiries which it was eligible to participate in.

In 2016-17, 53 national clinical audits and 8 national confidential enquiries covered relevant health services that The Rotherham NHS Foundation provides. During that period The Rotherham NHS Foundation Trust participated in 87% of national clinical audits and 88% of national confidential enquiries of the national clinical audit and national confidential enquiries which it was eligible to participate in.

As below audits are aligned to priorities:

Priority 1 (External Must Do)	• National Clinical Audit and Patient Outcomes Programme (NCAPOP) including National PROMS (Patient Related Outcome Measures) • National Clinical Audits specified on the NHS England Quality Account List • Audits demonstrating compliance with regulatory requirements • National, local and regional CQUINS and other commissioner priorities • DH statutory requirements • Audits required by Rotherham Safeguarding Board
Priority 2 (Internal Must Do)	• Priorities reflective of organisational objectives for clinical audit • Clinical risk issues • Serious incidents/adverse incidents • Issues raised via Dr Foster Quality Investigator/CHKS data analysis • Priorities identified via Patient and Public involvement initiatives • New Treatments and Techniques audits • External accreditation programmes • Trust Safeguarding Audits
Priority 3 (Department Priority – should do	• Audit identified as a Department priority where quality improvement or quality assessment is required • National Audits not part of NCAPOP/Quality Accounts e.g. Royal College
Priority 4 (Clinician interest)	• Topic of clinician interest, not identified as a Department priority (e.g. as part of personal development)

This system was implemented following findings of a previous internal audit. The classification allows the Clinical Effectiveness Department to retain a focus on those 1 and 2 priority audits to facilitate completion.

Progress is monitored through CEG and the draft annual report is due in January which then forms the basis of the new annual audit plan as a reflective process.

This is a rolling programme and will continue.

From a resource management point of view, the classification was hoped to provide a framework, due to limited resource, for allocating resource to higher priorities. In reality, we are required to support all priorities and adapt to changing timelines.

Local audits fall into 3 categories: Trust requirements (priority 2) as in ongoing reassurance activities e.g. consent and documentation audits or as a result of incidents or specific feedback; departmental interest (priority 3) for accreditation, compliance to NICE, reassurance that service is comparable to peers; or individual interest (priority 4) personal area of interest or audit required for revalidation purposes. Each Department Clinical Effectiveness Lead (clinician) is responsible for developing their annual plan with colleagues in line with their Department strategy and objectives. It is the Department Clinical Effectiveness Lead's responsibility to ensure oversight of progress of the audit plan and to ensure appropriate actions plans are developed and implemented. The Clinical Effectiveness Department provide the means (Audit database) by which progress can be tracked.

The specific reassurances/outcomes from local audits are listed in appendix 1.

How was progress monitored and reported?

Progress was reviewed at Clinical Effectiveness and Research Group meetings and Departmental Clinical Effectiveness meetings. Concerns were then reported to the Clinical Governance Committee.

What further actions need to be undertaken?

Further actions are needed to improve clinical engagement and the development and implementation of action plans to improve care. These will be achieved by 1) engagement events to promote Audit and its role in quality improvement and changes to the Clinical Effectiveness and Research Group to ensure effective and efficient use of Clinical Effectiveness Lead resource and 2) development of action planning process and guidance to use root cause analysis to develop action plans and a link to the use of audit results in the development of quality improvement projects.

3.1.3 Additional information about how we provide care

Friends and Family Test

The Trust continues to use the Friends and Family Test as one method of gaining feedback from patients and their families. The data is anonymised and reported to NHS England who publish the data each month. The latest data is for March 2018 and shows the Trust has approval ratings comparable to acute trusts across England. The 40% target for the response rate is not being achieved in some areas, however the Trust continues to explore ways for increasing the completion rate.

TRFT FFT results compared to England March 2018

Service	Rate of return	% recommending	% not recommending
A&E (Trust)	4.70%	93%	5%
A&E (All England)	12.80%	84%	9%
Inpatients (Trust)	46.80%	97%	1%
In Patients (All England)	22.60%	95%	2%
Outpatients (Trust)	4.56%	98%	1%
Outpatients (All England)	6.10%	93%	3%
Maternity Services			
Antenatal			
TRFT	18%	95%	2%
England	Not calculated	97%	1%
Birth			
TRFT	36%	100%	0%
England	21%	97%	1%
Postnatal Ward			
TRFT	52%	97%	0%
England	Not calculated	95%	2%
Postnatal Community			
TRFT	42%	100%	0%
England	Not calculated	98%	1%
Overall Community Services			
TRFT	2.12%	99%	2%
England	3.62%	95%	1%

Data Source NHS ENGLAND Friends and Family Test data – March 2018


NHS
Tell us what you think...

Friends and family Test Positive scores 2016 / 2017 (1st April 16 - 31st March 2017)

	Target	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Inpatients	95%	98%	96%	97%	96%	96%	98%	96%	97%	95%	96%	96%	98%
Day Cases	95%	99%	100%	100%	98%	99%	99%	99%	99%	100%	100%	100%	99%
Urgent & Emergency Care Centre	85%	92%	94%	95%	94%	95%	94%	94%	88%	88%	84%	90%	84%
Maternity Service	95%	98%	100%	98%	98%	98%	99%	88%	99%	100%	98%	98%	100%
Outpatients	95%	97%	96%	96%	98%	97%	96%	96%	96%	94%	98%	97%	97%
Community Services	95%	99%	100%	99%	99%	100%	96%	96%	97%	99%	98%	96%	98%

(Source: TRFT data capture system)

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

	Target	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Inpatients	95%	98%	97%	97%	98%	96%	96%	97%	97%	96%	95%	96%	97%
Day Cases	95%	99%	99%	98%	100%	100%	99%	100%	100%	98%	99%	99%	99%
Urgent & Emergency Care Centre	85%	84%	91%	96%	91%	97%	94%	93%	94%	93%	99%	99%	93%
Maternity Service	95%	100%	99%	98%	97%	97%	99%	100%	100%	98%	97%	98%	98%
Outpatients	95%	98%	98%	97%	95%	98%	98%	98%	96%	98%	97%	97%	98%
Community Services	95%	98%	99%	98%	97%	99%	99%	98%	96%	98%	98%	98%	99%

(Source: TRFT data capture system)

Mixed-sex sleeping accommodation

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

Additionally, there is also an internal process for monitoring and reporting 'pass by' breaches of mixed sex accommodation. In 2016/17 there were no reported breaches for pass-by of toilet facilities. When a bed area is reallocated to a different gender, the associated toilet facility and side room are also reallocated. This is monitored at ward and department level.

Never Events

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

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

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

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

Revision to the Never Event Policy framework has been made following consultation with their stakeholders at the end of 2016. The framework was released by NHS Improvement at the beginning of January 2018. The appropriate changes have been made to the Trusts Datix system to identify the two new Never Events added to the Policy framework and staff have been informed of these changes.

The two new Never Events are:

1) Unintentional connection of a patient requiring oxygen to an air-flow meter
2) Unintended oesophageal intubation

Following the changes to the Never Event Policy framework on the 1st February 2018, further communication was received from NHS improvement to temporally suspend the second additional Never Event , 'Unintended oesophageal intubation' until further notice. Communication regarding the suspension has been circulated to appropriate Trust colleagues and the Patient Safety team are monitoring any related incidents.

The Trust has not had a Never Event in 2017/18.

Patient-led assessments of the care environment (PLACE) 2017

The 2017 PLACE assessment was conducted in April 2017. Visits were made to 18 clinical areas at Rotherham Hospital and 2 at Breathing Space. The 2017 visits again involved Governors, Healthwatch and Trust colleagues. The 2018 visit will not be undertaken until after the report has been produced and so will be included in next year's report.

Trust results 2016 and 2017	Cleanliness		Food		Food (Organisational)		Ward Food	
	2016	2017	2016	2017	2016	2017	2016	2017
Breathing Space	98.56%	98.52%	90.11%	92.69%	88.52%	86.78%	91.45%	93.36%
Hospital	97.70%	98.72%	91.06%	83.36%	86.73%	87.53%	92.21%	82.47%

(Source: The Health and Social Care Information Centre)

Trust results 2016 and 2017	Privacy Dignity and Wellbeing		Condition Appearance and Maintenance		Dementia		Disability	
	2016	2017	2016	2017	2016	2017	2016	2017
Breathing Space	83.78%	90.91%	94.19%	90.48%	77.23%	88.35%	82.46%	84.02%
Hospital	73.13%	72.08%	87.94%	93.07%	69.24%	62.49%	72.83%	73.93%

(Source: The Health and Social Care Information Centre)

We have been working on a number of improvements around food service and working closely with ward teams to improve communications. We have a new menu coming out in April which will enhance patient choice at meal times.

Improvements against some standards, such as the dementia and disability sections are reliant on refurbishment of areas, as there has been little refurbishment of ward areas over the past 12 months, there has not been improvement in these domains. The Trust will be mindful of these standards when refurbishing any areas.

Inpatient Survey Findings

Introduction

The National Inpatient Survey was published by the Care Quality Commission (CQC) in May 2017, although the data was collected during 2016.

The CQC compare the Trust results with other organisations and classify whether Trusts are performing about the same as other Trusts, better than other Trusts or worse than other Trusts. Overall, for the eleven high level categories the CQC use, such as nurses or leaving hospital the Trust was rated as about the same as other Trusts. For five individual questions the Trust was rated worse than other Trusts. These questions relate to noise from other patients, information about their condition, privacy for discussions, advice after discharge and equipment and adaptations in the home.

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

- Following a review of the report at the Patient Experience Group, an action plan had been developed with input from the Heads of Nursing and wider Multi-Disciplinary Team.
- The Trust Catering Group has made good progress in addressing a number of areas to improve the quality of food and this has been apparent by the improvements identified via the survey responses. A review is held on a weekly basis regarding the quality of food and one of the Governors is involved in this review and feedback is provided to all concerned regarding the findings.

Governance Monitoring and Compliance

- The Action Plan is monitored via the Monthly Patient Experience Group.
- Dip sampling against the actions has been undertaken via a variety of measures including the use of the Quality Assurance Walk and triangulation via other methods of patient feedback such as Friends and Family and Health Watch information.
- A new local Monthly Inpatient Survey is now in place. This is led by the Patient Experience Group and the questions are based on the National Inpatient Survey and findings fed back to the Ward Manger and via the Patient Experience Group.
- Regular reports are provided to the Patient Experience Group on all the above areas.
- There is a 2018/19 quality priority in relation to Learning from the Views of Inpatients, further information is available on page 36.

Healthcare Associated Infections

The Director of Infection Prevention and Control (DIPC) published the annual infection prevention and control report in July 2017. The 2017/18 annual report will be completed in April 2018 with the aim to have final approval in June 2018.

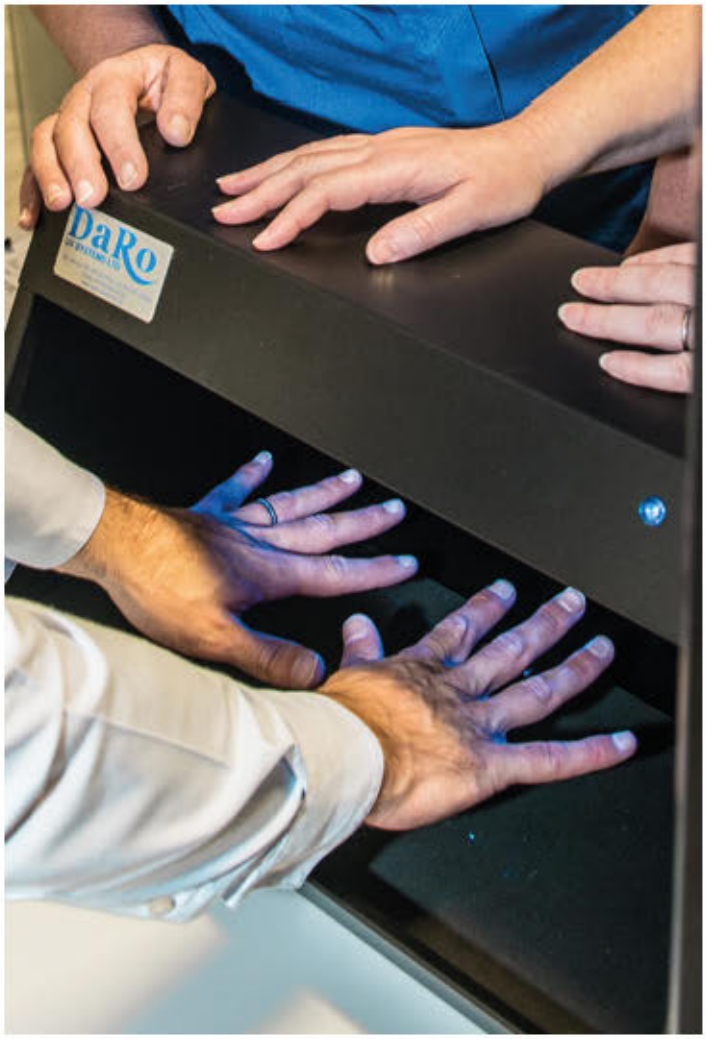
Throughout the year detailed updates on the incidence of healthcare associated infections have been provided to the Infection Prevention and Control and Decontamination Committee which reports to the Clinical Governance Committee. The Chief Nurse was the Executive lead for Infection Prevention and Control however as the Consultant Medical Microbiologist who was also the DIPC left the Trust in November 2017 the Executive Medical Director became the DIPC and the Executive lead for Infection Prevention and Control with a Locum Consultant Microbiologist in post to support the Associate Specialist in Microbiology pending the appointment of a Substantive Consultant Medical Microbiologist.

In year there have been three cases of hospital acquired Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia which was above the zero trajectory. Two of the results were not clinically infected cases but were contaminated blood culture samples which is classed as a lapse in quality and as such is allocated to the Trust. The third case was a clinical MRSA bacteraemia.

There were zero community acquired cases of MRSA bacteraemia.

Number of reported cases of MRSA bacteraemia Target = 0	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	1	0	0	0	0	0	0	0	0	0	1	0	0
2017/18	3	0	0	0	0	0	1	0	2	0	0	0	0

(Source: Trust Winpath System)



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 from the patient's skin. The Trust has continued to exceed the 3% target with monthly rates between 3.14% and 6.26% and an overall yearly rate of 4.40%. A review of actions to reduce contamination is now part of the remit of the sepsis group.

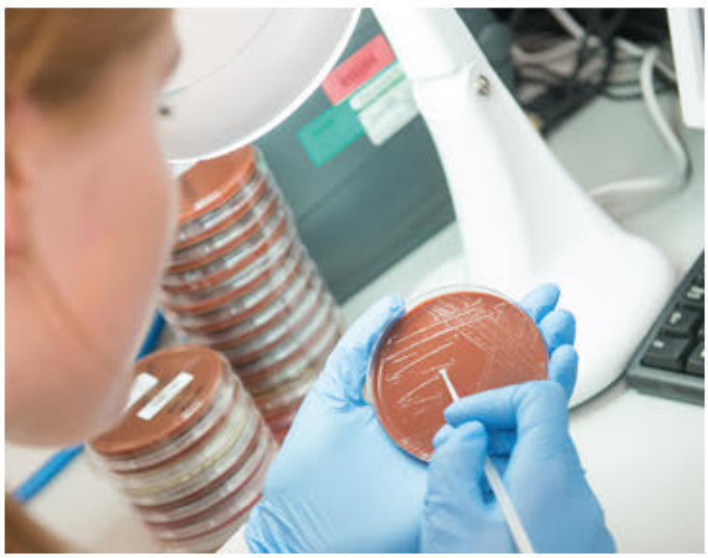
Details from the Infection Prevention KPI report March 2018	April	May	June	July	August	September
Blood culture contamination target: less than 3% every month	3%	3%	3%	3%	3%	3%
Blood culture contamination actual % 2016/17	3.35%	5.8%	4.39%	4.58%	4.66%	3.89%
Blood culture contamination actual % 2017/18	5.15%	3.14%	5.29%	5.45%	4.31%	4.32%
Details from the Infection Prevention KPI report March 2018	**October**	**November**	**December**	**January**	**February**	**March**
Blood culture contamination target: less than 3% every month	3%	3%	3%	3%	3%	3%
Blood culture contamination actual % 2016/17	2.87%	3.80%	4.03%	3.90%	3.79%	3.58%
Blood culture contamination actual % 2017/18	6.28%	4.77%	5.13%	5.49%	4.37%	3.47%

Rates of contaminated blood samples for 2016/17 & 2017/18 (Source: Trust Winpath System) cquin

MRSA and Clostridium difficile (C-difficile) are both alert organisms subject to annual improvement targets. The MRSA bacteraemia target for 2017/18 was 'zero preventable cases' which was not achieved due to the one case in September and two cases in November 2017. The C-difficile trajectory was 26 cases to year-end and the Trust achieved better than trajectory with 15 cases for 2017/2018. Further details of the performance are located at page 63.

Number of reported cases of C.diff Target = <26	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	19	0	0	2	2	1	3	1	3	1	5	1	0
2017/18	15	0	0	0	2	0	2	2	0	3	2	1	3

(Source: Trust Winpath System)



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

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

In 2017/18 four cases have been classed as unavoidable with no lapse in quality of care identified whilst eight cases did have an identified lapse in quality of care. Three cases have not yet been closed. The lapses identified were:

- Antimicrobial prescribing or documentation x 6.
- Lack of stool chart completion x 1.
- Delay in stool sample being obtained x 1

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 55 samples Ribotyped during 2017/18, of which 15 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 7 different Ribotypes identified from the 15 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. The predominant Ribotype for the year was 014 and was identified from 5 of the hospital cases and 2 of the community cases. A timeline of the 7 cases was completed and reviewed by the Microbiologist, Infection Prevention and Control Nurses (IPCN), Director of Infection Prevention and Control and the CCG IPCN. The cases were spread over a 6-month period and no correlation between time and place was identified and as such it was concluded that the cases were not linked.

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

The Trust is currently reporting a Hospital Standardised Mortality Ratio (HSMR) of 107 for sepsis against 100 overall which is not significantly different. The national CQUIN for Sepsis will only be partially achieved this year and a task and finish group has been formed to improve performance. The Sepsis Care Bundle (Sepsis Six) has been rolled out for several years and is well embedded in training and communication. Whilst timely recognition is achieved much of the time, this is harder to achieve when there are high levels of activity. Being able to administer antibiotics in a timely manner has been a challenge.

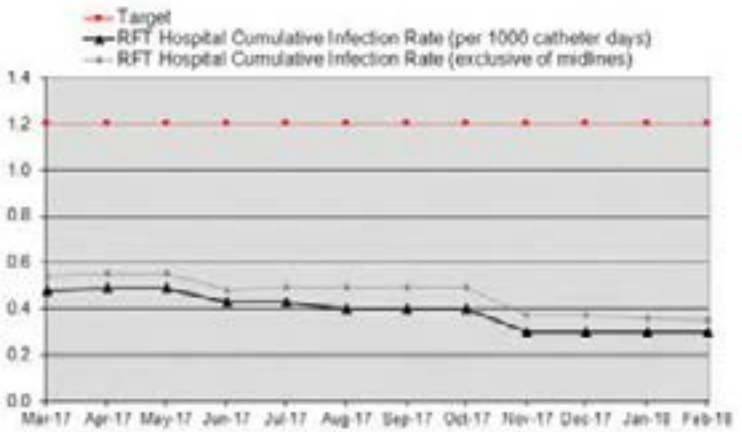
Process changes to address these issues have been introduced in the Emergency Department and on the wards and these are being regularly audited to monitor progress. The audit data is monitored through the task and finish group and a deep dive on sepsis was presented to the Quality Assurance Committee in February 2018.

The Trust continues to have an extremely low, rate of Central Line Associated Blood Stream Infections (CLABSIs).

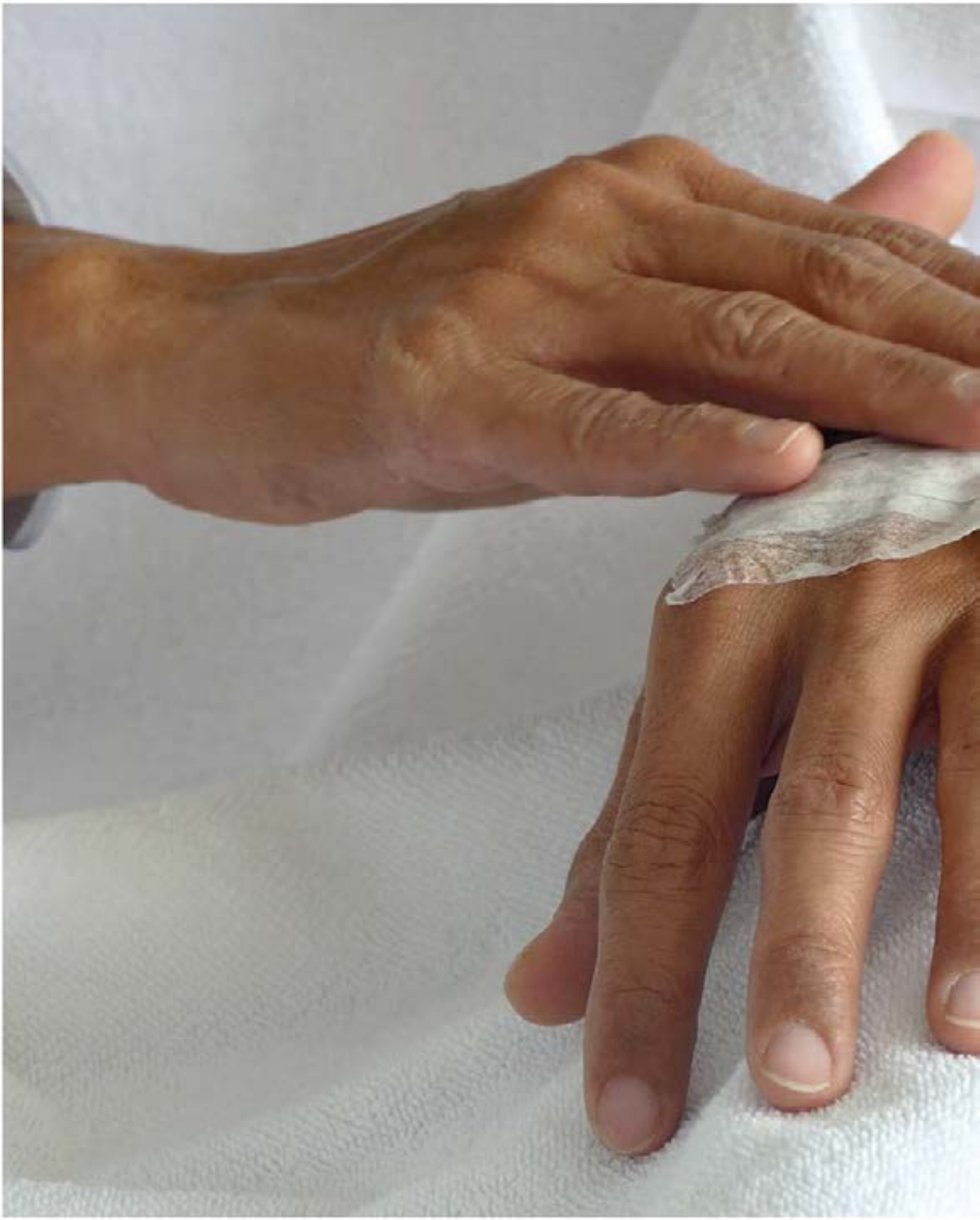
The data for CLABSI is monitored by the Intra-venous Access Group via the Vascular Access team and is re-analysed for monthly presentation on a rolling 12-month basis.

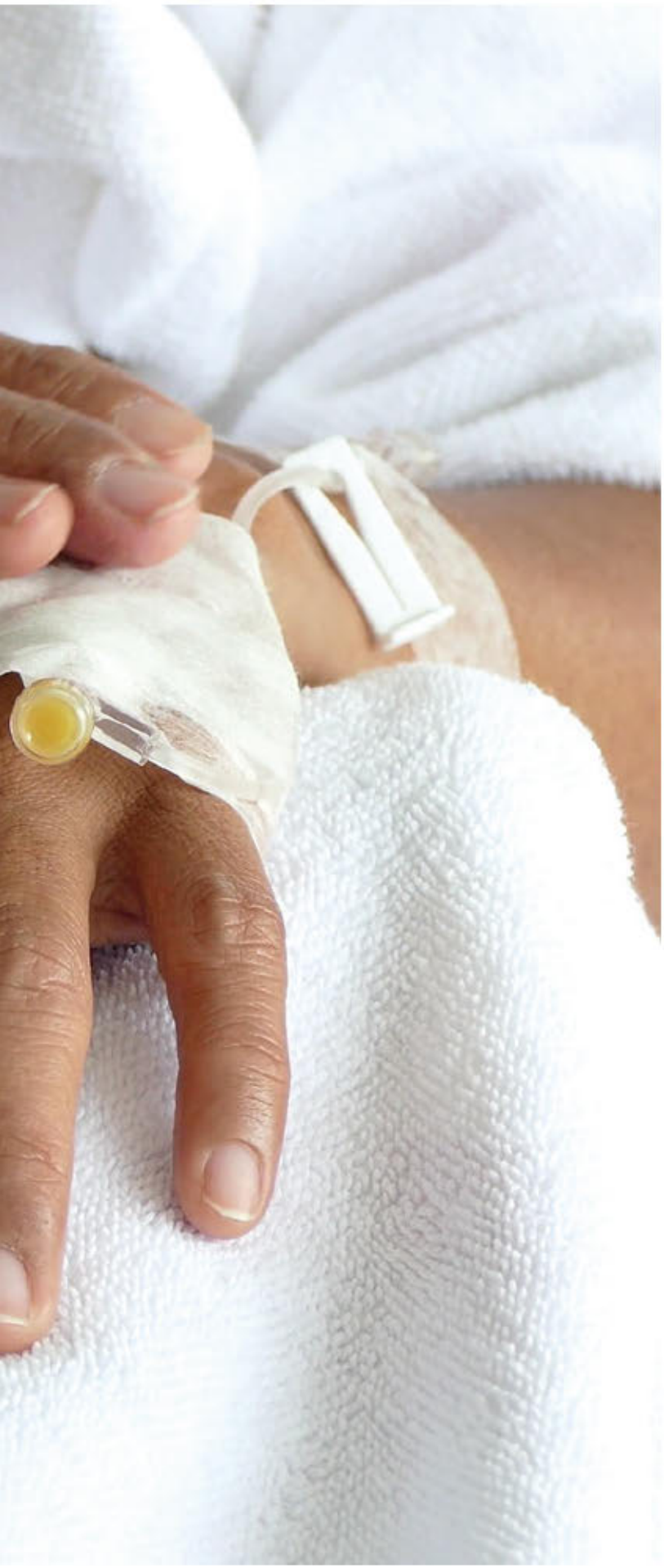
Each monthly report shows the cumulative line days and reported CLABSI incidents in the previous 12 months. This is intended to produce a more relevant and contemporaneous report of central line infections and a reflection of current practice.

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.



Incidence of CLABSI 2017/18 (Source: Trust Winpath system)





The intravenous (IV) access care provision has been incredibly successful in enhancing 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 which has reduced admission and length of stay for many patients.

The winter of 2017/18 has been challenging with an increase in numbers of cases of Influenza in line with the national picture, this has impacted upon side room availability at times during December 2017 and January 2018. Cases of Norovirus and Rotavirus gastroenteritis have been at expected seasonal levels and have been well managed to reduce further cases and with a number of beds closed where indicated to reduce onwards transmission risk whilst maintaining the operational flow of movement across the site.

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. Whilst they have demonstrated continually low rates of infection a number of cases of significant wound infection were identified, despite in depth investigation by the MDT no cause could be identified.

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 continued during 2017/18 to include continual local surveillance of all lower limb arthroplasty. The results of the surveillance were provided to the Orthopaedic Governance Group. The Consultant for Podiatric Surgery completes continual SSI surveillance via the speciality national data base and has had zero post- operative infection.

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

Reducing the incidence of Falls with Harm

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

The current rate of falls per 1,000 bed days

	2016-17	2017-18
Falls	611	675
Bed Days	144,505	145,153
Rate per 1000 Bed Days	4.23	4.65

(Source: Datix)

Monitoring of all falls is undertaken daily by the Patient Safety Team and the clinical areas are provided with data using a falls performance dashboard from Datix. The number of falls per 1,000 bed days is also monitored through the Trusts Falls Group who report into the Patient Safety Group.

The Trust has participated in the National Inpatient Falls Survey during 2017/18 and further actions for 2018/19 include, the need for the Trust's multidisciplinary group to reflect on the changes locally since 2015 and on its methods of quality improvement. Audit against NICE Quality Standard 86 (Falls in Older People) – (quality statements 4–6) (National Institute for Health and Care Excellence, 2017) which identify how a patient is managed following a fall need to be undertaken. This will help identify areas of weakness and improve the care of these vulnerable patients. The Trust is also reviewing its current falls assessment documents to ensure appropriate risk factors are identified and appropriate actions are put in place throughout a patient's pathway.

Duty of Candour

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

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

During 2017/18 we have introduced the use of stickers within the patients notes to help identify specific conversations with patients/ relatives and carers which demonstrate compliance with the Duty of Candour. This work is being led within the Divisions by the Governance Leads who then also ensure that the appropriate letters have been sent out to the patients/relatives and carers.

The Datix incident reporting system has been amended to provide the information needed for monitoring of compliance.

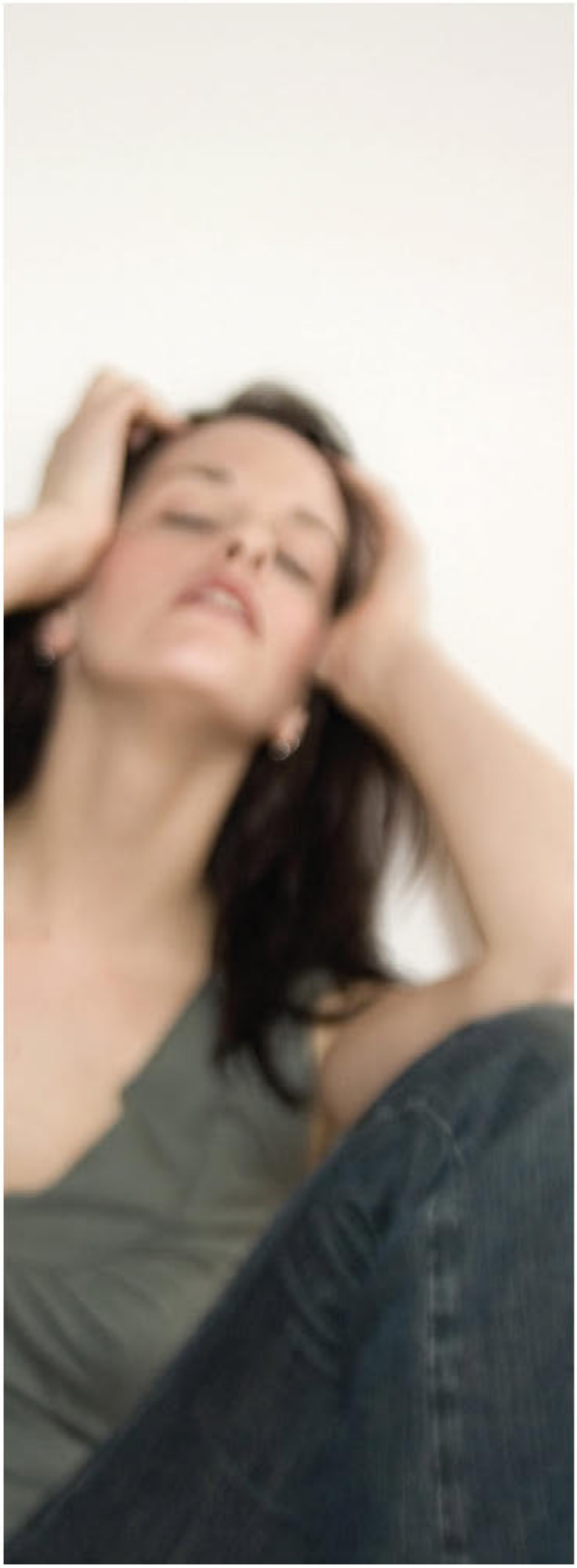
The Patient Safety team continue to monitor compliance with all the requirements identified in the initial audit and this work will continue to be monitored through the Patient Safety Group.

Sign up to Safety – Patient Safety Improvement Plan

The Trust is committed to delivering consistently safe care and taking action to reduce harm. TRFT works with partners to protect the most vulnerable. TRFT is supporting the NHS England Sign Up to Safety campaign and thereby the goal to reduce avoidable harm by 50% and save 6,000 lives over a 3-year period. The Plan was developed and submitted in January 2015. The plan is for three years and work is ongoing within the Trust to implement the plan, delivering on the key indicators as detailed below:

- The number of Patient Safety Champions already identified, their clinical areas and the amount of capacity allocated to their role in job plans
- The number of incidents, claims and complaints that feature missed or delayed diagnosis and failure to recognise and manage the deteriorating adult patient over the past 3 years
- The extent to which Patient at Risk (PAR) scoring is being used on adult in- patient wards (note - as part of the work undertaken this year we have changed the PAR to MEWS score (Modified early warning score))
- The number of cardiac arrest calls and admissions to the Adult Intensive Care Unit from in-patient wards with acute kidney injury or severe sepsis
- Patient safety knowledge of Patient Safety champions.
- Benchmark every consultant's office and clinical department against an agreed set of standards.

It is recognised that implementing the plan required system and cultural change, and there are complexities in this area. There is an ongoing commitment by the Trust to implement the plan and it is a priority for future years to ensure robust changes are made.



Safeguarding Vulnerable Service Users

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

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

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

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

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

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

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

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

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

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

Training has been provided and is on-going to support practice in respect of The Cheshire West Ruling and the changes to the implementation of the MCA and DoLS procedures. New MCA forms have been developed, agreed and circulated throughout the Trust and a number of improvement actions have been progressed in relation to compliance with the Mental Capacity Act.

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

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

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

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

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

Macmillan Cancer Information Support Service

The Macmillan Cancer Information Support Service (MCISS) provides awareness, information, signposting and first line support to anyone affected by cancer 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)'.

During 2017 a total of 3242 patients have accessed the service and we have prevented the need for:

- 2 A&E visits
- 195 GP appointments
- 55 Consultant contacts
- 296 Nurse Specialist contacts
- 251 other contacts, such as District Nursing and Social Care.

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

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

- Future development of primary care/General Practitioner champions
- Future development of an extensive training programme
- 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 Health Watch
  - Voluntary Action Rotherham (VAR) through their social prescribing programme
  - 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 since 2015 and are proud to announce that this year, that they have also developed a walk and talk cancer survivors support group with Macmillan and Walk for Health. The MCISS service has been nominated for a national Douglas Macmillan award in recognition for having a significant impact. This year the service was also nominated and shortlisted for 5 Trust Proud

awards in the following categories:

1. Excellence in Healthcare
2. Securing the future together
3. Outstanding volunteer team of the year
4. Partnership
5. Public Recognition

Dementia Care

We are reviewing our strategy for the provision of care supporting people living with dementia within a context of person-centred care across the organisation. This is consistent with national drivers.

We have started to review the ongoing provision of training to support people living with dementia, currently this training is delivered through e-learning, however it is felt that face to face training would be more effective, plans are underway for a person-centred care trainer to be recruited to deliver this format of training.

Although some wards have dementia link nurses, it is recognised that there is a need for more ongoing development and support for these roles and this will need to be coordinated by the proposed new frailty team.

We are working with an integrated team from the Clinical Commissioning Group and Rotherham Metropolitan Borough Council to determine the best way to promote support for people living with dementia and their carers.

Dr Kersh was appointed dementia clinical lead for the Trust in January, he is also the regional advisor for dementia and will link regional and national initiatives with work in Rotherham.

We are collaborating with Doncaster and Bassetlaw Teaching Hospitals to deliver person-centred care training which encompasses education in dementia and delirium.

We are involved with the 'EndPJParalysis' campaign, which promotes the independence of our patients, through encouraging patients to wear their normal clothes instead of pyjamas during the day whilst in hospital.

Learning Disability

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

- Having an electronic flagging system in place to identify that a person has a learning disability/and or Autism. This then identifies to the team to contact the Lead nurse in learning disabilities. It is also linked and populates a data base that the lead nurse has access to, so she is aware of the admission of people with learning disabilities and Autism.
- Championing the introduction of a Health Passport system, a person centred assessment tool for people with learning disabilities and Autism that helps staff to learn about how to care appropriately for each individual.
- Providing training that supports staff to improve their skills and knowledge. Recently completing development of an e-learning package with a local advocacy organisation in Rotherham, called 'Speak Up'. This will hopefully be available to all staff at our Trust very soon.
- Fostering links with established organisations to support learning, such as CHANGE organisation, Health Education England and Royal Mencap.
- Developing a mentoring programme for learning disability nurse/social worker students from Hallam University in conjunction with the Integrated Care Team, who mentor the social work aspect of their placement.
- Setting up of a learning disability/autism sub group, which has members from community learning disability teams, care providers for people with learning disability, such as Mencap, Voyage and Exemplar Health care.
- Working closely with the volunteer coordinator at the Trust to mentor and support our volunteers in the Trust who have a learning disability/Autism.

Future projects include:

- Supporting the development of care planning tools that will identify vulnerable patients and improve care for individual patients and the responsiveness of the Trust
- Encouraging all clinical areas to develop learning disability champions
- Improving engagement with people with learning disability, their carers and representative organisations to create partnerships that make best use of their knowledge and experience.
- Adapting the Trust's environment and signage to improve access for all patients, developing the hospital to be a more accessible environment for all people with additional needs, whatever they may be.
- Using the recently adopted Accessible Information Standard to create a person-centred approach to Trust communications such as patient letters.
- Encouraging the wider use of people with a learning disability or autism as volunteers and paid employees within the Trust in line with the guidance published by NHS England as part of the update of the 'Five Year Forward Review'
- The Lead nurse in learning disability commencing and completing the non-medical prescribing course, which will give a better, timelier, outcome to this group of patient around treatment and discharge.
- Liaising with professionals in the community to set out advanced care planning and prevent recurrent admissions
- Developing more specific/bespoke care pathways for people with learning disabilities/Autism for specific conditions.
- Working towards the Trust gaining accreditation and the 'Autism Friendly Award' which has been developed by The National Autistic Society.

Engaging with Colleagues

The Trust continued throughout 2017/18 with its commitment to harnessing the energy and skills of its workforce through encouraging a culture of openness and inclusivity. We have continued to embed our Trust Core Values; Ambitious, Caring and Together (ACT).

Throughout the year 14 clinical and non-clinical teams have utilised Together We Can (TWC) methodology to successfully support and deliver organisational change. TWC puts colleagues at the heart of change using the 'Five Factors to Success' methodology. Each team was able to demonstrate the improvements achieved and this was shared with colleagues to inspire others to be ambitious and promote grass roots changes. The 14 teams looked at a variety of projects:

1) Improving patient pathways in the community and our Care Co-ordination Centre. This team was able to improve the referral process, reduce the interruptions to front line clinicians and increase the face- to-face care hours as well as forging great team working
2) The porters and the Head of Health and Safety worked together to improve the efficiency of waste collection. This team also developed a work plan to address other factors that improved working lives, through giving greater opportunities for feedback. This resulted in the acquisition of better work wear, improved working and more regular meetings between teams
3) Our Communications team used the TWC Five factors to Success toolkit to gather intelligence and feedback from across the Trust that contributed to the project planning for the new intranet site

4) The Chief Nurse spearheaded innovation week, delivered by the Practice Development Team. Through listening to colleagues and direct observations the adoption of simple safety strategies to improve medicines rounds, identification of the nurse in charge and the reintroduction of protected meal times were implemented
5) Development of the Trust Communication Strategy. Making content concise, clear and easy to read. Producing information in a variety of formats. Using social media reach colleagues as well as the public
6) Work to develop simplified nursing records, reducing duplication
7) Developing the patient complexity tool in the community. Enabling the acuity and allocation of appropriate clinical time allocation for patients and their care dependency.

Together we can

8) Developing our seasonal Wellbeing Strategy - meaningful activities, accessible for colleagues, to promote wellness at work and at home, building resilience and having fun
9) Remodelling our Seasonal Influenza programme. Promoting opportunities for all colleagues to receive their vaccination from their divisional peers making access easy, inclusive and timely
10) Developing our Mental Health Champions – fulfilling our Time to Change Pledge. Building and training teams to foster a positive mental health culture and awareness in the organisation
11) Medicines optimisation – reducing the medicines omission rates. A significant reduction in medicines omissions was delivered resulting in a greater understanding of barriers to delivery of critical patient medicines leading to further work to continue to build on the improvements
12) Having their say - making change happen - the estates and facilities team: responding meaningfully to their staff survey results. Ensuring that the improvements were relevant to colleagues and prioritised in accordance with the colleagues views in the specific department
13) Building the Library retreat: supporting colleague mindfulness and wellbeing. It also provides a quite space and access to wellbeing books and resources promoting a culture of wellness
14) Community teams train the trainer for vaccination programmes, delivering in house cost effective training reducing the need to purchase university training places and have the ability to train more community colleagues

Every quarter the Friends and Family Test for staff 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. We have seen a decline in these results which has also been reflected in our National Staff Survey Results (please see overleaf for more details)

Team Brief is a monthly opportunity for colleagues to find out more about the Trust's priorities and progress. Sessions are hosted by the Chief Executive, along with members of the executive team and cascaded throughout the organisation via the divisional structure.

Throughout the year a number of other themed events took place to engage with our workforce, these are:

- Values Week, a celebration and showcase of the Trust values and what they mean to colleagues,
- Innovation Week, a week of gathering great ideas and innovations to improve how we work and deliver care
- Proud Week, a celebration of colleague achievements ending with a celebration and presentation event (see page 106 for further details).

The NHS Annual National Staff Survey

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.

The 2017 Trust National Staff Survey was facilitated through the Picker Institute Europe. The Picker Institute was commissioned by 20 Trusts classified as Acute and Community Trusts. The Trust undertook a full census of eligible employees, achieving a 41.5% response rate (an increase from last year); a mixed census 50:50 online/paper.

The overall colleagues' engagement score shows 3.60 which is slightly poorer than our previous year, the national average being 3.78. A general decline has been noted more widely across the NHS, the Trust is committed to working to improve the overall engagement scores.

Key work streams to address the downturn to be prioritised for the following year will include:

1) Improving the quality of our appraisals
2) Improving the way in which our senior managers communicate with colleagues
3) Continuing to use our Together We Can Engagement Methodology in each division to engage with the workforce to ensure colleagues identify the value their role makes in the provision of patient care, strengthen practices that foster great team working and motivation.
4) Develop a standardised divisional leadership approach to share news locally and strengthen our Trust briefings and application of tailored local team briefings.
5) Place more emphasis on sharing the work undertaken across the Trust in response to the national staff survey results.

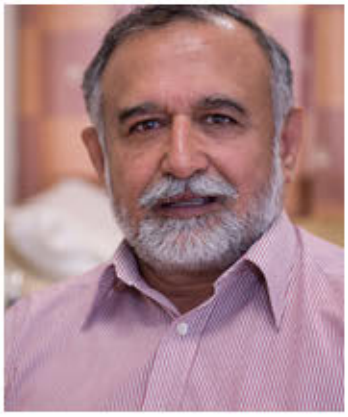
Where the Trust has increased focus on key areas we have seen positive reporting in the survey. Examples of these include work to improve appraisal uptake for colleagues. This has seen a positive increase. In addition, fewer staff are working extra hours, or experienced discrimination at work. Whilst we have seen a slight deterioration of staff witnessing potentially harmful errors or near misses, the Trust remains in the top ranking scores for this area which demonstrates that this is lower than the national average. There have also been fewer reports of staff experiencing harassment, bullying or abuse from patients, relatives or public.

The Rotherham NHS Foundation Trust Response rate	2016/17 Trust (previous year)	2017/18 Trust (current year)	Benchmarking group (trust type) average (17/18)	Trust improvement / deterioration
Response rate	40.8%	41.5%	43.0%	Slight increase

Trust Top 5 ranking scores	2016/17 Trust (previous year)	2017/18 Trust (current year)	Benchmarking group (trust type) average (17/18)	Trust improvement / deterioration
Percentage of staff appraised in the last 12 months	93%	94%	86%	Improvement
Percentage of staff working extra hours	68%	65%	71%	Improvement
Percentage of staff experiencing discrimination at work in the last 12 months	9%	8%	10%	Improvement
Percentage of staff witnessing potentially harmful error, near misses or incidents in last month	24%	25%	29%	Deterioration
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	20%	24%	27%	Deterioration

(Source: Picker Institute, Europe)

Where we have seen a decline in performance, attention in the next year will aim to address these findings.



Bottom 5 ranking scores	2016/17 Trust (previous year)	2017/18 Trust (current year)	Benchmarking group (trust type) average (17/18)	Trust improvement / deterioration
Staff motivation at work*	3.82	3.80	3.91	Deterioration
Percentage of staff agreeing that their role makes a difference to patients/service users	89%	86%	90%	Deterioration
Percentage of staff reporting good communication between senior management and staff	28%	24%	33%	Deterioration
Quality of appraisals*	2.98	2.90	3.11	Deterioration
Effective team working*	3.76	3.65	3.74	Deterioration

* Scale summary score out of 5 (1 = poor, 5 = high)

(Source: Picker Institute, Europe)

For further details, see Appendix 2

Performance against priority areas

The Trusts performance against the staff survey priorities have been reported to the Operational Workforce Committee. Whilst we have not achieved the whole CQUIN value the Trust remains above average against its peers in its performance on wellbeing initiatives.

The Trust has achieved its target performance in respect of frontline flu vaccination uptake and had an inclusive approach to ensure all colleagues employed by the Trust were offered free vaccinations.

Staff Friends and Family Test

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

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

	Quarter 1 2017/18		Quarter 2 2017/18	
	Response %	Response Count	Response %	Response Count
Extremely likely	20	75	10	39
Likely	34	129	34	137
Neither likely or unlikely	20	75	20	80
Unlikely	16	61	13	54
Extremely Unlikely	9	36	21	85
I don't know	1	3	0	0
No response	0	0	3	11

	Quarter 3 2017/18 *		Quarter 4 2017/18	
	Response %	Response Count	Response %	Response Count
Extremely likely	10	163	16	50
Likely	36	601	39	123
Neither likely or unlikely	32	540	15	48
Unlikely	13	215	15	49
Extremely Unlikely	8	142	14	44
I don't know	0	0	1	3
No response	0	0	0	0

(Source: TRFT Survey Questions)

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

	Quarter 1 2017/18		Quarter 2 2017/18	
	Response %	Response Count	Response %	Response Count
Extremely likely	25	96	12	50
Likely	42	159	39	159
Neither likely or unlikely	16	61	21	84
Unlikely	9	35	17	69
Extremely Unlikely	4	16	11	44
I don't know	3	10	0	0
No response	0.5	2	0	0

	Quarter 3 2017/18		Quarter 4 2017/18	
	Response %	Response Count	Response %	Response Count
Extremely likely	11	176	18	56
Likely	45	738	46	146
Neither likely or unlikely	30	495	18	57
Unlikely	9	154	9	28
Extremely Unlikely	5	90	6	20
I don't know	0	0	3	10

(Source: The Rotherham NHS Foundation Trust Staff survey questions 21c and 21d)

Monitoring Arrangement and future priorities and how they will be measured

The wider engagement activities will be monitored through the Operational Workforce Committee, chaired by the Executive Director of Workforce. The actions from this Committee and any associated work plans will provide the appropriate assurance to the Strategic Workforce Committee members.

At a local/operational level each division will develop 3 key priority action areas to focus on in response to their divisional staff survey feedback, supported by their Human Resources (HR) Business Partner. The progress of this work will form part of the monthly divisional performance meetings with regular updates to the Trust Management Committee and Board, as required.

Freedom to Speak up (FTSU) Guardians

The FTSU Guardian role was first introduced at the Trust in July 2015, with the appointment of 6 FTSU guardians. In September 2016 a Lead Guardian role was advertised and appointed to, which enabled the separation of the FTSU guardians from the HR functions of the organisation. Subsequent to this appointment further FTSU guardians have been recruited to ensure that all Divisions have representation, there are currently 10 Guardians, the majority of whom undertake this role on a voluntary basis in addition to their substantive post. This now includes representation from the Medical workforce. At the current time the FTSUG lead role is 0.1WTE. Individual contact details for all FTSUG are available on posters throughout the Trust and via the Trust Intranet.

Colleagues are able to contact the FTSU Guardians through a confidential answer machine service, which is forwarded to the Freedom to Speak up Guardian email address, or they can use the email address. A significant number of concerns have, however, been addressed directly to the FTSUG Lead.

All concerns are responded to within 5 working days. If colleagues wish to meet with a guardian to discuss their concerns, meetings are arranged at a time and venue convenient to the complainant.

The FTSU Guardian Lead meets formally monthly with the Executive Director of Workforce and biannually with the Chief Executive and the Senior Independent Director. The lead role has direct access to and works closely with the Senior Independent Director.

In 2017/18 the FTSU guardians received 17 concerns. The concerns have been received either through the FTSU email address (10), through calls to the FTSU guardians (4) or discussions with the FTSU guardians (3). Of these concerns, 5 relate to attitudes and behaviour, with colleagues being directed to HR or union support for further advice. Of the remainder, 6 related to quality and safety of patient care, 4 to policy and procedures, and 1 other undisclosed.

An increased number of concerns have been raised to the FTSU guardians over the past 12 months, compared to the previous 12-month period. Robust reporting systems are in place through which the FTSUG Lead reports biannually to the Audit Committee and Board of Directors with regular reporting to the Operational Workforce Committee.

Key learning from the issues raised over the last 12 months, include the development and ratification of a new Freedom To Speak Up: Raising Concerns (whistle blowing) policy, in line with national guidance. The cases raised this year have informed the content of the policy which includes greater protection of colleagues from detriment as a result of raising a concern. It was also evident that the process for escalation of concerns was not robust whereas there are now formal routes into the serious incident investigation process, when required, and into Trust governance processes.

Part of the FTSU guardian role is to ensure that colleagues who raise a concern do not suffer any resultant detriment. To demonstrate this all colleagues who raise a concern are contacted after three months by the FTSU guardian involved with the case to undertake a well-being check to ensure no detriment has been suffered. In the last year, 3 issues raised through the FTSU guardian route were from individuals who felt that they had suffered detriment as a result of raising a concern. In addition to amendments to the policy, work has also been undertaken with Human Resources to ensure that concerns raised through whistleblowing are managed appropriately.

The wellbeing check also requests feedback from concern raisers on the service provided by the FTSU guardians. To date feedback has been mainly positive with colleagues finding it easy to contact a FTSUG and pleased with the support that has been received.

Since the appointment of the National Guardian, Dr Henrietta Hughes, there has been increased direction from the National Office regarding the role of FTSU guardians. The regional network meets every 2 months and there are biannual national events which our FTSU Guardians have been supported to attend. In September 2017 TRFT hosted the Regional Meeting, to coincide with a FTSU week within the Trust, which was also attended by 2 representatives from the National Guardians Office. The FTSU Guardian week aimed to raise the profile of FTSU Guardians across the Trust.

The Trust is required to submit data to the National Guardian Office on a quarterly basis, however the nature of FTSU makes it difficult to benchmark our performance against that of other organisations.

E-learning developed nationally is now included as part of mandatory training for the next 3 years and included on induction training going forward, to ensure all colleagues are familiar with their responsibilities in relation to 'Reporting concerns'. There will be an additional expectation for colleagues involved with the management of teams to also complete the responding to concerns E-learning.

Proud awards: Recognising the contribution of colleagues at The Rotherham NHS Foundation Trust

The Rotherham NHS Foundation Trust's Proud Awards 2017 took place in December 2017. The Proud Awards celebrate dedicated and caring colleagues who ensure patients receive the high quality and most compassionate treatment they deserve. The event was held at a local sports venue with more than 200 colleagues attending to support the amazing shortlisted nominees.

This year's awards received over 470 nominations, including almost 160 being received from members of the public and colleagues across the Trust for the Public Recognition Award.

Chief Executive Louise Barnett was joined in presenting the awards by the Mayor of Rotherham, the Trust's Directors, Heather Craven, Non-Executive Director, and Andrew Mosely the editor of the Rotherham Advertiser. The Chairman, Martin Havenhand, was also present.

The awards championed individuals and teams who embody the Trust's strategic objectives and values.


Proud AWARDS 2017
Shortlisted Nominees
Follow us on Twitter
@RotherhamNHS_FT
#TRFTproud
GUESTS TO BE SEATED FOR 1pm

Staff Proud Awards 2017 **Winners**

Patients Award
Ruth Roddison, Pain Management

Colleagues Award
Annette Trehern-Walker, Locality Therapy

Governance Award
Paul Ralston, Procurement

Finance Award
Family Health Divisional Team

Partners Award
Dr Simon Smith, Cardiology

Core Values: Ambitious
Sri Kakarlapudi, Nutrition and Dietetics

Core Values: Caring
Pauline Dean, Employee Relations

Core Values: Together
Nigel Good, IT Support

Learning and Development Award
Jill Brown, 0-19 service

Outstanding Volunteer Award
Chris Yarrow and Rosie Thornhill

Unsung Hero Award
Robert Lumby, Stores and Distribution

Partnership Working Award
Rotherham Heart Support Group

Team of the Year Award
(Non-Clinical): Orthopaedic Secretariat
(Clinical): Community Locality Leads, Adult Nursing

Public Recognition Award
Mr Richard Crosher and the Oral Maxillofacial Team

Our Top Leader Award
Abigail Starr, Adult Speech and Language Therapy

Innovation Award
Rachel Radford, Speech and Language Therapy

Shining Star of the Year
Debby Foster, Ward A5

Chief Executive's Award
Dr Nadi Gupta and the Integrated Sexual Health Team

Chairman's Award
Dr Kim Russon and the Day Case Surgery Team

Lifetime Achievement Award
Sue Hill, Clinical Radiology
Dr Christine Harrison, Child Health

The runners-up are:
Core Values: Ambitious
Michael Stevens, Domestic Services

Core Values: Caring
Joanne Coy, ITU

Core Values: Together
Josh Parker, Procurement

Learning and Development Award
Angela Ariyibi, Learning and Development

Outstanding Volunteer Award
Pharmacy Volunteers

Unsung Hero
Christine Jupp, Care Homes Team

Partnership Working Award
Mark Beck, M&S Food

Team of the Year
(Non-Clinical): Library Service
(Clinical): Single Point of Access Team, Community Occupational Therapy

Our Top Leader
Louise Barclay, Anticoagulation

Innovation Award
Kim Russon and Gaynor Rollin, Day Surgery
Joanna Tissington, UECC
Roxarne Salt, Staff Nurse

Public Recognition Award
Photopheresis Team
Clare Storer, Midwife













Innovative ear care service wins national award

A service providing improved ear care services for the over 55s in Rotherham has won a national award for its innovative approach.

The Ear Care and Audiology Service at The Rotherham NHS Foundation Trust won the 'Care of Older People' category at the Nursing Times Awards which were held in London in November 2017. The annual Nursing Times Awards recognise the innovation and excellent care nurses provide every day across the country.

The service has brought two formerly separate teams together and now provides a seamless ear care and hearing service from Rotherham Community Health Centre.

Previously, many patients would have to wait up to six months and attend a number of separate appointments before receiving a hearing aid. Now, a one-stop-shop approach means that most of these patients can have their appointments and go home with a hearing aid on the same day.

A particular area of the service highlighted by the award's judges was in relation to a range of training courses that the team deliver to nurses, doctors and audiologists from around the country. By doing so the team have created additional revenue which is then reinvested into NHS services.

Linda Mills, Head of the Ear Care and Audiology Service at The Rotherham NHS Foundation Trust, said: "We are absolutely thrilled to have won this award. We have an amazing multi-disciplinary team who work extremely hard to provide our patients with a high quality service.

"Our patients think it is great that they can see the right healthcare professional and potentially go home with a hearing aid on the same day."

Linda Mills, Head of the Ear Care and Audiology Service

The Rotherham NHS Foundation Trust Baby Box Programme Launch Event

As of 25 October 2017 all expecting and new parents across Rotherham and South Yorkshire will receive a free Baby Box through the Baby Box University education programme to support safer sleeping for their new arrivals.

The aim of the programme is to encourage early engagement with maternity services and access to care for all pregnant women. In order to receive a free Baby Box, expecting parents will need to complete the South Yorkshire syllabus, created by the experts at The Rotherham NHS Foundation Trust on www.babyboxuniversity.com, a comprehensive maternal and childcare education platform.

The South Yorkshire syllabus, along with all other UK syllabi, includes a short educational video specifically produced by Highways England to inform expectant parents of what vehicle checks they should undertake before they use it to transport their family on a journey.

Upon completion of the Baby Box University syllabus parents will receive a certificate that can be redeemed for their free Baby Box.

Debbie Ellis, Infant Feeding Coordinator at The Rotherham NHS Foundation Trust, said: "It's really important to us that we support expectant parents to give their babies the very best start and a good awareness of safe sleep is essential for mums and dads."

"We're really pleased to be a part of this initiative and to be able to offer our families support both through baby box and through the work our professionals do daily." Debbie Ellis, Infant Feeding Coordinator

Jennifer Clary, CEO of The Baby Box Company, said, "Our Baby Box outreach is not simply about offering every baby a safe place to sleep. Baby Box University is an all- encompassing programme that offers parental engagement, education and aims to unite the whole community to offer every child a safe and supported start in life."

Ferns ward helps patients regain independence

Over recent months the Trust has been working closely with RDaSH (Rotherham, Doncaster and South Humber NHS Foundation Trust) to provide the Ferns project. The 12 bedded ward provides patients with specialised mental health care and cognitive rehabilitation following an admission to Rotherham Hospital.

The ward, which is at The Woodlands on the Rotherham Hospital site, is specifically aimed at patients with dementia and some other types of cognitive impairment who no longer require an acute hospital bed but would benefit from rehabilitation for their health and wellbeing.

Cognitive rehabilitation is a multi-disciplinary approach which helps people achieve their optimum level of functioning and wellbeing. This approach provides patients with individualised care and support to help with daily routines, independence and preferences with the overall aim of these patients returning home.

"We've already received some really positive feedback from carers and patients who have quickly started to regain their independence in a tranquil and therapeutic environment on the ward."

Gemma Spilsbury, Ward Manager at The Ferns Ward

Health Village Pilot results in fewer hospital admissions

The Rotherham Health Village pilot has resulted in fewer urgent admissions to hospital compared with the Borough average.

The pilot began in July 2016 and is located at the Health Village which is the base for Clifton Medical Centre and St Ann's Practice. The team consists of GPs, the community matron service, district nurses, therapists, a social worker, a community physician, social prescribing brokers and a community link worker. There is also dedicated mental health support and further links are being explored with the fire service, police, pharmacies and wider voluntary services.

The approach was developed to ensure that Rotherham health and social care services are able to continue to meet the needs of an ageing population with multiple health needs in a joined up way by working together.

The team proactively manages the care of their locality population by providing coordinated care closer to home, improving the experience of patients and their families and carers, helping to avoid hospital admissions, increasing independence, where possible, and aiming to improve mental health and well-being.

New technology solutions are critical to support the work. The Rotherham Health Record (RHR) allows them to track their patients' journey through health services and plan their care accordingly. In the future social care and primary care colleagues will also have access to the Rotherham Health Record as well as their data being available within the system.

The key functions of the integrated pilot are:

- Early identification and prevention of patients who need additional help or support
- Reablement and rehabilitation
- Community engagement and development
- Case management and integrated assessment of need
- Parity of esteem; equal value given to mental health and physical health

The pilot is beginning to make links with the Integrated Rapid Response and Care Co-ordination Centre transformation initiatives and an external evaluation has just got underway. It is envisaged that the learning and next steps will be explored in early 2018.

Respiratory Nurse Receives Royal Recognition

The dedication of one of our nurses to improving the care available to people with respiratory conditions was recognised as part of the Queen's Nursing Institute awards.

Gail Miles, Respiratory Nurse Consultant at the Trust, was awarded The Queen Elizabeth the Queen Mother Award for Outstanding Service earlier this year at a ceremony in London.

The award was in particular recognition for her instrumental work and leadership in helping set up and run BreathingSpace, the only nurse-led model of care for respiratory inpatients and outpatients in Europe.

BreathingSpace provides treatment for people with respiratory disease including bronchiectasis, pulmonary fibrosis, chronic obstructive pulmonary disease (COPD) and asthma. The model of care at BreathingSpace promotes patient self-management and participation, particularly with exercise as well as more conventional management.

"I am extremely honoured to receive this award and consider this to be on behalf of all the staff who have contributed to the success of BreathingSpace over the last 10 years."

Gail Miles
Respiratory Nurse Consultant

Earlier this year BreathingSpace celebrated its 10th anniversary by holding a special event attended by patients, members of staff and partners where they had the opportunity to reminisce over the past decade.

Children set to benefit from Community Children's Nursing Service pilot

A new scheme was launched at the beginning of October 2017 by the Community Children's Nursing Service. It aims to ensure children are managed and supported by the right healthcare staff, closer to home, whenever possible.

The pilot, which will run for six months, will see the implementation of a rapid response team and collaboration across the whole of Children's Services.

Initially, referrals to the team will be received by paediatricians; they will review the referral to see if children can be seen in areas other than the Children's Assessment Unit at Rotherham Hospital, hopefully reducing stress and anxiety for children and families that can come from attending hospital.

As well as ensuring children are being treated in the most appropriate place, the pilot will aim to avoid unnecessary admissions and help children to be discharged from hospital sooner, by offering more support at home. This will help to ensure that hospital beds are available for children who need an in hospital stay.

The Community Children's Nursing Service Team Leader, said: "We're really excited about this pilot. We're hoping it will deliver a high quality service whilst reducing waiting times in hospital.

"One of the great things about this plan is that it has come from within the team. We realised that we can make things better for our patients and for a number of teams – everyone has been very supportive in getting us to this point."

The Community Children's Nursing Service Team Leader

If the pilot is a success, the service will be rolled out further to enable the team to receive referrals directly from the Urgent and Emergency Care Centre and GPs – with the aim of further reducing referrals and admissions to the hospital.

Laboratory Medicine

In July and August 2017 Laboratory Medicine was assessed for compliance with, the international standard ISO15189 (Medical laboratories – Requirements for quality and competence). Subject to closure of findings raised during the visit the department has been recommended for accreditation to the international standard. Excellent feedback was received for all departments regarding the professional high quality service that was observed. Of particular note the assessors remarked that it was clear all staff had embraced the accreditation process, indicated with far fewer findings than would normally be expected at a transition visit.

Implementing the priority clinical standards for 7-day hospital services

The Trust has agreed the need to develop a 7 Day Services Strategy and plan following the national guidance and local requirements. It is linked to our operational plan and features in our transformation program the key work is around providing 7 day services with our acute facilities, ensuring that pathways are available 24/7. The initial priority in relation to this is the development of:

- Weekend ward rounds
- Patient reviews.
- Consultant reviews
- 7 day Hospital at night services rolled out to 24 hours at weekends
- 7 day cover of the Ambulatory service
- 7 day Consultant cover within the AMU
- Improved out of hours rotas to mirror in hours' support
- Increased GP Ratting services (pilot commenced)
- Further roll out of the ANP model to support 7 day working in ED AMU Hospital at Night teams
- Review of outreach and Hospital at night teams to increase 7 day coverage

The national focus is still only on four of the 10 clinical standards:

Standard 2: Time to initial consultant review
Standard 5: Access to diagnostic tests
Standard 6: Percentage of diagnostic interventions available
Standard 8: Ongoing daily consultant reviews

The Trust participates in the national 7-Day Services Survey and compares similar to the national picture.

The March 2017 survey now has national comparative data. The next survey is due for submission in May 2018.

External Agency Visits

During 2017/18 there have been 31 external agency visits. Details of these visits are included in Appendix 4 (page 144). Action plans are developed, where required, and monitored through the Clinical Governance Committee.

3.2 : Performance against relevant indicators

The Trust is required to report performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For 2017/18 these are:

i. The Risk Assessment Framework for 1 April – 30 September. (Appendix A of that document)
ii. The Single Oversight Framework) for 1 October – 31 March 2017. (Appendix 2 and Appendix 3 of that document.)

For the purposes of this Quality Report, only the indicators that appear on both the lists above, are required. For The Rotherham NHS Foundation Trust therefore, the five following indicators must be reported:

1. Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway
2. A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge
3. All cancers: 62-day wait for first treatment from:
   - urgent GP referral for suspected cancer
   - NHS Cancer Screening Service referral
4. C.Difficile
5. Delayed Transfer of Care

18 weeks from point of referral to treatment (RTT)

Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

% of Admitted patients Target >=90%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	84%	84.00%	88.00%	86.59%	84.80%	84.00%	84.89%	85.93%	84.60%	85.41%	82.30%	78.60%	80.52%
2017/18	84%	83.23%	87.12%	85.96%	84.15%	85.55%	86.89%	82.98%	82.70%	85.89%	84.72%	83.07%	79.95%

% of Non- Admitted patients Target>=95%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	96%	96.00%	96.00%	96.11%	96.30%	95.80%	95.09%	95.68%	96.23%	96.44%	95.40%	95.30%	95.81%
2017/18	95%	95.84%	95.91%	96.01%	94.76%	95.46%	95.45%	96.18%	95.80%	95.06%	95.12%	94.11%	94.24%

% of patients waiting less than 18 weeks Target >=92%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	95%	95.00%	95.00%	95.02%	94.20%	93.80%	94.17%	94.53%	94.90%	94.39%	93.70%	94.60%	94.79%
2017/18	95%	95.0%	96.0%	95.5%	96.0%	95.2%	95.4%	95.9%	94.9%	95.41%	94.23%	93.42%	93.24%

(Source: Meditech)

The criteria for this indicator are defined in NHS guidance and details are on the NHS Digital indictor portal. These are used by TRFT and for ease of reference these are:

"The percentage of patients waiting to start non-emergency consultant led treatment who were waiting less than 18 weeks at the end of the reporting period. Numerator is the number of incomplete pathways within 18 weeks at the end of the reporting period. Denominator is the total number of incomplete pathways at the end of the reporting period. Indicator is numerator/denominator expressed as a percentage. RTT (referral to treatment) consultant-led waiting times only apply to services commissioned by English NHS commissioners and for those patients that English commissioners are responsible. Therefore, RTT pathways commissioned by non-English commissioners are excluded from the calculation."

A number of TRFT specialties are currently excluded from 18 weeks RTT report. These are excluded because (as per national guidance) TRFT don't provide these services or they are non-consultant led activity.

This data was subject to External Audit assurance. (A)

The Trust continues to maintain performance against the Referral to Treatment time indicator with a strong performance throughout the year. With 95% performance year to date well above the 92% target.

The A&E four hour waiting time target

% of A&E attendances seen within maximum waiting time of 4 hours from arrival to admission/transfer/discharge													
Target >=95%	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	*88.40%	92.94%	90.10%	91.89%	89.1%	95.0%	92.76%	85.18%	*	79.20%	79.81%	85.06%	90.11%
2017/18	84.99%	87.15%	88.08%	87.20%	81.15%	82.41%	81.79%	85.50%	81.36%	85.64%	87.13%	87.70%	83.05%

"Note – there is a difference in the YTD reporting figure from 2016/17 as reported in the Quality report last year and this report. This is due to the reconciling of year end data"

*November migrated to Meditech from Symphony and it was agreed with NHS Improvement that the Trust would not report any performance data between 2 November 2016 and 18 December 2016. The Trust recommended data reporting on 19 December 2016. As with any large change within a clinical area, the Trust recognised that there would be a period of bedding in of systems, processes and subsequent reporting as the organisation became accustomed to using the new system. This was planned as part of the switchover in November with our regulators and commissioners.

Standard data from the Trust's Meditech system as reported to SUS (Source: Meditech patient information system)

The criteria for this indicator are defined in NHS guidance and details are on the NHS Digital indictor portal. These are used by TRFT and for ease of reference these are:

'A&E attendances and emergency admissions data reported through a central return are split into two parts. These are A&E Attendances which collects the number of A&E attendances, patients spending greater than 4 hours in A&E from arrival to discharge, transfer or admission and the number of patients delayed more than 4 hours from decision to admit to admission and Emergency Admissions which collects the total number of emergency admissions via A&E as well as other emergency admissions (i.e. not via A&E). These are reported for type 1, 2 and 3 department types.'

This data was subject to External Audit assurance. (A)

The maximum wait time of 4 hours' standard has proven difficult to achieve throughout the year. The performance has shown an improvement during the main winter period despite the national picture being one of difficulty and increasing attendance numbers. TRFT along with other acute providers have not managed to hit the 95% standard for admitted patients although we have on a large number of occasions hit the non-admitted target. Reinforcing the ability of the Urgent Care Centre and Emergency Department team to treat patients in a timely manner, highlighting the issues with the admitted patients who are reliant on flow through the hospital and community facilities for beds.

Cancer National Waiting Times

Trust performance against national waiting times for cancer services 2014/15, 2015/16, 2016/17 and 2017/18:

Metric	Target	2014/15	2015/16	2016/17	2017/18
Cancer 2 week wait from referral to date first seen, all urgent referrals	93%	94.90%	95.12%	95.89%	95.1%
Cancer 2 week wait from referral to date first seen, symptomatic breast patients	93%	94.70%	97.43%	94.98%	90.9%
Cancer 31 day wait from decision to treat to first treatment	96%	99.40%	98.82%	99.21%	97.6%
Cancer 31 day wait for 2nd or subsequent treatment - surgery	94%	100%	98.67%	96.85%	98.8%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100%	100%	100%
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	92.70%	88.46%	86.93%	84%
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	100%	98.20%	96.28%	90.8%
Consultant Upgrade	TBC	TBC	94.72%	91.95%	92.8%

(Source: Infoflex/Open Exeter)

Performance against all cancer waiting time standards has been good throughout the years 2014/15, 2015/16, 2016/17 but has proved more challenging in 2017/18. The reason for this is:

Screening:

Screening is a centralised service commissioned by PH England/ Specialised Commissioning. There have been some issues at the Screening Hub which has led to some patients being referred late from the Screening Hub. This can be due to capacity issues and/or medical reasons and/or patient choice. This has made achieving the screening target challenging. In addition, small numbers of patient within the screening programme only allows for 2 breaches per quarter.

62 Day Cancer Waiting Times:

The deteriorating performance (by approximately 1.2%) for this Trusts 62 day cancer waiting times has been recognised and cannot be attributed to any one issue. A number of significant reasons are:

- The increasing trend in 2 week wait workload which has shown increases linked to national campaigns
- The use of the referral protocols for inter-provider transfers
- The increase in diagnostic tests brought about by the increase in referrals
- The complexity of tracking and supporting the clinical pathways
- Workforce challenges across a number of tumour sites and cancer tracking

Steps are in place with the Cancer Alliance, Clinical Commissioning Group and NHS Improvement to review the issues leading to this performance and put in place actions to improve the Trust performance against this important standard.

Delayed Transfer of Care

The Governors asked the Trust to reduce the rate of delayed transfers of care, with an annual target of 3.5%. The Transfer of Care Team has had a significant impact during the year, with the Trust achieving the target despite issues related to winter pressures in the final quarter. Work has been undertaken over the last 12 months reviewing and revising the processes which have been facilitated by an external consultant who specialises in delayed transfers of care.

In addition, the hospital social care team and transfer of care team are now co located and this has helped streamline processes and improved the experience of patients, who have complex needs, whilst the Trust and partners plan their discharge from hospital. The Trust has revised the internal and external escalation process which further assists ward teams to manage patients through the discharge pathway.

Delayed Discharges	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2016/17	<= 3.5%	2.5%	1.3%	2.5%	1.6%	2.4%	3.4%	3.3%	2.9%	3.4%	5.2%	5.3%	8.0%	3.41%
2017/18	<= 3.5%	6.8%	7.5%	6.8%	5.7%	6.1%	5.4%	2.4%	2.8%	2.6%	2.5%	2.1%	3.02%	4.61%

(Source: Trust Information System)

The criteria for this indicator are defined in NHS guidance and details are on the NHS Digital indicator portal. These are used by TRFT and for ease of reference these are:

'Delayed Transfer of Care (DTOC) from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when a clinical decision has been made that patient is ready for transfer AND a multidisciplinary team decision has been made that patient is ready for transfer AND the patient is safe to discharge/ transfer.'

This data was subject to the External Audit assurance (A)

Incidence of C.difficile

Number of reported cases of C.diff													
Target= <26	YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	19	0	0	2	2	1	3	1	3	1	5	1	0
2017/18	15	0	0	0	2	0	2	2	0	3	2	1	3

(Source: Trust Winpath System)

The Trust improved its performance on C Difficile compared to 2016/17 and was under the trajectory of 26 that it had been set.

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

National and local priorities and regulatory requirements:

The Trust is assessed through the submission of wide range of data.

Measure	Department of Health	NHS Improvments	2015/16		2016/17		2017/18	
			Year end Position	National Target	Year end Position	National Target	Year end Position	National Target
Number of cases - clostridium Difficile infection (C-difficile)	x	x	19 cases	26 cases	19	>24	15	>26
Number of cases - MRSA	x	x	0 cases	0 cases	1	0	3	0
Delayed transfers of care	x	x	3.41%	3.50%	3.41%	3.50%	4.61%	3.50%
Infant health & inequalities: breastfeeding initiation	x	x	60.52%	66%	57%	66%	57%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	97.30%	95%	96.89%	95%	95.92%	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	92.30%	90%	84%	90%	84%	90%
Non - Admitted	x	x	97.90%	95%	96%	95%	95%	95%
Incomplete	x	x	96.20%	92%	95%	92%	95%	92%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	0.40%	less than 1%	2.40%	Less than 1%	0.60%	Less than 1%
Patients waiting less than 4 hours A&E	x	x	90.59%	95%	88.63%	95%	84.95%	95%
Cancelled operations for non-medical reasons	x		0.80%	0.80%	0.76%	0.80%	0.73%	0.80%
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		89.60%	90%	92%	90%	91.34%	90%
Patients who spend at least 90% of their time on a stroke unit	x		86.10%	80%	85%	80%	75%	80%
Higher risk TIA cases who are scanned and treated within 24 hours	x		90%	60%	66%	60%	81%	60%
Elective Adult patients readmitted to hospital within 28 days of discharge from hospital	x		5%	6%	5%	6%	2.06%	6%
Non Elective Adult patients readmitted to hospital within 28 days of discharge from hospital	x		13.24%	11.50%	13.60%	12.50%	11.86%	12.50%
Elective patients 0-15 years readmitted to hospital within 28 days of discharge from hospital	x		0.50%	3%	0.60%	3%	1.19%	3%
Elective patients >16 readmitted to hospital within 28 days of discharge from hospital	x		2.60%	3%	5.38%	3%	2.08%	3%
Non-Elective 0-15 years patients readmitted to hospital within 28 days of discharge from hospital	x		8.70%	10.40%	6.50%	10.40%	8.30%	10.40%
Non-elective>16years patients readmitted to hospital within 28 days of discharge from hospital	x		9.80%	12.50%	14.50%	12.50%	11.82%	12.50%

Measure	Department of Health	NHS Improvments	2015/16		2016/17		2017/18	
			Year end Position	National Target	Year end Position	National Target	Year end Position	National Target
Ensuring patients have a positive experience of care (Pt survey overall score)	x	x	7.9	10	8	10	Not yet available	10
Community care data completeness - activity information completeness		x	100%	100%	N/a	100%	N/a	N/a
Community care data completeness - patient identifier information completeness		x	100%	100%	N/a	100%	N/a	N/a
Community care data completeness - End of life patients deaths at home information completeness		x	100%	100%	N/a	100%	N/a	N/a
Patients waiting no more than 31 days for second or subsequent cancer treatment								
Anti-Cancer Drug Treatments - Chemotherapy	x		100%	98.00%	100%	98%*	100%	98%*
Surgery	x		98.70%	94.00%	96%	94%*	98.8%	94%*
Radiotherapy	x		N/a	94.00%	N/a	94%	N/a	94%
62-Day Wait For First Treatment (All cancers)								
From Screening Service Referral	x		98.20%	90%	95%	90%*	90.8%	90%*
Urgent GP Referral	x		88.50%	85%	87%	85%*	84%	85%*
31-Day Wait For First Treatment (Diagnosis To Treatment)								
All cancers	x		98.80%	96%	99%	96%	97.6%	96%*
Two week wait from referral to date first seen								
All cancers (%)			95.10%	93%	95%	93%*	95.1%	93%*
For symptomatic breast patients (cancer not initially suspected)			97.40%	93%	98%	93%*	90.9%	93%*
Health visitor numbers against plan	x		65.48	54wte	59.77	54wte	N/a	N/a

(Source: Various Information Systems including Infoflex/Open Exeter and Trust Information System)

For further details of readmission rates see Appendix 3.

Annex 1: Statements from Commissioners, the local Healthwatch organisation and the Overview and Scrutiny Committee

Statement on behalf of the Council of Governors

The comprehensive Quality Account Report which details the progress and delivery of quality improvement initiatives is welcomed by the Governors. We believe the report is an accurate and true reflection in terms of actions supporting chosen priorities and is seen as an indication of the seriousness the Trust places on safety and quality. We support the chosen priorities for the coming year, both those newly identified and the continuing focus on those areas where improvements still need to be made. We also wish to acknowledge our appreciation for involvement in defining the quality indicators for the coming year.

We wish to acknowledge the considerable progress made in the complaints process and we now see a robustness in this important aspect of patient relationships. The Trust throughout the year has maintained contact with the CQC, with their requirements and the Annual Quality Report priorities being continually reviewed, monitored and refined.

Whilst we share the disappointment that our CQUINs targets for the past were not fully achieved, we acknowledge the effort and assurances received and have been fully updated on progress throughout the year.

In the area of Harm Free Care we are disappointed that the Trust will not achieve the target score of 95% although we have seen a sustained improvement during 2017/18. With regard to the Trust policy in relation to DNACPR, a Together We Can group was established with a number of actions being monitored which resulted in significant improvements in compliance. This priority indicator was chosen by the Governors as an area of particular concern and will be monitored on a continuing basis during the coming year.

It is pleasing that the Health Village Pilot which began in July 2016 has undergone a very thorough external evaluation process resulting in a very positive outcome which in turn will eventually lead to a controlled expansion of the project. It is clear that the pilot has resulted in a reduction in urgent admissions to the hospital. The Governors wish to acknowledge the tremendous effort made by all parties involved in making a success of this futuristic looking project.

July 2017 saw the opening of the Trust's new Urgent and Emergency Care Centre. This provides staff with a facility more appropriate to a modern hospital and thus provide better care for our patients. Although disappointed that we were unable to meet the four hour waiting time target, the Governors recognise that figures have shown a steady improvement during recent weeks despite difficult weather conditions and we wish to acknowledge the considerable effort and dedication of both management and staff who continually display excellent care and attention to our patients.

With regard to Delayed Transfer of Care (DTOC) which is a quality indicator chosen by the Governors, it is pleasing that the Transfer of Care Team have had a positive impact and despite some difficulties the related target has been achieved.

Throughout the year Governors have held Governor Surgeries to gather at first hand opinions of the services provided by the Trust from both patients and visitors with any issues passed to the appropriate responsible officers with actions taken reported back to the Governors. Taking part in quality senior nurse walk rounds throughout the year offers an important opportunity to establish both staff and patient opinion regarding our standards of care. Both these vehicles will continue to be a valuable source of information during the year ahead.

With thanks to the Chairs of the various Board Committees, as Governors we are able to attend the monthly meetings of the committees. This enables us to be continually kept up to date with the workings of the Trust particularly in respect of quality improvement and care for our patients. We are also invited to comment and question as appropriate which makes Governors comfortable in that their opinions are valued and taken into account.

The Trust continually seeks to improve in terms of quality and by addressing issues in an open and honest manner is able to meet difficulties and problems with a united approach. The Governors appreciate and acknowledge this openness which is a vital element in the Trusts ambition to be outstanding in terms of the quality of care for our patients. Whilst wishing to acknowledge the honesty and openness shown by the Board as Governors we will continue to question, challenge and influence appropriately during the year ahead.

Dennis Wray
Public Governor, Rother Valley West and Lead Governor

Statement from NHS Rotherham Clinical Commissioning Group

Throughout 2017/18, TRFT have worked with RCCG to secure continuous improvements in the three domains of Patient Experience, Patient Safety and Clinical Effectiveness through engagement from TRFT clinicians and executives at contractual meetings and other key committees between the two organisations. RCCG and TRFT will continue to ensure consistent and appropriate representations at all committees. Commitment to work in partnership with the CCG and other local partners as part of the Integrated Care Partnership in Rotherham to develop and deliver joint initiatives has also been evident.

RCCG are particularly keen to highlight the achievements of TRFT in relation to a number of areas which are detailed below.

RCCG recognises that TRFT has committed to developing, responding and implementing a standardised approach for reviewing processes for incidents that both do and do not meet the threshold for investigation in line with national serious incident requirements. The outcome of this commitment is that the serious incident management processes have significantly improved, additionally the trust has continued to work throughout 2017/18 with national leaders and partners to inform the national approach to Pressure Ulcer management which has significantly reduced incidents of serious harm.

TRFT Infection Prevention and Control team and the lead Infection Prevention and Control Nurse for RCCG work in collaboration to attempt to prevent, manage and reduce the healthcare associated infections in Rotherham. The success of the collaborative work is highlighted in the reduction in HCAIs that has been seen in Rotherham. In addition, the recent expectation of a 10% reduction in E Coli's has been exceeded with a greater than 10% reduction due to the joint work that has taken place.

Outbreaks of norovirus and flu – within the hospital and also care homes, and Incidents relating to TB, Legionella and diphtheria have presented a challenge within Rotherham during 2017/18 and through working together across the two organisations, the management has been appropriate and undertaken well and the outcomes from these have been positive.

TRFT provided RCCG with full assurance on the review process and governance arrangements for risk assessments and sign-off in relation to the quality impact assessments of cost improvement plans. Of particular importance was the assurance that there hasn't been a need for any high risk schemes and that none of the identified schemes have had a detrimental effect on patients. RCCG have noted the potential change to the QIA process for 2018/19 and will look forward to receiving the same level of assurances for the forthcoming year.

RCCG wish to commend TRFT on the notable improvements that have been made in relation to the Trust's complaints process in particular the achievement of complaints responded to within the agreed timescale remaining at 100% for the three consecutive months up to and including February 2018.

RCCG and TRFT participate in an annual programme of clinically led visits. The purpose of these visits is to facilitate assurance about quality and safety of healthcare services; providing an opportunity for commissioners to inspect facilities and engage directly with patients, clinicians and management to hear any concerns and ideas for improvement under a guarantee of anonymity. Four visits have been conducted during 2017/18, these being Dermatology, Community Unit, Gynaecology and Urology. Overall the four visits concluded with positive feedback from RCCG clinicians with a series of recommendations for improvement to be implemented. A programme of visits is in the process of being agreed for 2018/19 and further joint work is required to ensure that this programme of work is delivering the outcomes required by both organisations.

The achievement of the 'seen within 4-hours of attending A&E' target proved to be extremely challenging for all providers this year and this Winter has been particularly difficult with high levels of acutely unwell patients. 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.

NHS Rotherham Clinical Commissioning Group (RCCG) is supportive of The Rotherham NHS Foundation Trust's (TRFT) vision to be an outstanding Trust delivering excellent healthcare and will work collaboratively with TRFT to achieve this. RCCG agree that quality improvement is vital to delivering excellence and are pleased to note the 2018/19 focus on quality priorities under the three domains of Patient Experience, Patient Safety and Clinical Effectiveness.

Dr Anand Barmade
GP Executive Lead – TRFT Contract
NHS Rotherham CCG

Sue Cassin
Chief Nurse
NHS Rotherham CCG

Statement from Rotherham Healthwatch

Healthwatch Rotherham continues to have an excellent co-operative working relationship with The Rotherham Foundation Trust.

Healthwatch Rotherham are invited to attend the Clinical Governance Committee and act in an observer capacity on that committee.

Healthwatch Rotherham attends Patient Experience Group meetings chaired by the Head of Patient Experience to review complaints, comments, compliments and concerns we have received from the public. The Head of Patient Experience also periodically attends Healthwatch team meetings and this facilitates cooperative working whereby we can jointly resolve issues informally without resorting to the official complaint process. Healthwatch has also facilitated the ability of the Head of Patient Experience to respond to comments or issues raised on Healthwatch's website.

Volunteers from Healthwatch Rotherham are attending training to enable their participation in PLACE (Patient-led assessments of the care environment) which will be beneficial to both organisations.

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 opinion.

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.

Having read the Quality Accounts it is good to see Patient Experience at the top of the improvement priorities covering End of life care, Discharge and Learning from views of patients. We welcome the Trusts commitment to improving the complaints procedure by investing in additional training.

The majority of the comments received by Healthwatch Rotherham about The Rotherham Foundation Trust are positive with many 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

Statement from Rotherham Health Select Commission

The TRFT sub-group from the Health Select Commission held a detailed discussion on progress on the quality priorities in November 2017. This was then followed by a similar session in April 2018, after which Members had the opportunity to consider the draft Quality Account. Members value being presented with this information and asked questions in both sessions with regard to performance, challenges and delivering further quality improvements.

The Commission is pleased to see the progress made on the quality priorities during the year, in particular on End of Life Care and Mental Capacity Act compliance, and agrees with the nine priorities for 2018-19, recognising that as many of these are significant workstreams they are continuing from last year. Members are supportive of the approach to include incremental in-year targets and measures (where appropriate) to facilitate progress monitoring and reporting. They also welcome the disaggregation of data to division or team level within the Trust as this will help to identify any needs for additional support or training.

As Vice Chair I acknowledge the contribution of TRFT as a key partner in delivering the Integrated Health and Social Care Plan, scrutiny of which is an important part of the Commission's work programme. Notable aspects during 2017-18 have been the successful Health Village multi-disciplinary pilot and support for care homes. Members are keen to see the further development of the Care Co-ordination Centre and Integrated Rapid Response Team. Effective partnership working has also contributed to reductions in delayed transfers of care, and the continuing focus on discharge management as a priority is welcomed.

Rotherham Hospital has continued to perform well in a number of national priority areas, exceeding the national target for several of these, including cases of C-difficile, inpatients having a VTE risk assessment and diagnostic waiting times. The 4 hour target for A&E remains a challenge nationally for all hospitals and it was pleasing to see month on month improvements earlier this year between November and February, before a dip in March due to increased demand, particularly around respiratory conditions.

The Health Select Commission appreciates the willingness of the Trust to engage regularly with Members, by attending meetings and providing information, and anticipates that this will continue in 2018-19.

Cllr Peter Short
Vice Chair, Health Select Commission
13 April 2018

Annex 2: Statement of Director's Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 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 2017 to 31 March 2018
  - papers relating to quality reported to the board over the period April 2017 to 31 March 2018
  - feedback from commissioners dated 13/04/2018.
  - feedback from governors dated 11/04/2018.
  - feedback from local Healthwatch organisations dated 24/04/2018.
  - feedback from Overview and Scrutiny Committee dated 13/04/2018.
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/04/2018.
  - the national patient survey 17/02/2017
  - the national staff survey 06/03/2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 17/05/2018
  - CQC inspection report dated 02/03/2017

- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Martin Havenhand
Chairman
23 May 2018

Louise Barnett
Chief Executive
23 May 2018

Post script
Regulation 5 statement

The draft Quality Report was sent to stakeholders within the timeframes stipulated by the guidance and regulations.

Since receipt of the responses which are provided on pages 123 to 126, the Trust has undertaken further work to enhance the content of the document regarding the layout of the sections in the document and updating information which was not available at the time.

Independent Auditors' Limited Assurance Report to the Council of Governors of The Rotherham NHS Foundation Trust on the Annual 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 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject mailer

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by NHSI:

Specified Indicators	Specified indicators criteria (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.	Criteria can be found on page 116 of the Annual Report and Accounts.
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	Criteria can be found on page 117 of the Annual Report and Accounts.

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 specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed reuirements for quality reports for foundation trusts 2017/18" issued by Monitor (operating as NHS Improvement) ("NHSI").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below;
  and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT AR1VI and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; 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 the following documents:

- Board minutes for the period April 2017 to April 2018;
- Feedback from the NHS Rotherham Clinical Commissioning Group date 13/04/2018;
- Feedback from Governors dated 11/04/2018;
- Feedback from Healthwatch Rotherham dated 24/04/18;
- Feedback from the Overview and Scrutiny Management Board dated 13/04/2017;
- The Trust's complaints report published under regulation i8 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/04/18;
- The national patient survey dated 17/02/17;
- The latest national staff survey dated 27/03/2018;
- Care Quality Commission inspection report, publish date 15/06/2017; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 17 May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of The Rotherham NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Rotherham NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an indepeildent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Rotherham NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/16';
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18" and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandate indicators in the Quality Report, which have been determined locally by The Rotherham NHS Foundation Trust.

Basis for Disclaimer of Conclusion — patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

There is no supporting evidence to validate the time of departure (clock stop times) for patient transactions included in the A&E indicator. Therefore we have been unable to agree the departure time entered into the Meditech system to any corroborating evidence.

Conclusion including Disclaimer of Conclusion over A&E indicator

Because of the significance of the matter described in the 'Basis for Disclaimer of Conclusion - patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge', we have not been able to form a conclusion on the indicator 'patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge at the end of the reporting period'.

Based on our limited assurance procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trtists 2017/18";
- The Quality Report is not consistent in all material respects with the documents specified above;
  and
- The indicator incomplete pathways within i8 weeks for patients on incomplete pathways at the end of the reporting period has not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

PricewaterhouseCoopertTP
Chartered Accountants
Central Square
29 Wellington Street
Leeds
LS1 4DL
25th May 2018

The maintenance and integrity of the The Rotherham NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.


Urgent & Emergency Care Centre
Rotherham
EMERGENCY

Appendices

Appendix 1: Review of Local Clinical Audits

Review of Local Clinical Audits

The reports of 109 local clinical audits were reviewed by the provider in 2017-18 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
A&E	Pulmonary Embolism Rule Out Criteria (PERC) Guideline	The Pulmonary Embolism Rule Out Criteria (PERC) will be integrated into the department guideline.	R704
A&E	Antidote stock levels in the Emergency Department	A new box for the storage of antidotes in the department to be introduced. Guidance to be produced for each antidote which will provide details of where they can be found, etc. for staff.	R953
A&E	Management of chest injuries in the Emergency Department	Highlight local guidelines to medical and nursing staff by updating audit board and upload guideline to joint audit folder. Liaise with the Quality Governance Lead regarding the reading group for a chest injury patient advice leaflet and upload to Trust intranet site once approved.	R956
A&E	Re-audit (phase 5) of the CQUIN database of 2017 for potential rooms to improve sepsis care in TRFT Emergency Department (ED)	Undertake quality improvement projects to focus on increase/maintain awareness via continuous education for staff and decrease high acuity patient influx from care homes via educational outreach project.	R969
A&E, AMU, ENT, General Surgery, Medicine, Trust wide, Urology	Trust wide clinical audit of Antimicrobial Prescribing	Display the 'Start Smart and then Focus' flow chart in Surgical Assessment Unit (SAU). Provide education at Clinical Effectiveness meetings on documentation and sampling prior to antimicrobials.	S1386
AMU	Audit on PTWR (Post Take Ward Round) proforma in medical clerking notes	To present the findings in departmental teaching to make Junior doctors aware of the importance of filling in this form completely	R811
AMU	Management of Acute Kidney Injury (AKI) patients in AMU	To ensure that the AKI proforma is completed by attaching it to the notes. Ensure that discussion of all patients with AKI 3 and Chronic Kidney Disease (CKD) 4/5 take place with the renal team as part of the consultant plan. On discharge document the AKI stage so if the patient is readmitted the risk of developing AKI is considered.	S1525
AMU	Documentation 2016	To improve on basic data recording standards i.e. time, signature, legible name, location.	S1552
Anaesthetics	Pre-operative detection and management of anaemia in major joint surgery	Ensure the pre-assessment of the patient as soon as feasible after listing to perform full blood count well in advance of surgery to allow time for appropriate treatment of anaemia as needed. develop & implement guidelines to facilitate recognition, investigation and referral back to GP for treatment of anaemia to ensure haemoglobin is within normal ranges before elective major joint surgery.	R647
Anaesthetics	Sedation Audit	Revise paperwork for sedation in the Intensive Therapy Unit (ITU) to improve documentation regarding the sedation break i.e. the results during the sedation break, if sedation breaks are contraindicated/inappropriate and the target Richmond Agitation-Sedation Scale (RASS). Establish multidisciplinary ward round to improve good communication between doctors and nursing staff.	R734

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Anaesthetics	Location of Emergency Sugammadex - Awareness amongst Theatre staff	Create 'stress proof' method locating Sugammadex in theatres by labelling each theatre fridge containing Rocuronium with details of where the Sugammadex is kept (Sugammadex is an emergency reversal agent for vecuronium or rocuronium. When it is required it is usually a time critical situation and so awareness of where it is stored is important for theatre staff).	R878
Anaesthetics	Removal of Multi-lumen Cannula Connectors Audit	Hospital Patient Safety group to be made aware of outcomes	R947
Community Adult Services	Re-audit of appointment attendance failure in children from socially disadvantaged backgrounds and those that are self-referrals	Implement trial of sending text messages 1, 2 or 3 days before appointment to see if there is any difference in attendance. To highlight in the message, the cost to the NHS of not attending. Encourage health visitors or school nurses to support parents to bring their child to appointments, when notifying them of the child's appointment time.	R790
Community Adult Services	Clinical audit of the quality of radiographs taken in in Barnsley Community Dental service 2016 Clinical audit of the quality of radiographs taken in Doncaster Community Dental Service 2016	Presentation of the results at Doncaster Community Dental Staff (CDS) Meeting and individual results offered to operators. Re-iterate to dentists that all radiographs taken must be graded for quality. New dentists and trainees must be made aware of the systems in place to grade the quality of all radiographs as part of the induction process (and Dental Nurses working with them). Re-iterate to all operators that Radiation Protection Supervisor (RPS) checks must be done quarterly i.e. 4 x per year or 3-monthly. Discuss ideas of how to improve compliance with this e.g. buddy up named operator to named RPS, reminders in diaries or on white boards. Re-iterate to all dentists that reasons for Grade 2 & 3 radiographs must be recorded. Written audit report to be made available to staff electronically and final audit report to be stored on S-Drive.	R866
Community Adult Services	Quality of Radiographs taken in Doncaster Dental Access Centre 2016/17	Provide feedback from audit at Community Dental Service General Meeting and to individual members of staff, re-iterating that all radiographs must be justified, graded for quality and reported on. Clarify with all operators that radiation protection supervisor (RPS) checks must be done quarterly.	R876
Community Adult Services	Compliance with TRFT Standard Operating Procedure for Management of Clinical Areas within salaried Dental Services	All nurses to be reminded to wear adequate eye protection. Individuals to be emailed regarding this and communicated at team brief. All nurses to be reminded to flush carts through after every use for 15 seconds (30 seconds at the beginning and end of the day). Individuals to be emailed regarding this and communicated at team brief. All nurses to be told the answers to the five questions. Individuals to be emailed regarding this and communicated at team brief	R879
Community Adult Services	Documentation 2016	To be discussed during daily team brief to re-iterate the importance of signing, printing or stamping name and designation, recording time etc.	S1537
Children and Young People (CYP) Service	Asthma Referrals (Audit of adherence to asthma pathways in primary and secondary care)	Remind GPs of current referral pathway and arrange for consultants to triage all new referrals and pass on to the Asthma Clinical Nurse Specialist.	R686
CYP Service	Green Safeguarding pack audit	Encourage completion of Green Safeguarding packs by providing teaching on Specialist Nurse Training days; Delegate responsibility for oversight and supervision of staff on completion to Band 6 Staff.	R801
CYP Service	Parental consultation on admission to Special Care Baby Unit (SCBU)	Implement use the National Neonatal Audit programme (NNAP) documentation checklist on the front of neonatal case notes in SCBU to document Parental communication in 'pink communication' sheet. To monitor compliance of documentation on pink sheets on weekly grand round.	R805
CYP Service	Review of Infant feeding policy	Undertake an annual review of Infant Feeding Policy against Unicef UK Baby Friendly Initiative Standards (BFI).	R806

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service	Health visiting (TRFT) premises	Venues used by health visiting clinics are under review, as part of the 0-19 Service transformation. Visit venues which are not World Health organisation (WHO) code compliant by Infant Feeding Coordinators to discuss provision of private areas for mothers where possible. Purchase & display Unicef UK Baby Friendly Initiative Breastfeeding Welcome and Rotherham Parents Guide to Breastfeeding Policy Posters.	R807
CYP Service	Nursing documentation	Improve nursing documentation by discussing audit results at each ward meeting.	R813
CYP Service	Asthma/ Viral Wheeze Discharge planning	Create checklist stickers and posters; disseminate to ward staff and arrange training days. Relaunch Asthma Link Nurse by assigning responsibility to a ward nurse to link with Asthma Clinical Nurse Specialist.	R821
CYP Service	Diabetes Ketoacidosis Management Audit	Provide teaching for key stakeholders in management of Diabetes Ketoacidosis (ED and Paediatric trainee staff) in the National guidelines. Provide blood ketone meters for children's ward	R843
CYP Service	Home Intravenous (IV) policy	Include in the Home IV policy to allow planning time for equipment if a patient needs IV antibiotics, and discuss as part of the Rapid Response pilot.	R844
CYP Service	Giving Medication in Respite in Kimberworth Place	Attach guidelines for Administration of Medication in Respite to the consent form, so that both staff and parents are aware of the relevant standards. Revise form to record 'returned to parent'.	R845
CYP Service	Audit of Cleaning Schedules at Kimberworth place respite facility	Advise staff in Respite and at team meeting of areas for improvement identified by the audit.	R846
CYP Service	(Audit of Autism Action Plan) Social Communication Pathway	Review and refer children with developmental delay to paediatric consultant as a new patient appointment. Introduce head circumference measurement and growth monitoring in Nurse Practitioner clinic, where not recently done. Provide training for Nurse practitioner around vitamin D and iron deficiency anaemia and requesting bloods; provide training/involvement in Melatonin sleep pathway development.	R907
CYP Service	Nurse Practitioner Clinics at the Child Development Centre	Continue nurse led clinics	S1402
CYP Service	Asthma Management in Children's outpatients	Design and display checklist poster in clinic rooms to assist documentation of care of any patient seen in outpatients. Design and pilot stickers for documentation of care for asthma referrals and provide clinician training.	S1437
CYP Service	Documentation 2016	Establish a culture in which everyone signs and prints name on front sheet of booklets once to ensure signature is always identifiable - include in Junior doctor induction. Remind consultants to oversee compliance and alert ward clerks when patient ID stickers run out.	S1486
CYP Service	Audit of the Management of Sepsis in children	Consider implementing proforma for sepsis management 'tool' to perform risk stratification and checklist for pathway. Develop local guideline to follow Sepsis 6. Include teaching on Sepsis in the training programme. Develop local CYP guideline to follow Sepsis 6. Implement a proforma for sepsis management appropriate for use in CYP, as a tool to perform risk stratification and checklist for pathway. Include teaching on Sepsis in the training programme. Re-audit in 1 year, and revise method for identifying sample.	S1603
CYP Service	Documentation 2017	Disseminate documentation standards at CYP induction, especially deletions and alterations, and for recording location. Add recording of whether front sheets signed to next audit cycle.	S1637

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service, O&G	QI initiative to introduce and evaluate Newborn Early Warning Trigger & Track (NEWTT) for babies in Postnatal ward and Random safety audit.	Discuss improvements required on documentation of: risk factors on NEWTT chart; whether jaundice looked for and escalation and communication with parents, with Midwifery and neonatal team. To develop a local guideline for routine pulse oximetry screening for all newborn babies to ensure saturations are checked as a part of observations.	R780
CYP Service, O&G, Safeguarding	Safe Sleep Assessment Re-audit (2016)	Deliver Safe Sleep training event for nurses and midwives. Develop Safe Sleep Standard Operating Policy (SOP) and incorporate into the joint TRFT Policy as an appendix. Embed the safe sleep assessment/questionnaire into 0-19s practice. To include assessment and reassessment where indicated. Flow chart to be made available for safe sleep training event SOP to be visible on the Trust intranet site once signed off through governance Raise awareness of safe sleep audit and SOP in the Children's Service Newsletter. To develop a standard system for vulnerable babies being discharged from SCBU. Incorporate system into the Safe Sleep SOP around SCBU discharge and ensure on 0-19 flow chart. To develop a standard where safe sleep advice is recorded in the parent held record and action as required. Monthly spot check SystmOne reports midwifery and 0-19 to ascertain if embedded into practice.	S1533
CYP Service, Safeguarding	Audit of the quality of the Electronic Multi Agency Referral forms (EMARF) to Multi Agency safeguarding Hub (MASH) from TRFT health staff	Remind staff & work with managers to ensure all sections in the EMARF are complete or reasons given as to why the section has not been completed. Completed EMARFs to be filed in the child's electronic record under attachments for SystmOne users or if not SystmOne users, into the child's paper medical record. For practitioners who do not have access to SystmOne, a copy of the completed EMARF to be sent in to the Safeguarding department to be filed in to the child's record by safeguarding under attachments. Support understanding and recording of risk assessment and analysis. To increase the use of the Threshold Descriptors in the identification of risk.	R793
CYP Service, Safeguarding	Looked After Children (LAC) Clinic Procedures Compliance	Present audit to social care and discuss letter redesign within LAC team & social care.	R848
Dermatology	Adherence of psoriasis biologics and systemics prescribing to National Institute for Health and Care Excellence (NICE) Guidelines	To address inconsistent and insufficient recording of Psoriasis Area & Severity Index (PASI) and Dermatology Life Quality Index (DLQI) scores, by reminding staff at departmental meetings and via email of the importance of recording data. Systemics and biologics proformas have been developed as an aide-memoire Clinical Nurse Specialist for chronic inflammatory diseases which will give clear guidance as to which tests, investigations, scores and tools have to be recorded. Clinicians will be reminded to perform a PASI/DLQI in the consultation. Stress levels will be recorded on a Visual Analogue Scale and included in the work-up/follow-up proformas mentioned above. A resource list providing information about self-help tools to address stress and increase resilience will be put together by a clinician.	R786
Dermatology	Monitoring of serum lipids during osotretinoin treatment and dose changes in these patients	Clarification regarding initial dosage and monitoring will be emailed to all doctors and all nursing staff.	R802
Dermatology	Documentation Re-audit	Raise at Governance meeting and highlight to the team the areas where improvements are required i.e. recording of time, designation of author, securing case notes and the process of managing alterations/deletions.	S1681

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
ENT	Documentation 2017	Remind colleagues of the importance of completing documentation in full, particularly time of appointment; designation of author and add ID labels to each side of history sheets, Circulate reminder to colleagues by email.	S1629
General Surgery	Consultant reviews on High Dependency Unit (HDU)/ Intensive Therapy Unit (ITU)	Raise awareness at staff meetings	R890
General Surgery	Multidisciplinary emergency laparotomy pathway implementation audit	Raise awareness of MELP pathway. Data entry to be reviewed on a fortnightly basis and where required feedback provided to individual consultants.	S1580
Genito-Urinary (GU) Med	Re-audit of Chlamydia text reminders for re-test in patients under 25 (Jan 2017)	Review wording and language used in the retest text reminder by other Trusts, and consider potential for using more persuasive techniques. Evaluate response to a postal kit sign up automatically at 3 months.	R681
GU Med	Re-audit of HIV in pregnancy	HIV service to address the lack of funding for formula milk with HIV mothers at next SYHIV networking meeting, or refer mothers to HIV charity for financial support if required. Encourage pregnant HIV patients to have regular STI screen throughout pregnancy. Raise awareness by giving audit presentation at Gynaecology Department.	R699
Haematology	Documentation 2017	Discuss at Governance meeting and disseminate results to all staff, highlighting issues in regard to documenting location/deletions/alterations should be countersigned, date/time recorded and score through with a single line.	S1623
Laboratory Medicine (Lab Med)	Compliance with Transfusion Integrated Care Pathway	To undertake a review of the transfusion ICP documentation.	R842
Lab Med	Rotherham NHS Foundation trust ability to meet National guidelines for laboratory investigation for poisoned patients in the UK	No actions required.	R948
Lab Med	Audit of NICE Quality Standard 113 on Healthcare-Associated infections	Discuss results at the next Infection Prevention & Control Committee.	S1586
Lab Med	What is the rate of potentially inappropriate repeat biochemistry test requesting in Rotherham Hospital Foundation Trust	Further review of the data to see if these patients are located in specific areas.	S1590
Medicine	Tuberculosis (TB) audit	To provide training sessions for GPs and TRFT staff to improve education of staff in regards to the isolation of patients suspected of having TB. To look at the possibility of developing a template for clinic that supports improvements in record keeping quality.	S1456
Medicine	Consent 2016	No actions required	S1477
Medicine	Tuberculosis (TB) Contact tracing re-audit	Continue to change practice in line with NICE 2016 guidelines	S1599
Medicine	Audit of the Diabetic ketoacidosis (DKA) protocol	Rolling teaching programme to trainees on current management of Diabetic ketoacidosis (DKA). Re-write proforma to include: Space for recording trend of ketones, bicarbonate and pH; highlight glucose prescribing and advice on discontinuing sliding scale	S1608

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Neuro-rehabilitation	Re-audit of Spasticity Management Service	Business managers to agree business case for Allied Health Professionals (AHP) lead clinic and AHP clinic to be established. Meet with clinical leads and business managers to review existing staffing resource and possibly consideration for developing band 4 staff to carry out 4 week follow up review. Business managers to submit business case for provision of ultrasound.	R828
Neuro-rehabilitation	Re-audit of Spasticity Management Service	Collate activity data to support discussion with business managers regarding addition of more clinics in order to address oversubscription and to ensure patients receive timely follow up. Review existing staffing resource and consider developing Band 4 roles to carry out 4 week follow up reviews. Undertake risk assessment of impact of not having Electromyogram/ultrasound to ensure localisation technique available.	S1316

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Obstetrics &Gynaecology (O&G)	Massive Post Partum Haemorrhage blood loss >1500 mls.	Incorporate into mandatory training: Declare Massive Obstetric Haemorrhage; Use bimanual compression early; assessment of estimated blood loss and 'Turn off the tap' by use of top tips, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) slides and interactive Estimated Blood Loss assessment.	R440
O&G	Colposcopy clinical indication referral rates	Circulate advice re clinical indication on Learning Points and in Newsletter. Include Cervical examination and swab results in referral letters.	R691
O&G	Re-audit on Caesarean Sections Category 1&2	Circulate in Obs newsletter to always document reason for delay on IR1. Improve filing of WHO checklists. Provide training to improve VTE prophylaxis prescribing and administration. Review and update the audit proforma to confirm whether categorisation was correct and include consent on the audit.	R694
O&G	UNICEF Baby Friendly Initiative audits for assessment for accreditation	Ensure the Infant Feeding Policy is checked against UNICEF guidance - Maternity and Health Visiting. Incorporate all other infant feeding related guidelines into one guideline. Complete Practical Skills Reviews (PSR's) with all health visiting team all staff members – using Baby Friendly Initiative PSR forms. Develop a 'Pocket guide to positioning and attachment and hand expression' for provision to health visiting team members. Ensure health visiting and family nurses remain up to date with current developments in Infant Feeding and Baby Friendly Initiative Standards by providing an annual 3 hour Infant Feeding Update. Community IFC to develop and deliver a Mandatory infant feeding update package on an annual basis. Update training 2015/16 Curriculum development.	R713
O&G	Medical Termination of pregnancy (outpatient)	Documentation of Specific swab tests, Implement booklet for recording swabs and blood tests. Check completed weekly. Always ensure HSE4 notification form (yellow sheet) sent, Remove HSE4 form from notes as soon as procedure is complete.	R834
O&G	Re-audit of Obstetric Anal Sphincter Injuries (OASIs) 2016	Ensure Datix completed at time of incident. Disseminate through Mandatory and Statutory Training (MAST) / learning points. Include patient experience videos into MAST training (already produced). Update labour and birth notes to include discussion with patient re: perineal support/techniques to reduce OASIs; Warm compress. Remove figure of 8 suture technique from guideline and change to end-to-end sutures. Quality improvement project looking at Episcissors – use and outcomes – Allocate trainee/s to design project, Data collected by Clinical Leadership Fellow until mid- September and delegate responsibility. Further work to introduce second checking for diagnosis of 3rd degree tears in day time hours to include in Junior doctor teaching.	R838
O&G	Venous thromboembolism (VTE) risk assessment and thromboprophylaxis in pregnancy and puerperium	To improve risk assessment during admission and intercurrent problems, and reduce errors in risk assessment to <5. Ensure all patients requiring low molecular weight heparin (LMWH), receive the 1st dose by 4 hours of admission or delivery, by disseminating audit results via teaching, clinical area display and newsletters.	S1085

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
O&G	Management of RPOC (Retained products of conception)	Update Miscarriage Guideline / Expectant Management of Miscarriage flow chart and distribute to EPAU, B11 and PAS. Put visible flow chart on B11 / EPAU (and signpost access to further guidance). Write and distribute Management of RPOC protocol to EPAU, B11 and PAS. (and where to access further guidance). Communication from Matron to ensure that all women undergoing expectant management of miscarriage have a baseline FBC + G&S. Present audit at Ultrasound Audit meeting and discuss consideration of Colour Flow Doppler when assessing RPOC on ultrasound. Send a communication from Matron to improve systematic / chronological filing / documentation in EPAU / PAS notes. List re-audit to Register for June 2019	S1439
O&G	Severe pre-eclampsia and eclampsia	Add key findings to mandatory training. Update crib sheet to include wording that ensures consultant anaesthetist is informed, if not in attendance. Update audit form to include: time of entry onto PET protocol to monitor evening /out of hours reviews; Parity / gestation / Induction of Labour /Method of Delivery; time taken to control blood pressure; timely diagnosis made, and whether consultant anaesthetist informed/attended.	S1446
O&G	Readmissions of new-born babies with weight loss	Add training on positioning and attachment on to MAST for midwives, to prevent poor feeding leading to weight loss.	S1459
O&G	Management of Hyperemesis gravidarum	Consider extending accupins into the community and for patients to self-administer. Create ward attender form on the electronic record (Meditech) or sticker for patients notes to make auditing accupins easier. Consider day-case facility. Education of junior doctors on anti-emetics. Review guidelines on monitoring ketones.	S1462
O&G	Post Treatment HR Human Papillomavirus (HPV) test of Cure, are we meeting standards?	Discuss with all colposcopy staff the requirement to write 'Treatment of Cure' on cytology requests, as well as ticking 'follow up post treatment', at patients 6 months' post review appointment in Colposcopy to assist laboratory staff. Strengthen links with Migrant Services & Mental Health Team/Key Workers by being mindful to make a note name of key worker (where applicable) and to include them in the discharge information if follow up is needed.	S1538
O&G	Re-audit of smoking in pregnancy (March 2016)	To inform all community midwives to follow TRFT guideline regarding Carbon Monoxide (CO) monitoring and to perform a CO reading at booking appointment with ALL patients, regardless of their smoking status, and as per guideline throughout the pregnancy. To provide training for all staff for smoking in pregnancy and 'Opt Out' referral adherence.	S1551
O&G	In Utero Transfers audit	Contact IT to ensure all In Utero Transfers (IUT) information is saved in IUT folder on the desktop of system. Results to be disseminated at labour ward learning points, labour ward forum and perinatal meeting.	S1592
O&G	Documentation 2017	Discuss with Ward re-filing so that all sheets were secured chronologically. Include a reminder for accurate documentation and location of review in the weekly 'learning points' read out at handover. Make a note to include 10 elective and 10 emergencies in 2018 re-audit.	S1636
O&G	Women attending hospital with history of changes/ reduction in baby's movements	Display poster containing information on changes / reduction in baby's movements poster for patients in Antenatal clinic.	S1679
O&G, Safeguarding	Midwife to Health Visitor handover audit (4th Audit - February 2017)	Disseminate the audit results, Standard Operating Procedure and the recommendations for using the 0-19 service handover template in conjunction with using the electronic referral at 15 weeks gestation and the use of the template at discharge from the community midwifery service.	R815

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
O&G, Safeguarding	Re-audit of Perinatal Domestic Abuse Screening	Monthly mandatory updates for all midwives and Maternity Support Worker, Power point and discussion on the policy and expectations on monthly maternity MAST Further audit to take place on births in June 2018, Register re-audit	R841
Oral & Maxillo Facial Surgery (OMFS)	Audit of World health Organisation (WHO) checklist as used in OMFS outpatient department	Further training to be introduced in using the checklist, to ensure a team member is given the role of conducting the check and the addition of sharps disposal in the sign out section	R679
OMFS	Venous Thromboembolism (VTE) risk assessments: are they completed at 24hours?	Ensure VTE assessments are repeated at 24 hours by reviewing as part of the drug chart review at ward rounds	R820
OMFS	OMFS Consent audit	All staff to be made aware that patients should be reminded to date the consent form	R873
OMFS	Antibiotic prescribing for dento-alvolar surgery and facial space infections. What is our current practice? Comparison with Royal College of Surgeons guidelines and evidence based literature	Ensure consistent approach to the prescription of antibiotics in OMFS by implementing a more substantive list in the antimicrobial policy for use in OMFS	S1240
OMFS	Removal of fixation plates following fractured mandibles	Develop a succinct patient information leaflet to provide at discharge to ensure patients follow the advised post-operative instructions	S1414
OMFS	Appropriateness and quality of 2 week wait cancer referrals	Improve awareness of referral criteria amongst dentists, with a presentation at an appropriate Dentist's meeting	S1563
OMFS	Do we follow guidelines for the management of dog bite wounds	Accident & Emergency/ pharmacy confirmed availability and use of tetanus immunoglobulin as per recommendations	S1564
OMFS	Documentation 2017	To raise awareness of documentation requirements	S1630
Ophthalmology	Documentation 2016	Educate on documentation standards at Junior Doctor induction	S1497
Ophthalmology	WHO Checklist Re-Audit for Laser Treatments	Email colleagues to remind them that the WHO checklist is to be completed in full for laser treatments.	S1609
Ophthalmology	Documentation 2017	Email to doctors and lead outpatient nurse to remind colleagues to make sure date & time of appointment is recorded when vision checked by nurse and to make notes legible	S1631
Ophthalmology	Emergency clinic Follow up	To ensure that appropriate patients are seen in the emergency clinic: email and reminders to be sent to A&E clinic/receptionist staff that any general clinic (not casualty) can be booked where a patient that requires a review after 2 weeks; make checks that appointments are booked only in allocated slots and last slot on each list should be blocked for ''on the day referral ''only"	S1652
Orthopaedics	Post-operative Venous Thromboembolism (VTE) prophylaxis of arthroplasty patients	Displaying placards in staff rooms and wards to educate ward clinical and nursing staff on appropriate Post- operative VTE prophylaxis	R816
Orthopaedics	Accuracy of documentation of neurovascular examinations in upper limb fractures	Standardise the patient neurological assessment to ensure all neurological observations are recorded and documented by displaying Posters in Fracture clinic, orthopaedic wards and Accident & Emergency and adding forms to the patient notes	R823

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Orthopaedics	Compliance with British Elbow and Shoulder Society guidelines for traumatic unidirectional shoulder instability	Posters to demonstrate British Elbow and Shoulder Society (BESS) guidelines to be placed in clinic rooms for fracture clinic	R954
Orthopaedics	On the day cancellations for Orthopaedic Surgery	To amend the patient information to include contacting Theatre Admissions Unit (TAU) should they have any recent injury/infection. Consultants and Trauma Co-ordinators to identify on the day cancellations as soon as possible to allow trauma utilisation	S1435
Orthopaedics	Documentation 2016	No actions required	S1498
Orthopaedics	Compliance of BOAST 12 guidelines on the management of ankle fractures	Present findings to Accident & Emergency department to facilitate adherence to the BOAST 12 standards (skin integrity documented, neurovascular examination documented after manipulation, x-ray repeated after treatment)	S1549
Orthopaedics	A re-audit of the management of displaced paediatric supracondylar humeral fractures at Rotherham Hospital	Consider adding a section on the orthopaedic clerking booklet for neurovascular examination in supracondylar fractures. Work with Children's Ward Sister to ensure patients are not discharged prior to post-op review by Orthopaedic Specialist Registrar or consultant. Stress importance of Contra-lateral limb examination documentation on admission and in operation notes.	S1557
Orthopaedics	Audit on compliance of form 4 consent form	Educate staff that all consent 4 forms to be completed in post take ward round pre-theatre and should have consultant signature	S1651
Radiology	Accident & Emergency (A&E) Computerised Tomography (CT) head timings	Remind reporters at Governance meetings of the importance of reporting A&E CT heads in a timely manner and to inform off site radiologist as soon as an A&E CT head is performed.	R697
Radiology	Investigation of Pulmonary Embolus in Pregnancy	No actions required	R814
Safeguarding, Trust wide	A comparative audit of Deprivation of Liberty Safeguards (DoLS) requests made by RGH staff in Q2 of 2016-2017 and Q2 2017-2018	Provide support by visiting the wards 1-2 times a week to identify with the nurse in charge, any patients who may require a DoLS (Deprivation of Liberty Safeguards) request in a timely manner. Audit compliance with the DoLS SOP and include patient admission dates against DoLS referral dates and feedback to the Strategic Safeguarding Group. DoLS administration support worker to identify patients with extended admissions on a weekly basis, to enable the safeguarding team to review if a DoLS is required and thereby reduce the risk of breaching the patient's human rights. To ensure improved compliance with the MCA (Mental Capacity Act) & DoLS by monitoring the completion of MCA assessments on patients for whom DoLS have been requested. Present the audit at Operational Safeguarding Group and DoLS Operational Group to give operational leads for departments the opportunity to assess the progress and compliance of their respective areas and enable them to target their support to ensure they are meeting their legal obligations under the MCA & DoLS. Keep MCA and DoLS on the agenda for the Operational Safeguarding meeting and the quarterly MCA/DoLS lead meetings to review the individual department responsibilities including the quality assurance process by the Matrons.	R851
Safeguarding, Trust wide	Audit of compliance with the TRFT Health Records Policy	Briefings to be sent out via Communications to remind all colleagues to record the name and contact details of the person/people accompanying the patient to a clinical consultation.	R949
Safeguarding, Trust wide	A qualitative audit of Deprivation of Liberty Safeguards (DoLS) requests made by RGH staff in Q2 of 2016-2017 and Q2 2017-2018	As per R851 (above)	S1583

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Therapy Services & Dietetics	Therapy Records Audit	Discussion with team to ensure all recommendations are applied (separate detailed document available)	R313
Therapy Services & Dietetics	Assess if amino acid formula prescribing by dieticians is in line with current guidance.	To update all paediatric dieticians that they should ensure that an extensively hydrolysed formula for cow's milk allergy has been used for at least 2 weeks before considering changing to an amino acid formula if symptoms are persisting.	R869
Therapy Services & Dietetics	Audit to identify if patients within the at risk groups are taking vitamin D supplementation	Share the results with the dietetic team to ensure they review vitamin D status and supplementation with all patients and to inform them to recommend over the counter vitamin D supplementation.	S1547
Therapy Services & Dietetics	Is the process used for delivery of snacks and supplements as per dietetic recommendation effective?	To disseminate the results to the Nutrition and Dietetic department and present the findings at the department meeting in January 2017. To disseminate the results to the Nutrition and Hydration group and present the findings to the catering team at the February Nutrition and Hydration group. Adapt and update the training packages to include information relating to the Catering Service Level Agreement (2015).	S1587
Therapy Services & Dietetics	Assessment of calcium intake in patients with coeliac disease	Calcium intake assessment form to be added to Electronic Record (SystmOne) questionnaire to continue focus on assessing calcium intake at annual review appointments and ensure advice is provided to support patients in meeting their calcium requirements via oral diet where possible. Dietetic team to advise If calcium intake is not being met by diet then an over the counter supplement should be recommended, as per NICE guidance.	S1612
Urology	British Association of Urological Surgeons (BAUS) - Nephrectomies 2015	Ensure copies of BAUS nephrectomy information sheets are available in clinic & documented that given to patient. Ensure all patients to have Surgical Outcome Risk Tool (SORT) mortality risk documented in the notes/consent form, with patients with a mortality risk >2% performed as joint cases. Ensure anaesthetic consultants involved regularly works on these lists are informed in advance of the above cases so that they can be seen in pre-assessment. Use agreed consent information for each procedure, including mortality risk, taken in clinic & confirmed on day of surgery. Copy given to patient documented in the notes/letter. To discuss weekend ward rounds, remuneration & job plans, in short term. Consultant to review Friday nephrectomy patients on Sundays if able to.	R550
Urology	Are we recording stent placement	"Has the patient been registered on British Association of Urological Surgeons (BAUS) registry"? question to be added to World Health Organisation (WHO) theatre checklist to reiterate the importance to log data on BAUS registry and clinicians/theatre staff to taking responsibility to enter data. All patients to be given a stent card/leaflet.	S1640
Urology	Risk of retention in Intravesical Botox injection	Botox pathway circulated to team members to ensure that all patients have urodynamics testing before initial Botox and all female patients should be referred to Uro-Gynaecological Multidisciplinary team before initial Botox.	S1657

(Source: Trust Audit Database)

Appendix 2: Staff Survey

Changes in the Key Findings for The Rotherham NHS Foundation Trust since 2016 survey

(Source: Picker Institute, Europe)
Note – there are other minor differences between the data reported for 2016 below and that in the previous quality report. This is due to the annual weighting of questions by the NHS Coordination Centre.

	2017 score	2016 score	Change	Change statistically significant?
Response rate	41.5	40.8	+0.7	n/a
Appraisals & support for development				
KF11. % appraised in last 12 mths	94	93	+1	No
KF12. Quality of appraisals	2.90	2.98	-0.08	No
KF13. Quality of non-mandatory training, learning or development	4.00	4.01	-0.01	No
Equality & diversity				
* KF20. % experiencing discrimination at work in last 12 mths	8	8	0	No
KF21. % believing the organisation provides equal opportunities for career progression / promotion	84	87	-3	No
Errors & incidents				
* KF28. % witnessing potentially harmful errors, near misses or incidents in last mth	25	24	+1	No
KF29. % reporting errors, near misses or incidents witnessed in last mth	87	91	-4	No
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.62	3.68	-0.06	Yes
KF31. Staff confidence and security in reporting unsafe clinical practice	3.57	3.65	-0.08	Yes
KF32. Effective use of patient / service user feedback	3.62	3.72	-0.10	Yes
Health and wellbeing				
* KF17. % feeling unwell due to work related stress in the last 12 months	40	38	+2	No
* KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure	57	54	+3	No
KF19. Org and mgmt interest in and action on health and wellbeing	3.64	3.62	+0.02	No
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	49	50	-1	No
* KF16. % working extra hours	65	66	-3	No

	2017 score	2016 score	Change	Change statistically significant?
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.43	3.54	-0.11	Yes
KF4. Staff motivation at work	3.80	3.82	-0.02	No
KF7. % able to contribute towards improvements at work	64	66	-2	No
KF8. Staff satisfaction with level of responsibility and involvement	3.83	3.86	-0.03	No
KF9. Effective team working	3.65	3.73	-0.08	Yes
KF14. Staff satisfaction with resourcing and support	3.19	3.27	-0.08	Yes
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.32	3.39	-0.07	No
KF6. % reporting good communication between senior management and staff	24	28	-4	Yes
KF10. Support from immediate managers	3.71	3.72	-0.01	No
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.77	3.88	-0.11	Yes
KF3. % agreeing that their role makes a difference to patients / service users	86	89	-3	Yes
KF32. Effective use of patient / service user feedback	3.62	3.72	-0.10	Yes
Violence, harassment & bullying				
* KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths	12	10	-2	No
* KF23. % experiencing physical violence from staff in last 12 mths	2	1	+1	No
KF24. % reporting most recent experience of violence	65	67	-2	No
* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	24	20	+4	Yes
* KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths	22	23	-1	No
KF27. % reporting most recent experience of harassment, bullying or abuse	49	45	4	No

(Source: Picker Institute, Europe)

Appendix 3: Readmissions within 28 days

NHS Digital have not yet updated this data (see below). The Trust still collects this data as part of the performance dashboard for the Board and uses the internal TRFT Data Warehouse as an alternative means of validation.

The latest figures are:

Re admissions within 28 days of discharge from Hospital	1st April 2016 - 28th February 2017	1st April 2017 - February 2018
Age 0- 15 years	5.77%	8.33%
Age 16 years and above	12.22%	11.84%

(Source: NHS Digital)

'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)

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.

Appendix 4: External Agency Visits

The table on page 145 details the external agency visits undertaken during 2017/18.

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Detail of Visits	Date of Visit
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	24 April 2017
RCCG visit to Stroke Unit (not a clinically led visit)	24 May 2017
RCCG Clinically led visit to Dermatology	21 June 2017
UKAS accreditation of Laboratory Medicine	Biochemistry: 12- 14 July Microbiology: 12-14 July Histology: 12-14 & 19 July Andrology: 12-13 July Blood Transfusion & Haematology: 19-21July & 9 August Immunology:19-20 July
RCCG Clinically led visit to Community Unit	23 August 2017
Pharmacy Aseptic Audit	21 September 2017
Bowel Cancer Screening QA visit	28 – 29 September 2017
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	2 – 3 October 2017
Rhona Collins, Regional Director of Productivity at NHSI	6 December 2017
GIRFT Surgery	15 December 2017
Weston Park Hospital site visit to Oncology Service	19 December 2017
NHSE Quality Surveillance Team Neonatal Critical Care peer review visit	23 January 2018
Cervical Screening Quality Assurance Visit to South Yorkshire and Bassetlaw Local Area Team	25 January 2018
RCCG Clinically led visit to Urology	31 January 2018
GIRFT visit to Urology	29 January 2018
NHS Improvement re: Grip and Control Checklist	1 February 2018
RCCG Clinically led visit to Gynaecology (incl. pregnancy advisory)	7 February 2018
South and Mid Yorkshire Bassetlaw and North Derbyshire (SMYBND) Children's Surgery and Anaesthesia Managed Clinical Network Designation Visit	7 February 2018
NHS Improvement meeting re: Corporate Services Productivity Programme	19 February 2018
Breast Screening Quality Assurance visit	20 February 2018
Police / Environment Agency visit (EA) to Medical Physics department	12 March 2018
British Standard Institute (BSI) inspection / accreditation for the Safe Decontamination and Sterilisation of Medical Devices	12 – 13 March 2018
GIRFT ENT	20 March 2018
NHSE deep dive on Cancer as part of the Cancer Alliance	28 March 2018

(Source: Trust Database)

Acronyms

A&E	Accident & Emergency Department
AKI	Acute Kidney Injury
AMU	Acute Medical Unit
CEO	Chief Executive Officer
CHKS	Comparative Health Knowledge System
CCG	Clinical Commissioning Group
CEG	Clinical Effectiveness Group
CLABSIs	Central Line Associated Blood Stream Infections
CSE	Child Sexual Exploitation
C-difficile	Clostridium Difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
Datix	Computer software used by health services for risk management and reporting incidents
DIPC	Director of Infection Prevention and Control
DNACPR	Do not attempt cardio-pulmonary resuscitation
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
EOLC	End of Life Care
ENT	Ear Nose and Throat
EPACCS	Electronic Palliative Care Co-ordination System
EPAU	Early Pregnancy Assessment Unit
FTSU	Freedom to Speak Up
GAfREC	Governance Arrangements for Research Ethics Committees
GAP	Growth Assessment Protocol
GP	General Practitioner
HCSW	Health Care Support Worker
HDU	High Dependency Unit
HFC	Harm Free Care
NHS DIGITAL	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
ITU	Intensive Therapy Unit
IV	Intravenous
KPI	Key Performance Indicator
MARAC	Multi Agency Risk Assessment Conference
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act 2005
MCISS	Macmillan Cancer Information Support Base
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning System
MQEM	Macmillan Cancer Support Quality Environment Mark
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
NGO	National Guardians Office
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NRLS	National Reporting and Learning System
PAR	Patient at Risk chart
PIR	Post Infection Review
PLACE	Patient-led Assessment of the Care Environment
PROMS	Patient Reported Outcome Measures
QAC	Quality Assurance Committee
RCA	Root Cause Analysis
RCOG	Royal College of Obstetricians and Gynaecologists
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
RLSAB	Rotherham Local Safeguarding Adult Board
RLSCB	Rotherham Local Safeguarding Children Board
RMBC	Rotherham Metropolitan Borough Council
RN	Registered Nurse
SAU	Surgical Assessment Unit
SCBU	Special Care Baby Unit
SGA	Small for Gestational Age
SHMI	Summary level Hospital Mortality Indicator
SI	Serious Incident
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
T&F	Task and Finish
TRFT	The Rotherham NHS Foundation Trust
TTOs	To Take Out
TWC	Together We Can
UTI	Urinary Tract Infection
VAR	Voluntary Action Rotherham
WHO	World Health Organisation
YTD	Year To Date
VTE	Venous Thromboembolism

Glossary of Terms

CHANGE organisation
Is a human rights organisation led by Disabled People, working to build an inclusive society where people with learning disabilities are treated equally.

Clinical Coding
The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.

Comparative Health Knowledge System (CHKS)
A web based performance benchmarking system, utilised by many Trusts

Commissioning for Quality and Innovation (CQUIN)
A series of nationally and locally agreed improvement targets, linked to a proportion of Payment by Results funding as an incentive to achieve agreed outcomes.

Data Quality Index
A composite indicator reflecting data quality, provided by CHKS.

Datix
An Incident reporting system used by many NHS Trusts.

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.

Exemplar Health Care
Exemplar is one of the UK's leading providers of specialist nursing care and neurorehabilitation for adults with complex needs.

FFFAP
Falls and Fragility Fracture Audit Programme, led by the Royal College of Physicians, gathering and analysing data on serious harms across the NHS.

Healthcare Resource Groups (HRGs)
HRGs are standard groupings of clinically similar treatments which use common levels of healthcare resource.

HRGs help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

HRGs are currently used as a means of determining fair and equitable reimbursement for care services delivered by providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the service.

Presently, the Trust complies with HRG4 to code clinical activity.

Healthwatch
The independent consumer champion that gathers and represents the public's views on health and social care services in England.

Mencap
Mencap is a UK charity for people with a learning disability. Mencap also support their families and carers.

Monitor
Sector regulators for health services in England.

Mortality Rate
The rate at which patients die in a hospital. Data is collected nationally by HSCIC and enables Trusts to look at trends in Mortality Rates and make comparisons with other hospitals.

Mortality is generally measured in one of two ways: The HSMR measures the actual number of deaths occurring in a hospital compared to the number of deaths that might have been expected. The SHMI is a ratio of the actual number of patients who die against the number who would be expected to die on the basis of average England figures. The SHMI ratio includes those patients who die within 30 days of discharge from hospital.

Never Event
Defined by the DoH as a very serious, largely preventable, patient safety incident that should not occur if appropriate preventative measures have been put in place.

NHS Digital
Provider of data for the NHS; formerly known as the Health and social care information centre (NHS DIGITAL).

NHS Improvement
NHSI was launched on 1 April 2016. It was formed from the two previous regulators, Monitor and the Trust Development Authority (TDA).

Patient-led assessments of the care environment (PLACE)
PLACE is a new way of assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. They look at how the environment supports patient privacy and dignity, the meeting of dietary needs, cleanliness and general building maintenance.

Results from the annual assessments are reported publicly to help drive improvements in the care environment; they show how the Trust is performing by comparison with other Trusts across England.
For more information visit www.england.nhs.uk/ourwork/qual-clin¬lead/place.

Ribotyping
Ribotyping is a molecular technique that takes advantage of unique DNA sequences to differentiate strains of bacteria.

Risk Assessment Framework
This document sets out Monitor's approach to making sure NHS Foundation trusts are well run and can continue to provide good quality services for patients in the future.

Safeguarding
A process used to identify adults and children at risk and provide protection against further harm.

Safety Thermometer
The expanded national patient safety improvement initiative, promoting 'Harm Free Care' and linked to National CQUINs.

The Secondary Uses Service (SUS)
The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Voyage
Voyage Care supports thousands of people with learning and physical disabilities, brain injuries, autism and other needs across England, Scotland and Wales.

They offer person centred care and support in a range of settings and have experience of supporting people to move from one type of service to another as their needs change or they become more independent.

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 and Senior Independent Director	
Joe Barnes	Non-Executive Director	
Cheryl Clements	Director of Workforce	
Heather Craven	Non-Executive Director	
Mark Edgell	Non-Executive Director	
Lynn Hagger	Non-Executive Director and Vice Chair	
David Hannah	Non-Executive Director	From 11 January 2018
Chris Holt	Director of Strategy & Transformation and Deputy Chief Executive	
Barry Mellor	Non-Executive Director	
Chris Morley	Chief Nurse	From 2 October 2017
Simon Sheppard	Director of Finance	
Conrad Wareham	Medical Director	
Directors who served during the year, but who had left office before year end		
Ellie Monkhouse	Acting Chief Nurse	Until 1 October 2017
Paul Smith	Non-Executive Director	Until 12 December 2017
Maxine Dennis	Acting Chief Operating Officer	From 20 December 2017 to 31 March 2018

Directors' biographies can be found within the Governance Report beginning on page 181, together with details of Directors' attendance at Board and Board Committees.

Directors' Register of Interests

The Directors' Register of Interests is available to view on the Trust's website (http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Our_Board_of_Directors/) or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec, Company Secretary
General Management Department, Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

Under the NHS Act 2006, NHS Improvement has directed The Rotherham NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction.

The Directors are responsible for preparing the accounts on an accrual basis, which gives a true and fair view of the state of affairs of The Rotherham NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Directors are required to comply with the requirements of NHS Improvement's Foundation Trust Annual Reporting Manual 2017/18 and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health Group Accounting Manual)* have been followed, and
- Disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Prepare the financial statements on a going concern basis.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Directors are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors of The Rotherham NHS Foundation Trust confirm that as far as they are aware there is no relevant audit information of which the Trust's auditors are unaware.

The Directors have taken all steps they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The Directors consider that the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Cost Allocation and Charging Guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury. The Trust will participate in a national audit of the implementation of the national costing standards being run by NHS Improvement at the end of 2017/18 and beginning of 2018/19.

Political Donations

There are no political donations to disclose.

Better Payment Practice Code

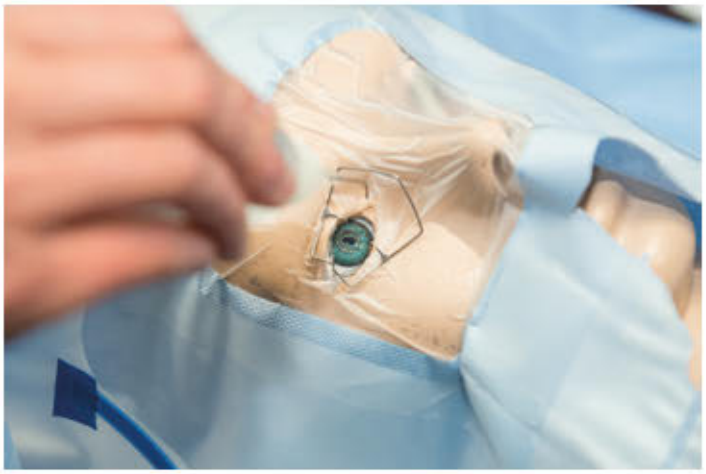
The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. However, the Trust, in common with all sectors of the economy, has to primarily manage its cash flow according to the requirements of the organisation in order to ensure it has sufficient liquidity, prevent unforeseen bank charges and minimise the extent of interest payable on loan financing.

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.

As detailed in the table below the Trust paid 20.13% (by value) of its Non-NHS invoices, and 5.01% (by value) of its NHS invoices within 30 days. The overall position was 18.61% (by value) of invoices paid in 30 days. This was due to challenging in- year financial performance resulting in a need to increase borrowings to manage working capital. The timing of receipt of additional borrowings delayed payments over the year.

	Number	Value £000's
NON-NHS		
Total Bills Paid in Year	54,974	87,622
Total Bills Paid Within Target	7,793	17,634
Percentage of Bills Paid in Target	14.18%	20.13%
NHS		
Total Bills Paid in Year	1,846	9,794
Total Bills Paid Within Target	35	491
Percentage of Bills Paid in Target	1.90%	5.01%
TOTAL		
Total Bills Paid in Year	56,820	97,416
Total Bills Paid Within Target	7,828	18,125
Percentage of Bills Paid in Target	13.78%	18.61%

In 2017/18 the Trust became liable to pay interest which accrued by virtue of failing to pay invoices within agreed payment terms where obligated to do so. This was £606.67 and all related to non-NHS transactions




The National Autistic Society
STAND OUT FOR AUTISM!
The National Autistic Society

Information on Fees and Charges

The Trust has nothing to disclose in relation to any individual service having full costs exceeding £1 million.

Income Disclosures required by Section 43(2A) of the NHS Act 2006 (as amended by the Health & Social Care Act 2012

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Rotherham NHS Foundation Trust meets this requirement.

As required by section 43(3A) of the NHS Act 2006, an NHS foundation trust must provide information on the impact that other income it has received has had on its provision of goods and services for the purposes of the health service in England.

The Rotherham NHS Foundation Trust has not received any income which was not for the purposes of the health service in England during 2017/18.

Disclosures relating to NHS Improvement's Well-led framework

During 2017/18, the Board of Directors built upon its earlier self-assessment against the Well-led framework, by looking at the revised guidance, supported by both the CQC and NHS Improvement, and carrying out an updated assessment. This session identified some areas of further work, and recognising that the framework is primarily for providers themselves to facilitate improvement, some of that work has been incorporated into the Board's ongoing development programme. For 2018/19 the Trust plans to commission an external Well-led review to be undertaken and completed in year.

The Trust did not receive a further inspection from the Care Quality Commission (CQC) during 2017/18 and the CQC assessment of well-led remains at 'requires improvement'. The Trust did commission and complete an external quality governance review in 2017/18 and has now developed an action plan to take forward the recommendations from this review. In addition, a review of the arrangements for risk management has been undertaken with further work planned during 2018/19.

There are no material inconsistencies between the annual governance statement and the information provided by the Trust to NHS Improvement on an in-year, annual and ad-hoc basis in line with the Single Oversight Framework.

Patient Care

The last year has seen numerous service developments which have positively impacted on patient care.

The Trust has seen an increase and more recently a decrease in the Hospital Standardised Mortality Ratio (HSMR) during the year. At the end of the year the Standardised Hospital Mortality Index (SHMI) was raised.

HSMR and SHMI provide a rolling 12-month picture of mortality data for a time period ending either six or 12 months previously (respectively) at the time of publishing. This means that the data that has led to the rise in the mortality figures actually occurred at the beginning of the 2016/17 financial year. The causes for this were determined at the time and steps taken to improve performance. Current mortality figures for the Trust are much improved and in line with those expected for the case mix being managed in the organisation.

During the year a number of changes were made in the way that the Trust reviews and learns from deaths. These included the:

- Appointment of a Non-Executive Director Lead for Mortality – Mr Mark Edgell
- Appointment of an Executive Director Lead for Mortality – Dr Conrad Wareham, Medical Director
- Publishing of a Mortality Policy in September 2017
- Publishing of Avoidable Deaths number in December 2017

In addition, the Trust continues to run a monthly multidisciplinary Mortality Group to review performance and learnings from deaths which reports to the Clinical Governance Committee.

The Trust is continuing ongoing work to improve the timeliness and effectiveness of responses to clinical deterioration. Changes were made to the trigger tools used and the response processes during 2016 which made a clear improvement. This is now being fully evaluated with the intention to make the system as robust, and the Trust as safe, as it can be. The multidisciplinary group responsible for making the changes during 2016 has been reconvened and expanded to achieve these aims.

The Trust has reported delays in the administration of antibiotics after the identification of sepsis. Sepsis has a high mortality which is recognised to worsen with delayed treatment. Whilst the Trust is able to demonstrate a good performance in identification of sepsis it is not yet able to demonstrate that antibiotics are given within a suitably short timeframe to many patients. The Trust already actively promotes the 'Sepsis Six' campaign with mandatory training, posters in clinical areas, screen savers on computers and in its policies and procedures.

A multidisciplinary team was formed to address this issue and focussed on three major areas:

- Education of staff to ensure the recognition of the importance and urgency of giving antibiotics in sepsis
- Practical steps to facilitate the availability of suitable antibiotics for staff to administer 24 hours a day, seven days a week
- Simplifying documentation and increasing its robustness

During 2016 the Trust introduced a 'Hospital at Night' team to support the care of inpatients outside of office hours. This has proven to be both effective and popular with on-call staff. A formal evaluation of the programme took place in late 2017 with a view to potentially making improvements and / or expanding the service in terms of hours and / or areas covered.

Extensive work also took place during the year focussing on missed and delayed diagnoses. This was to ensure that when a test is performed the result is viewed in a timely manner and, if abnormal, suitable actions are taken. Process changes are being made and increasingly electronic solutions implemented to increase the robustness of the process.

Monitoring Improvements in the Quality of Healthcare

The arrangements for monitoring improvements in the quality of care, and monitoring progress towards meeting any national and local targets and improvements required following the September 2016 Care Quality Commission inspection are managed through the assurance structure of the organisation and its committees, both Trust-wide and within the clinical Divisions.

Board Committees seek evidence as to performance and compliance in order that they are able to provide assurance to the Board of Directors that quality objectives are being met. The Clinical Governance Committee is the highest level operational committee responsible for monitoring all aspects of the quality of the healthcare the Trust provides.

The Clinical Governance Committee, chaired by the Medical Director and supported by the Chief Nurse, has a key role in overseeing the operational delivery of high quality healthcare through the work of a number of sub-groups including those relating to patient experience, patient safety and clinical effectiveness. The role and functions of these groups and their interface with the governance arrangements in the clinical Divisions has been the subject of an external review during the year and the changes recommended by this review are being implemented and their implementation will be completed during 2018/19.

Service Improvements

A number of service improvements have been undertaken as part of the Trust's Quality Priorities and following on from the Care Quality Commission inspection and recommendations and are described in the Quality Report section of this Annual Report.

Following the publication of the 2016 National Inpatient Survey, it was recognised that the Trust needed a method of obtaining a range of feedback on the care provided to its inpatients. As a result, each month, a selection of patients from each ward is surveyed about their experience. The results from these surveys are used to highlight where improvements are required either Trust-wide or in a specific area and also monitor the impact of any initiatives designed to improve the care on wards. It is expected that this approach will help to more effectively learn from patients' experiences. In addition, this will allow the Trust the opportunity to address some concerns as they arise.

Children's Community Services

The children's community service is a very diverse service comprising a number of specialist services.

0-19 Service

During 2017/18 the Trust won the tender for the 0-19 Service bringing the Health Visiting and School Nursing services together as the first step on the journey to becoming Public Health Practitioners. This has required a significant transformation programme with a two-year mobilisation plan. The service continues to work in partnership with the local authority to tackle areas of high demand in particular the increase in safeguarding work.

Looked After Children

Achieving the initial health assessment target for children who are taken into care requires the service to undertake an initial medical

review within 20 days for all such children. The Trust's performance against this target was poor at the beginning of the financial year. Following extensive work on the pathway in partnership with Rotherham Metropolitan Borough Council, timely appointments and report writing, as well as collaborative working with social services, the team improved performance against this target, achieving 81% compliance in November 2017. However, performance deteriorated at the beginning of Q4 but it is anticipated that this will improve during the new financial year.

Children's Development Centre

Over the past year the Children's Development Centre has continued to focus on reducing waiting times for follow up appointments. An initial pilot demonstrated the value of using a nurse practitioner to conduct some routine health assessments and reviews, thereby reducing waiting times. This has now been implemented into routine practice thereby relieving pressure on the medical staff. Over the coming year, the focus will be on 'what good looks like' and how this can be achieved, consulting with parents via the Rotherham Parents' Forum. The primary aim of the service is to reduce waiting times for diagnostic assessment for social communication disorders (including Autism) which remain high, although this is problem both locally and nationally.

Children's Community Nursing Team

During this year the team worked closely with the acute service to support and enable earlier discharge from the children's ward and assessment unit. The team worked closely with ward staff to identify and discharge children and continue their care in the community. Referrals from medical consultants and general practitioners have been accepted and the next phase will include referrals from the Emergency Department to enable admission to be avoided where possible.

The New Urgent and Emergency Care Centre

The new Urgent & Emergency Care Centre (UECC) opened on 6 July 2017 providing a single point of access for the population of Rotherham into the emergency care system.

The building provides state of the art facilities and equipment to support the delivery of the service. The model of care is to provide an integrated response to urgent and emergency care in Rotherham and, therefore, the service is an integrated Emergency Department and urgent primary care service, including the GP Out of Hours Service.

The service is supported by a diverse clinical team from both primary care and the Emergency Department who are able to stream patients into the most appropriate care, thus ensuring right care, first time, 365 days a year. This innovative approach combines the best practice guidance published about how to develop new Urgent and Emergency Care Services.

In addition, the UECC accommodates the Care Co-ordination Centre, the Mental Health Liaison Team and space for Social Work input, which means that almost all urgent care services are co-located.

Complex Cardiac Devices

In March 2018, The Rotherham NHS Foundation Trust began the insertion of Complex Cardiac Devices. This ensured that all Rotherham patients who require a complex device, such as an Implantable Cardioverter Defibrillator (ICD) or a Cardiac Resynchronisation Therapy Pacemaker (CRT-P) were able to have their procedure carried out locally rather than having to travel to Sheffield.

Patients also receive their follow up care locally and remote monitoring is carried out by local clinicians who know the patients. Patients benefit from: continuity of care as they remain under the care of Rotherham Cardiologists throughout their care; convenience of location; timely insertion of the device (within 6 weeks) and an improved support network due to the development of a local support group within the community setting, which supports Rotherham patients throughout their journey.

How Health Informatics have supported service improvements

Throughout the year the Trust has updated its community clinical software to a mobile-friendly version which allows nurses to securely access their electronic records even when no internet connection is readily available. In addition, the public sector Wi-Fi network 'GovRoam' has been enabled which enables all staff across the public sector to access secure internet from most hospital and health centres across the Yorkshire and Humber region.

Clinical trials have taken place using the organisation's electronic patient record system to record nursing observations and automatically calculate clinical escalation scores. Early indications from these trials suggest this is working well consequently the Trust is planning a further rollout alongside the implementation of e-Prescribing during 2018/19.

During 2017/18 the Trust's external-facing website was updated to a fresh, mobile friendly version that handles over 6000 users a week, 45% of whom access it from a mobile device.


NHS
NHS

CQUIN (Commissioning for Quality and Innovation)

As previously reported in the Performance Analysis section of this Annual Report, the Trust's performance against the four key health care targets during 2017/18 was mixed.

The Commissioning for Quality and Innovation (CQUIN) scheme includes locally agreed and nationally mandated goals for improving the quality of healthcare provided. The schemes agreed with NHS Rotherham Clinical Commissioning Group and the Trust's forecast year-end position against each scheme is detailed below. It should be noted that the final reconciled position will not be available until the end of May 2018 although provisional figures are provided below based on current data.

CQUIN Indicator Description	Forecast Year-end Position
NHS Staff Health & Wellbeing Initiatives	Partial Achievement
Healthy Food for NHS staff, visitors and patients	Achieved
Uptake of Flu Vaccinations for front line staff	Achieved
Reducing the impact of serious infections	Partial Achievement
Improving services for people with Mental Health needs who present to A&E	Achieved
Offering electronic Advice and Guidance to General Practitioners	Achieved
Increase use of e-referrals	Achieved
Strengthen Proactive and Safe Discharge	Partial Achievement

In addition to the national CQUIN schemes detailed above, the Trust monitors progress against delivery of an agreed set of community services indicators. The indicators and the Trust's forecast year-end position are detailed below:

Community Key Performance Indicator	Forecast Year-end Position
Community Services Benchmarking	Achieved
Personalised Care & Support Planning	Achieved
Community Services Key Performance Indicators aligned to admission avoidance and utilisation of Alternative Levels of Care	Achieved

Additionally, during 2017/18, the Trust continued to report centrally to NHS England and locally to NHS Rotherham Clinical Commissioning Group its position against the Seven Day Services clinical standards. Whilst information is provided on a quarterly basis there were no financial implications / penalties associated with compliance during 2017/18. The indicators monitored were:

7 Day Clinical Standard Name
Time to Consultant First Review
Access to Diagnostics
Access to Interventional / Key Services
Consultant Review of Inpatients

Other areas where the Trust sustained previous performance above expected levels, or improved performance in areas which deliver quality benefits to patients, were:

- MRSA and C. difficile rates
- Ward reconfigurations which actively supported the avoidance of mixed sex accommodation breaches
- Compliance against the 18 week wait targets
- Recovered and maintained compliance against the 6 week wait diagnostic targets
- Achieved cancer pathway waiting times

New or significantly revised services

The Trust provided a full range of acute and community services throughout 2017/18.

July 2017 saw the opening of the state of the art Urgent and Emergency Care Centre (UECC) incorporating the transfer of activity previously delivered at Rotherham Community Health Centre in the town centre. This centre now provides a single access point for all urgent and emergency conditions with streamlined pathways to ensure patients are effectively sign-posted into the right part of the urgent and emergency service. The overarching principle and purpose of this significant transformational development was to deliver the right care, by the right person, in the right place, at the right time.

Linked to the opening of the UECC, the Trust took over managerial responsibility for the delivery of the GP Out of Hours provision and this service was relocated to, and provided from, within the UECC building. This facilitated a timelier interaction between the out of hours and emergency services in managing the needs of patients through a more holistic and integrated approach.

In October 2017, the Trust assumed responsibility for the management of diagnostic services at Rotherham Community Health Centre. This allowed the expansion of the Trust's overall capacity to deliver a range of diagnostic services and supported the offer of a choice of location for their diagnostic test to patients. Timely access to diagnostics is an essential part of the pathway to support effective and timely clinical decision making. This extension in capacity provided a positive impact on sustaining and further improving already good waiting times for access to diagnostics.

During the year the organisation continued to build upon previous work to progress and extend the locality based model of delivery for community services. This new way of working brings together colleagues from different disciplines caring for the patient to ensure their overall clinical needs are understood and managed efficiently with the ultimate aim of keeping patients safe and well in their own homes. This has financial benefits for the Rotherham health economy as patients receiving care in their home setting are less likely to require hospital admission, which is more expensive.

Following a rigorous procurement process undertaken by Rotherham Metropolitan Borough Council in 2016/17, the Trust was awarded winning bidder status for the delivery of the 0-19 Children's Services and Integrated Sexual Health Services (across hospital and community settings). Whilst both services were provided by the Trust prior to the procurement process, each area underwent a complete transformation of the service delivery model and clinical pathways to offer enhanced services to these patient groups.

The Trust was also successful during 2017/18 in being selected as the second implant centre within South Yorkshire and Bassetlaw for complex cardiac devices by Sheffield Teaching Hospitals NHS Foundation Trust. Work was undertaken to complete the new cardiac catheter laboratory from which the service would be delivered and which opened in early 2018.

ICS Hospital Services Review

The Trust is fully sighted on, and engaged in, the South Yorkshire and Bassetlaw Integrated Care System (ICS) Hospital Services Review. The ICS Hospital Services Review is likely to have an impact on the provision of healthcare across the ICS footprint, including Rotherham. It is focusing on the following issues and how they can be addressed across a sub-regional footprint.

Workforce:	Developing a joint approach to training, development and recruitment
Standardisation:	Standardised clinical pathways across South Yorkshire and Bassetlaw
Reconfiguration:	How to reconfigure health services to improve sustainability of services across the ICS.

This year the review has focused on the following care pathways:

- Urgent and Emergency Care
- Maternity
- Care of the Acutely Ill Child
- Gastroenterology and Endoscopy
- Stroke

The Review reported in May 2018. Rotherham clinicians have been involved in the review alongside other key stakeholders. The Trust is committed to working closely with patients, families and partner organisations to build on the positive foundations in place to continue to improve the quality, resilience and sustainability of services for the future, for the population we serve.

Patient/Carer Information

Previously the Trust's website was unresponsive and as a result, was difficult for visitors to read. Updates to the Trust's web hosting arrangements and work carried out by the Health Informatics team mean that the website is now much more responsive, for example it resizes its content to smaller screen sizes such as mobile phones and tablets, improving the experience for visitors to the site.

The standard font used across the site is now larger and the colour scheme has more contrast for readability. A footer has been added to every page displaying contact information and visiting times as these pieces of information were amongst the top search queries entered into the site. In addition, the Trust's online departmental A-Z functionality has been improved.

The Trust's Communications Team works closely with clinical and non-clinical teams to update information for patients and visitors and every effort is made to ensure that information on the site is in plain English, is concise and well presented to make the access to information as easy as possible. As part of wider Informatics and Communications strategies, plans are in place to continue to make further improvements to the Trust's website to improve the information available.

The Patient Information Group is responsible for the review of information developed by colleagues for patients. A significant amount of patient health information is produced through third party organisations and where appropriate the Trust is seeking to utilise these resources to ensure the accuracy of information and minimise the reproduction and review costs associated with the development of in-house patient health information.

Information on Complaints Handling

The Trust recognises the importance of managing any concerns or complaints raised by patients or families on a patient's behalf, in a timely effective manner.

During the year there has been focused work on encouraging more face to face meetings between patients with concerns and staff, this has resulted in 27% of complaints received during 2017/18 being addressed through a meeting.

In addition, for those patients who would rather receive a written response, work has been undertaken to ensure that they receive that response within 30 working days. This work has resulted in the Trust improving its performance such that in December 2017, 100% of complaints were answered within the agreed timescale. This performance was then sustained during Q4 of 2017/18.

Partnerships and Alliances

The Trust continues to work in well-established partnerships with Doncaster & Bassetlaw NHS Foundation Trust for the delivery of ENT and Oral Maxillofacial services. Management of these services across the sites is embedded and has been in place for a number of years.

In addition, work was undertaken with Doncaster & Bassetlaw NHS Foundation Trust during 2017/18 to embed joint pathways in support of the out of hours gastrointestinal bleed rota.

The Trust continued to engage with other provider colleagues both within the South Yorkshire and Bassetlaw footprint and slightly further afield for example with Chesterfield and Mid Yorkshire provider organisations.

The Trust is a proactive member of committees and clinical networks for the Working Together Programme, the Rotherham Place Plan and the wider South Yorkshire and Bassetlaw Accountable Care Partnership.

Through a range of transformational developments (including the community integrated locality which supports more effective and efficient hospital discharge and effective usage of intermediate care capacity) the organisation has continued to work very closely with Rotherham Metropolitan Borough Council and other health and voluntary sector organisations to support delivery of its overall vision.

Development of services involving local agencies

The Trust is actively engaging with other local services across the health economy to further develop and/or enhance service delivery. In 2017/18 work continued with Social Care colleagues at Rotherham Metropolitan Borough Council (RMBC) on an initiative to facilitate multi-system, multi-disciplinary working to support patient needs, both clinical and social, to be managed collectively at the right time during the patient pathway.

Active engagement with Public Health colleagues both at RMBC and at NHS England in supporting health awareness messaging has continued in year, as has work with the voluntary sector to provide support where appropriate.

The Trust continues to work extremely closely with RMBC and other agencies to address any safeguarding concerns identified within maternity and children's services. This has resulted in significant improvements to systems, processes and communications across both organisations to support effective and timely management of concerns. This joint approach further facilitates a shared knowledge and understanding of issues relevant to both organisations allowing sharing of learning to support continued development.

The Trust has also worked in partnership with Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) on the development and enhancement of joint working relationships for adults, older adult's mental health services and child and adolescent mental health services (CAMHS). The two Trusts have developed a Memorandum of Understanding regarding standard setting and shared responsibility for improving the mental health of patients. A number of significant improvements have been implemented via this joint working including: support and implementation of a CAMHS Interface Liaison Nurse; development of shared pathways of care for children; improved communication and support for adults and older adults through the location of the mental health liaison team within the Emergency Department and the ongoing assessment of patients should they be admitted to an inpatient bed.

The Trust values a multi-disciplinary, multi-agency collaborative working approach and knows the benefit this can bring for patients. Forging effective relationships allows cross-organisation pathway reviews designed to shape seamless, patient-focused care pathways which improve clinical outcomes and patient experience.

The Health Village Integrated Locality pilot was implemented in July 2016. The overarching aims of the pilot were to:

- Prevent / reduce hospital admissions
- Reduce the length of stay in secondary care
- Reduce the cost of health and social care through early identification and intervention
- Reduce duplication for patients and professionals
- Improve communication and joint working between professionals
- Develop a holistic approach to care

The project is based upon the development of an integrated locality team servicing the adult population, to deliver joined up health and well-being support. The team consists of a community physician, community nurses, therapist, social workers, community link worker, a mental health worker and a social prescriber.

The pilot has recently been evaluated. The aims of the evaluation included an assessment as to the extent to which:

- this way of working was more effective at facilitating early discharge from hospital;
- the development of multi-disciplinary teams had helped to identify at risk patients and reduce unnecessary admissions;
- the pilot was successful in developing a single referral pathway to allow a more appropriate and rapid response;
- co-location of workers supported the development of a better understanding of others' roles and responsibilities.

Early indications are that the pilot is having an impact across all these areas.

As part of the Rotherham Place-based Plan the Trust has been working with Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) to develop an integrated point of contact for physical and mental health referrals via its Care Coordination Centre.

This development provides, for the first time, a 24/7, 365 days a year dedicated, staffed referral line for patients experiencing mental ill-health and living with learning disabilities. Three RDaSH staff have joined the Trust's Care Co-ordination Centre team to receive, process and signpost referrals.

The service provides a better patient experience as those in need and their health professionals are able to contact one location for physical and mental health needs to be considered holistically. It is also more efficient since it reduces the number of contact points being staffed across the borough. New algorithm-based processes have been introduced, building on RDaSH's system development work, to facilitate decision making and reduce risk. New e-referral processes have increased capacity by removing paper based manual activity.

Ferns is a 12-bedded unit owned by Rotherham Doncaster & South Humber NHS Foundation Trust, located at Woodlands, at the back of the Rotherham General Hospital site.

A joint pilot between the Trust and RDaSH operated between May 2017 and March 2018 to provide specialist expertise, assessment and interventions for patients with dementia, or similar cognitive impairments, who, following an acute medical admission to the Trust, no longer required inpatient care for physical health needs but instead required cognitive rehabilitation to enable their safe discharge. RDaSH provided the specialist cognitive rehabilitation and premises, supported by an Advanced Nurse Practitioner and Consultant Geriatricians from The Rotherham NHS Foundation Trust.

The pilot provided specialist support to bridge the gap from hospital to home or step down care to support a range of individual needs including physiotherapy interventions as well as coping skills for physical conditions such as diabetes or medication management. A home assessment of one patient's use of medication not only enabled that patient to return home but saved over £500 from prescriptions which were no longer required.

Outcomes from the first six months of the pilot included 20 of the 31 patients discharged being able to return home following their stay in Ferns. Of these, only four had had no mobility issues on admission and eight were confined to bed. The future of the Ferns pilot will be considered as part of the Rotherham Place Plan review of intermediate care and rehabilitation.

Consultation with local groups and organisations

The Rotherham NHS Foundation Trust views consultation as important. In January 2018, the Quality Priorities showcase for staff, patients, public and stakeholders took place. This allowed the Quality Priorities for the Trust to be shared with those present to make suggestions for how the improvements could be made.

During Values Week, in the summer of 2017, colleagues and members of the public were asked to give their views on what the Trust's values: Ambitious, Caring and Together meant to them and how these could be further incorporated into day-to-day work.

In January 2018, representatives from the South Yorkshire and Bassetlaw Accountable Care System (ACS), now known as Integrated Care System (ICS), held an informal drop-in session for Trust colleagues and members of the public. This was an opportunity for people to find out more information about the Hospital Services Review and how they could share their views.

The Trust has strong links with the local authority, and representatives from the Trust are often invited to attend meetings of the local Health Select Commission in order to provide an overview on arising health care matters.

Public and Patient Involvement Activities

The Trust has ensured that patients and members of the public were able to take part in activities across its services during 2017/18.

In April 2017, members of Rotherham's Haematology Support Group celebrated their first year supporting patients with a haematological diagnosis by hosting an Easter charity raffle. The group is the only one of its kind in Rotherham and meets once a month. It allows patients, their carers and families to come together and share their experiences as well as access support from the Trust's Haematology Specialist Nurses and Macmillan Cancer Support.

The Mayor of Rotherham helped the Trust mark Parkinson's Awareness Week in April 2017 by joining colleagues, patients, members of the public and Parkinson's UK volunteers at a special event at Rotherham Hospital. There are an estimated 500 people with the condition across Rotherham, and the event was used to raise awareness and to allow people to find out more information on the support available.

The Ophthalmology Service runs bi-annual open days which alternate between cataract and age related macular degeneration (AMD). More than 130 people attended the year's event in spring 2017, where past and present patients were invited to discuss the care they receive with nurses, consultants, support colleagues, volunteers and patient representatives.

The Trust's Learning Disability Lead Nurse was joined by colleagues and Learning Disability Nursing and Social Work students from Sheffield Hallam University during Learning Disabilities Week in June 2017. This was to promote the support available at the Trust for anyone who lives with a learning disability.

Ahead of the opening of the Rotherham's Urgent and Emergency Care Centre in July 2017, a range of open events were scheduled for Trust colleagues as well as patient and public representatives. These events were very well attended and helped ensure the message about the changes being made to urgent and emergency care reached people in the local area.

The Trust's research team held a series of events throughout the year to promote the research that takes place within the Trust and how people can get involved. One of these events was for Clinical Trials Day during May 2017.

Freedom to Speak Up Guardians from the Trust were joined by regional representatives to highlight their roles within the Trust to support colleagues to deliver high quality, safe and effective care. As well as promoting the roles to other colleagues, it gave patients and members of the public the opportunity to hear about the role of Freedom to Speak Up Guardians within the health service, both locally and nationally.

Throughout the year, 206 promotions were held in the Trust's 'Community Corner'. As part of self-care week a wide range of events took place with support from colleagues within the Trust and from partner organisations and volunteers. Other events included health campaign promotions, lifestyle changes and fundraising.

Remuneration Report

Annual Statement on Remuneration from the Chair of the Remuneration Committee (not subject to audit)

I am pleased to present the Remuneration Report for the financial year 2017/18 on behalf of the Board of Directors' Remuneration Committee with regard to executive directors, and the Council of Governors' Nomination Committee with regard to Non-Executive directors.

In accordance with the requirements of the HM Treasury Financial Reporting Manual (FReM) and NHS Improvement, we have divided this report into the following parts:

- The Directors' Remuneration Policy sets out the Trust's senior managers' remuneration policy; and
- The Annual Report on Remuneration which includes more detailed information and governance details.

Major decisions taken on senior managers' remuneration 2017/18

In detailing below, the definition for 'senior managers' as contained in the FReM has been applied and refers to Executive and Non-Executive directors only, i.e. those who influence the decisions of the Trust as a whole, rather than the decisions of individual directorates or sections within the Trust.

Colleagues on Agenda for Change terms and conditions were subject to the following changes that came into effect from 1 April 2017:

- 1% pay increase to all pay points;
- Increments were paid to those who were eligible.

During 2017/18 the Remuneration Committee and the Council of Governors continued to use annual benchmarked data, including that provided by NHS Providers, as the pay and reward framework on which to base Executive and Non-Executive salary amounts.

In determining the salaries of Executive directors for 2017/18, the Remuneration Committee took account of the national decision to award a consolidated pay award to colleagues who were on national terms and conditions. The Committee decided to mirror this approach in its decision to award a 1% consolidated increase in pay to Executive directors. This was the first pay increase awarded by the Trust's Executive directors since coming in to post.

The remuneration for Non-Executive directors is determined by the Council of Governors who also determined to award a 1% increase in pay to Non-Executive directors for 2017/18.

The Rotherham NHS Foundation Trust has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior managers and we will continue to do this going forward.

Signed:

Barry Mellor
Chair, Remuneration Committee

Senior Managers Remuneration Policy

This section describes the policy relating to the components of the remuneration packages for Executive and Non-Executive directors (senior managers).

The aims of the pay and reward framework currently in place, are to:

- Facilitate the recruitment and retention of high quality senior staff;
- Ensure that remuneration reflects the extent of the role and responsibilities of individual posts and their contribution to the Trust;
- Ensure that the remuneration is justifiable and provides good value for money; and
- Provides a transparent framework for determining senior level remuneration.

In setting and reviewing pay, it is vital to recruit and retain talent and to operate the pay system fairly; however, it is also necessary to have a robust process for reviewing remuneration and to be able to demonstrate sensible use of public money.

Element	Policy
Base pay	Base pay is determined by using annual benchmarked data in order to attract and reward the right calibre of leaders to deliver the Trust's short, medium and long term objectives.
Pension	Executive Directors are able to join the standard NHS pension scheme that is available to all staff members.
Bonuses	Bonuses were not given to staff, including the Executive and Non-Executive Directors.
On call payment	In relation to Executive pay, no Board members receive on call payment
Benefits	The Trust operates a number of salary sacrifice schemes including child care vouchers and a car lease scheme. These are open to all members of staff. The individual foregoes an element of their basic pay in return for a defined benefit.
Travel expenses	Appropriate travel expenses are paid for business miles.
Declaration of gifts	As with all employees Executive and Non-Executive Directors must declare any gifts or hospitality according to Trust policy with a value in excess of £25.

With the exception of the Chief Executive, the Executive directors and dental colleagues, all other non-medical substantive employees of the Trust, are remunerated in accordance with the national NHS pay structure, Agenda for Change. The majority of the Trust's substantive medical colleagues are remunerated in accordance with national terms and conditions of service for doctors and dentists.

Up until the end of December 2017 Guidance issued by the Cabinet Office, set 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 was exceeded in the case of two executive directors during the financial year. Both executive directors occupy statutory positions and their remuneration has been benchmarked with others respectively in the same posts. The benchmarking data used was provided by NHS Improvement, included national data and related to appointments in the NHS only. The Trust's remuneration policy is transparent and no performance related elements make up the total amount of remuneration.

From 1 January 2018, the Treasury revised the threshold for senior pay controls in the NHS to £150,000 and above. However, the previous threshold of £142,500 and above still applies to any proposals made prior to this date.

Service Contracts Obligations

The contracts of employment of substantive Executive directors are standardised and contain a notice period of six months. All such contracts are open-ended but are subject to earlier termination for cause or if notice is given under the contract.

Policy on Payments for Loss of Office

There is no entitlement to any additional remuneration in the event of early termination for any of the Executive directors. During 2017/18 no Executive director received additional remuneration for loss of office.

Statement of Consideration of Employment Conditions Elsewhere in the Trust

Except for 'senior managers' (as per the definition above) Trust colleagues are subject to national Agenda for Change, or national Medical and Dental Terms and Conditions.

When setting the remuneration policy for senior managers, the pay and conditions of these employee groups was taken into consideration, and the need for a transparent policy decided.

The Trust did not consult with employees when preparing the senior managers' remuneration policy, however annual benchmarked data, including that provided by NHS Providers, was used to determine the appropriate remuneration for the Executive and Non-Executive directors during the year.

Executive salaries are in line with national executive remuneration benchmarking, and comprise a transparent process. By using benchmarking guidelines, the Trust ensures that salaries are sufficient to attract and retain high calibre candidates, and are appropriate for the benchmarked role.

No performance related bonuses or long term performance related bonuses have been paid.

No additional fees or other items that are considered to be remuneration in nature are paid.

Annual Report on Remuneration

Information not subject to audit

Service Contracts

All Executive directors who served during the year did so on substantive contracts of employment with no end dates which include a notice period of six months. With the three exceptions listed below, all of the Executive directors served for the entirety of the financial year 2017/18 (1 April 2017 to 31 March 2018).

Maxine Dennis took up the role of Acting Chief Operating Officer from 21 December 2017 and retired from service on 31 March 2018.

Ellie Monkhouse served as Acting Chief Nurse from 01 January 2017 until 01 October 2017

Chris Morley took up the role of Chief Nurse from 02 October 2017.

Executive directors who were in post prior to 1 April 2017:
Louise Barnett, employed substantively by the Trust since 1 April 2014
Simon Sheppard, employed by the Trust since 3 November 2014
Chris Holt, employed by the Trust since 6 October 2014
Conrad Wareham, employed by the Trust since 15 July 2015
Cheryl Clements, employed by the Trust since 18 April 2016

None of the Trust's Executive directors were released by the organisation to serve as a Non-Executive director elsewhere or in any other capacity.

Non-Executive directors are generally appointed on terms of three years and for up to two terms, but they can be appointed for further one year periods on an exceptional basis, as follows

Gabrielle Atmarow:
01.04.11- 31.03.13
01.04.13 – 31.3.16
01.04.16 – 31.03.17
01.04.17 – 31.03.18
01.04.18 – 31.03.19

Mark Edgell:
01.06.12 - 31.05.15
01.06.15 – 31.05.18

Barry Mellor
19.09.13 – 18.09.15
19.09.15 – 18.09.18

Joe Barnes
26.09.13 – 25.09.16
26.09.16 – 25.09.19

Lynn Hagger (Vice Chair)
01.10.13 – 30.09.16
01.10.16 – 30.09.19

Martin Havenhand (Chairman)
01.02.14 -31.01.17
01.02.17 – 31.01.20

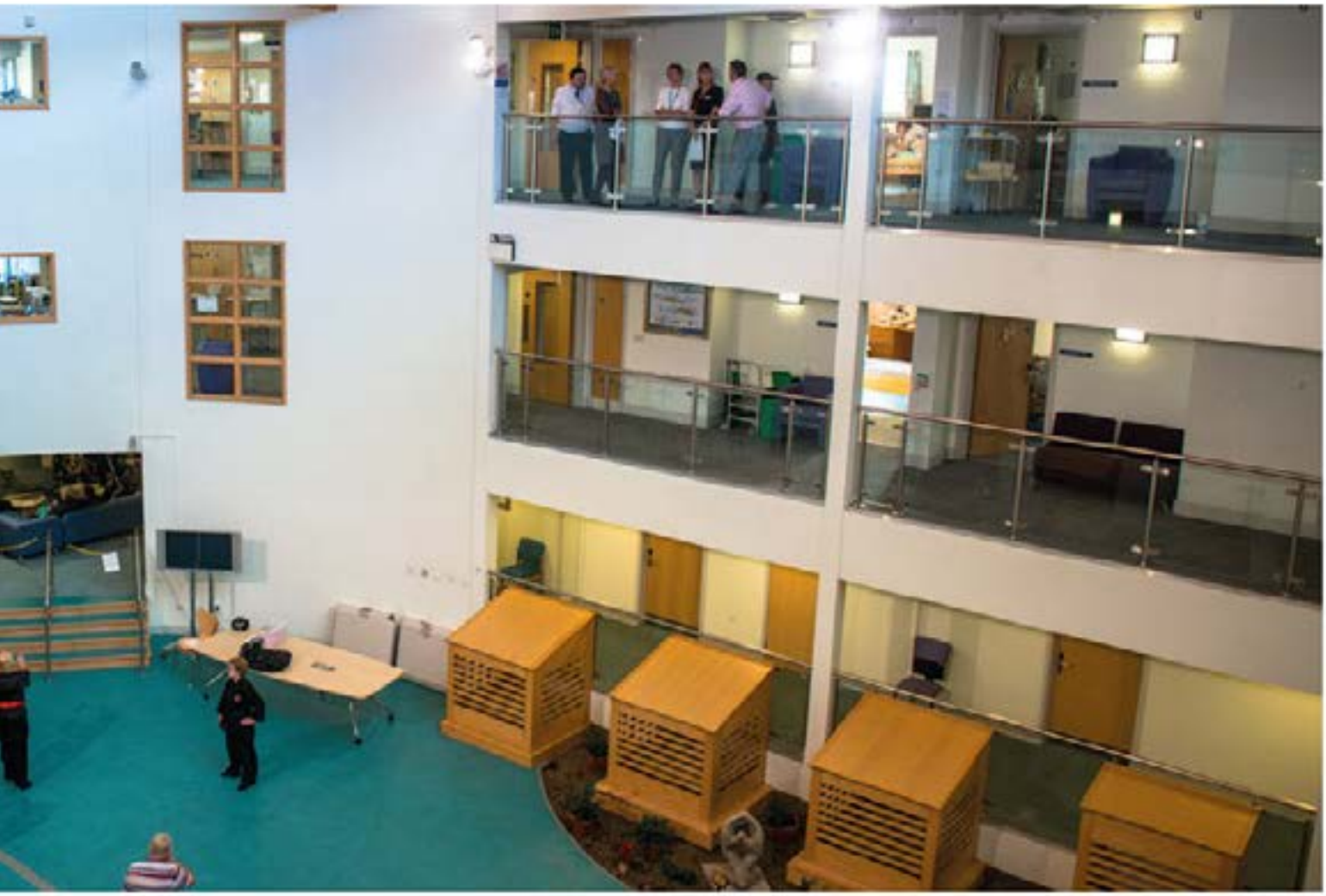
Heather Craven:
17.02.17 – 16.02.20

Dr Paul Smith[8]
01.03.17 – 12.12.17

Dr David Hannah:
11.01.18 - 10.01.20

Each of the NEDs and Chairman are able to resign by giving notice.

8 Dr Paul Smith resigned from his post as Non-Executive Director on 12 December 2017. His original three year term of office was from 01.03.17 to 29.02.20



Remuneration Committee

This committee is chaired by a Non-Executive director, Barry Mellor, and its responsibilities are set out in its Terms of Reference, which were updated during the year.

Following these Terms of Reference revisions, the Remuneration Committee continues to have delegated responsibility for determining the terms of remuneration for the Chief Executive and the Executive directors and also recommends and takes into account the structure and level of remuneration across the organisation as appropriate. Each member of the committee is considered to be independent and none has a personal financial interest in any of the Committee's decisions.

Other Trust employees attend the meeting as requested by the Chair where appropriate, including the Chief Executive, but none were party to decisions made by the Committee.

No services or advice was received by the Committee from third parties that may have materially assisted with their consideration of any matter.

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

	Barry Mellor (Chair)	Heather Craven	Lynn Hagger	Joe Barnes	Gabrielle Atmarow
25 July 2017	√	√	√	√	√
10 October 2017	√	X	√	√	√
9 Jan 2018	√	X	√	√	√
Attendance	3/3	1/3	3/3	3/3	3/3

On 1 April 2018, membership of the Remuneration Committee changed. Barry Mellor continued to chair the Committee, Joe Barnes replaced Lynn Hagger as Vice- Chair of the Committee, Gabrielle Atmarow and Heather Craven continued as members.

Not subject to audit
Disclosures required by the Health & Social Care Act

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

	Number in office		Number receiving expenses	
	2017/18	2016/17	2017/18	2016/17
Governors	28	27	4	3
Directors (including the Chair and Non-Executives)	17	16	7	5

Expenses shown in £00s	2017/18	2016/17
	£00	£00
Aggregate sum of expenses paid to Governors	6	8
Aggregate sum of expenses paid to Directors	73	28
Total	79	36

Information subject to audit

The Single Figure Total Table (1) appearing overleaf provides details of each of the components of the remuneration package for Executive Directors, who are subject to the senior managers' remuneration policy.

A separate table (2) provides details for Non-Executive Directors, whose remuneration is set by the Council of Governors.

Set out separately are details of the pension entitlements received by the Executive Directors.

Single Total Figure Table (1)

	Period 01/04/17 to 31/03/18						Period 01/04/16 to 31/03/17					
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)
Mrs L Barnett, Chief Executive	175 - 180	0	0	0	45.0 - 47.5	225 - 230	175 - 180	0	0	0	62.5 - 65	240 - 245
Mr C. Morley, Chief Nurse (from 2/10/17)	60 - 65	2	0	0	160.0 - 162.5	220 - 225						
Dr. C Wareham, Medicall Director	170 - 175	0	0	0	35.0 - 37.5	205 - 210	170 - 175	0	0	0	515.0 - 517.5	685 - 690
Mr S. Sheppard, Director of Finance	120 - 125	3	0	0	27.5 - 30.0	145 - 150	120 - 125	5	0	0	37.5 - 40.0	160 - 165
Mrs C Clements, Director of Workforce	120 - 125	0	0	0	25.0 - 27.5	145 - 150	110 - 115	0	0	0	772.5 - 775.0	885 - 890
Mr C Holt, Director of Strategy and Transformation (from 20/12/17. Previously Chief Operating Officer)	135 - 140	0	0	0	37.5 - 40.0	175 - 180	130 - 135	0	0	0	45.0 - 47.5	125 - 130
Mrs E. Monkhouse, Acting Chief Nurse (from 01/01/17 to 01/10/17)	45 - 50	4	0	0	132.5 - 135.0	180 - 185	20 - 25	4	0	0	30.0 - 32.5	50 - 55
Mrs M. Dennis, Acting Chief Operating Officer (from 20/12/17 to 31/3/18)	30 - 35	0	0	0	30.0 - 32.5	60 - 65						

Paragraph 4 - 16 inclusive of Part 3 of Schedule 8 to the Regulations requires the disclosure of the remuneration figures detailed above and includes a single remuneration for each senior manager who served during the year in tabular form as shown above.

Mr C Holt took up the post of Director of Strategy and Transformation on 20 December 2017.
Mrs M Dennis acted as Interim Chief Operating Officer from 20 December 2017 to 31 March 2018.
Mrs E Monkhouse was Acting Chief Nurse to 01 October 2017.
Mr C Morley took up the post of Chief Nurse on 02 October 2017.

Where the calculation of the increase in pension benefits results in a negative figure, this is entered as Nil in the table above. Only increases to pension benefit are shown. This is as per NHS Improvement's Foundation Trust Annual Reporting Manual.

In relation to Conrad Wareham, the amount of remuneration received during 2017/18 relates solely to his role as Medical Director.

Cash Equivalent Transfer Values (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The basis of CETV calculations are based in the Department of Work and Pensions regulations which came into force on October 13 2008. This year the CETV's shows reduction in real term in most cases due to not having any inflation factors applied.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. No inflation factors have been applied this financial year as per the guidance from NHS Pensions Agency

Single Figure Total Table (2)

The remuneration for Non-Executive Directors including the Chairman has been determined by the Council of Governors and is set at a level designed to recognise the significant responsibilities of Non-Executive Directors in foundation trusts, and to attract individuals with the necessary experience, expertise and ability to make an important contribution to the Trust's affairs.

	Period 01/04/17 to 31/03/18						Period 01/04/16 to 31/03/17					
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5000)	Long Term Performance Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)
Mr M Hazelwood, Chairman	50 - 55	0	0	0	0	50 - 55	50 - 55	0	0	0	0	50 - 55
Mrs O Attwaroe, Non-Executive Director	15 - 20	22	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr M Edgell, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr J Barnes, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mrs L Hagger, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr B Mellor, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mrs H Craven, Non-Executive Director	15 - 20	17	0	0	0	15 - 20	0 - 5	0	0	0	0	0 - 5
Mr P Smith, Non-Executive Director (to 12/12/17)	10 - 15	17	0	0	0	10 - 15	0 - 5	0	0	0	0	0 - 5
Dr D Hannah, Non-Executive Director (start 11/01/18)	0 - 5	0	0	0	0	0 - 5						

Paragraph 4 - 16 inclusive of Part 3 of Schedule 8 to the Regulations requires the disclosure of the remuneration figures detailed above and includes a single remuneration for each senior manager who served during the year in tabular form as shown above.

Dr P Smith's tenure as a Non-Executive Director ended on 12 December 2017.
Dr D Hannah took up post as a Non-Executive Director on 11 January 2018.

The Non-Executive Director remuneration framework, agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2017/18 has been consistent with this framework. No additional payments are made for any additional duties carried out.

The Non-Executive Directors accepted a 1% pay rise during 2017/18.

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

Pension Entitlements of Executive Directors

Details of pension entitlements of Executive Directors are shown above. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

Name and title	Real increase during the reporting year in pension at pension age (bands of £2,500) £000	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at 31 March 2018* (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real increase in Cash Equivalent Transfer Value (for period in post) £000	Employer's contribution to stakeholder pension £000
Mrs L. Barnett, Chief Executive	2.5 - 5.0	0.0 - 2.5	35.0 - 40.0	80.0 - 85.0	509	565	51	0
Mr C. Morley, Chief Nurse (from 2/10/17)	7.5 - 10.0	20.0 - 22.5	40.0 - 45.0	120.0 - 125.0	555	699	138	0
Dr. C Wareham, Medical Director	2.5 - 5.0	0.0 - 2.5	25.0 - 30.0	55.0 - 60.0	623	688	59	0
Mr S. Sheppard, Director of Finance	0.0 - 2.5	0.0 - 2.5	35.0 - 40.0	90.0 - 95.0	501	564	58	0
Mrs C Clements, Director of Workforce	0.0 - 2.5	5.0 - 7.5	35.0 - 40.0	110.0 - 115.0	740	826	79	0
Mr C Holt, Director of Strategy and Transformation (from 20/12/17. Previously Chief Operating Officer)	2.5 - 5.0	0.0 - 2.5	10.0 - 15.0	0.0 - 5.0	117	153	35	0
Mrs E. Monkhouse, Acting Chief Nurse (from 01/01/17 to 01/10/17)	2.5 - 5.0	2.5 - 5.0	25.0 - 30.0	60.0 - 65.0	301	390	43	0
Mrs M. Dennis, Acting Chief Operating Officer (from 20/12/17 to 31/03/18)	0.0 - 2.5	0.0 - 2.5	45.0 - 50.0	140.0 - 145.0	942	1,011	16	0

* The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary for State, in England and Wales. As a consequence, it is not possible for the Trust to identify its share of the underlying scheme assets and liabilities. Further details can be found in the Annual Accounts at note 1.2.

Fair Pay Multiple

The Trust is required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce at the reporting period end date on an annualised basis.

The banded mid-point remuneration of the highest paid director in the financial year 2017/18 was £177,500 (2016/17, £177,500). This was 7.2 times (2016/17, 7.2) the median remuneration of the workforce, which was £24,547 (2016/17, £24,554).

In 2017/18, one (2016/17, 0) employee received remuneration in excess of the highest-paid director. Remuneration ranged from £6,844 to £221,608 (2016/17 £6,453 - £180,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The median is the middle number in a sorted list of numbers. The ratio is the number of times the median can be divided into the highest paid director's total remuneration

	2017/18	2016/17
Mid-Point of Band of Highest Paid Director's Total (Remuneration £000)	**177.5**	177.5
Median Total Remuneration (000s)	**24.5**	24.6
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	**7.23**	7.23

Definition of Senior Managers

For the purposes of this Remuneration Report 'senior managers' are defined as those who influence the decisions of the Trust. This means those who influence the decisions of the Trust as a whole rather than the decisions of individual divisions or sections within the Trust. At The Rotherham NHS Foundation Trust, and for the purposes of this report, the term 'senior manager' applies to the Chair, Non- Executive Directors and Executive Directors only, whether substantive or interim.

This Remuneration Report covers all individuals who hold, or have held, office as Chairman, Non-Executive Director or Executive Director for The Rotherham NHS Foundation Trust during 2017/18, whether or not they were substantively appointed.

Senior Managers with Additional Duties

There were no payments made during 2017/18 to Senior Managers with additional duties.[9]

Payments for Loss of Office

There were no payments made during 2017/18 to Senior Managers for loss of office.

[9]FReM refers to "medical directors and similar staff", and does not include 'deputy CEO' type roles

Payments to Past Senior Managers

There were no payments made during 2017/18 to past Senior Managers.

Louse Barnett
Chief Executive
23 May 2018

Staff Report

Analysis of Staff Costs	2017/18			2016/17		
	Permanent	Other	Total	Permanent	Other*	Total
	£000	£000	£000	£000	£000	£000
Salaries & wages*	128,570	4,755	133,325	122,266	5,235	126,849
Social security costs	12,842	-	12,842	12,928	-00	12,928
Apprenticeship levy	633	-	633	-	-00	-
Employer's contributions to NHS pensions	15,848	-	15,848	15,284	-00	15,284
Pension cost - other	19	-	19	25	-00	25
Termination benefits	83	-	83	-	-00	-
Temporary staff - agency/contract staff	-	10,453	10,453	-	12,518	12,518
TOTAL GROSS STAFF COSTS	**157,996**	**15,208**	**173,204**	**150,503**	**17,753**	**167,604**
Of which: Costs capitalised as part of assets	61	6	67	239	413	652

*'Other' staff includes secondments in and trainee medial staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation. This re-categorisation is also reflected in prior year analysis.

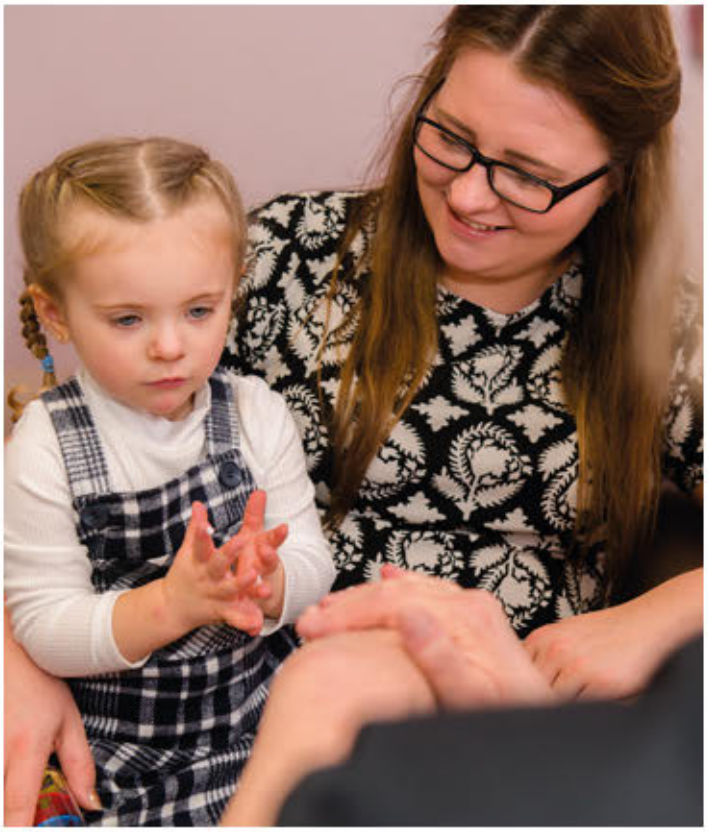
Analysis of Staff: Average Number of Employees (WTE basis)	2017/18			2016/17		
	Permanent No.	Other* No.	Total No.	Permanent No.	Other** No.	Total No.
Medical and dental	315	102	417	289	116	405
Ambulance staff	-	-	-	-	-	-
Administration and estates	1,043	7	1,049	1,019	9	1,028
Healthcare assistants and other support staff	812	1	813	793	7	800
Nursing, midwifery and health visiting staff	1,162	41	1,203	1,162	59	1,221
Nursing, midwifery and health visiting learners	-	-	-	-	-	-
Scientific, therapeutic and technical staff	417	10	427	392	15	407
Social care staff	-	-	-	-	-	-
Healthcare Science Staff	89	-	89	87	-	87
	3,838	**161**	**3,998**	**3,741**	**206**	**3,948**
Of which: Number of employees engaged on Capital projects	2	0	3	2	0	13

*2016/17 categorisation restated to reflect current year improvements in categorisation.
**'Other' staff includes secondments in, and trainee medial staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation. This re-categorisation is also reflected in prior year analysis.

Analysis of Staff: Gender of Staff

As at end March 2018 the breakdown of Trust employed staff by gender was as follows:

	Male	Female	Total
Executive Directors	4	3	7
Non-Executive Directors	5	3	8
Employees	864	4098	4962
Total	873	4104	4977



Sickness Absence Data

The Trust's overall sickness absence level for the year was 3.98%. The Trust reduced sickness absence over the year despite a peak of 5.03% in January 2018.

Figures showing average sick days per Full Time Equivalent (FTE), rather than overall sickness absence as a percentage, are below, with data having been provided by NHS Digital, and based on the 2017 calendar year:

Figures converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2017	Adjusted FTE days lost to Cabinet Office Definitions	Average Sick Days per FTE	FTE - Days Available	FTE - Days Lost to Sickness Absence
3,709	33,969	9.2	1,353,873	55,105

Note:

Source: NHS Digital - Sickness Absence and Publication – based on data from the ESR Data Warehouse

Period covered: January to December 2017

Data items: ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365 – day year.

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 (with a further adjustment where the figures are based on less than 12 months' data).

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 (with a further adjustment where the figures are based on less than 12 months' data).

Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE – days sick by the average FTE, and multiplying by 225 (the typical number of working days per week).

Staff policies and actions applied during the financial year

The Trust has a suite of policies, procedures and initiatives in relation to the workforce in order to support colleagues in their roles. Some of the key policies and actions are detailed below.

The introduction of the Workforce Disability Equality Standard (WDES) is a positive step forward for disabled people working in both the NHS and at the Trust and signals widespread recognition amongst NHS leaders of the significant contribution that disabled staff make to workforce equality and to patient care and will form a key strand of the Trust's equality agenda over the next year.

A review of the Trust's approach to equality, across all the protected interest groups, and respecting basic human rights has been undertaken and the outputs from this review will now shape the work plan and renewed membership of the Equality & Diversity Steering Group in 2018/19. The proposal sets out to strengthen and deepen the equality and diversity agenda and build on the previous Equality Schemes and action plans. It incorporates information on the Trust's approach to equal opportunities for staff in relation to recruitment, training and promotion and therefore replaces the need for a dedicated Equal Opportunities Policy.

The Recruitment, Selection and Promotion Policy contains full information on the processes for recruitment and the various Training Policies contain information on access to training for staff.

The organisation's policy in respect of disabled applicants who clearly indicate that they wish to be considered for a post under the 'Positive about Disability Scheme' is that they will be shortlisted and invited for interview where they meet the requirements for the post.

Trust managers, with the help from the Workplace Health and Wellbeing team and Human Resources, regularly make workplace modifications for staff that are reasonable and ensure that disabled colleagues can not only continue in their role with the Trust but also seek promotion opportunities. Work is undertaken on a proactive basis, where applicable, with outside agencies to help support the continued employment and promotion of colleagues.

The Learning and Development department acts as a contact point for all colleagues for special requirements for training provided by the Trust. In this way the organisation ensures that reasonable adjustments are made to support colleagues who disclose a disability which may mean they require extra support with their learning and development.

All colleagues have access to local workforce development programmes and training courses; colleagues discuss their training needs with their line manager during their annual appraisal, at one-to-one meetings or at other times, as arranged locally.

The Trust continues to strive for continuous improvement and to prioritise engagement with colleagues, setting high standards, learning from colleague experience, and strengthening partnership working. Ensuring active colleague involvement in the management and direction of services at all levels is achieved through valuing colleagues, listening and responding to their views and monitoring quality workforce indicators. Equally, the organisation acknowledges that its colleagues should have confidence that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship.

There are a number of mechanisms through which information is communicated to employees. These include weekly all user e-mails and bulletins, monthly Team Brief, departmental meetings, ad hoc briefings, Twitter and Facebook accounts, personal letters, and pay slip messages and attachments. The 'Dear Louise' facility is also available to enable colleagues to ask questions of the Chief Executive (anonymously if desired). The method(s) used will be the most appropriate for the particular information to be conveyed but one or more methods will be used for all matters of importance.

There is a colleague intranet which provides information regarding the latest changes and developments as well as routine information. Not all clinical and support colleagues use electronic communication methods and consequently, managers are asked to make all colleagues aware of information communicated by electronic means.

The weekly all user e-mails, the intranet and Team Brief are all used as a means of conveying official information, as appropriate, which is of benefit to colleagues in a social, personal and developmental way. Examples include reporting on the achievements of colleagues, benefits and services available, activities and events taking place, health related information and offers. There are separate pages on the intranet for colleague health, benefits and wellbeing offering an extensive range of discounts and contacts as well as sources for support, development and training.

Colleagues are actively engaged with and their feedback obtained on matters being communicated. This occurs through the 'Team Brief' process, Colleague Forum and through the regular meetings of the Joint Partnership Forum and Local Negotiating Committee where Trade Unions and professional association representatives meet with senior managers to discuss issues affecting staff and local conditions of service. A sub group of the Joint Partnership Forum, the Joint Policy Group, agrees and updates HR policies in line with current employment law and ensures they have broad agreement within the organisation. The Local Negotiating Committee is the forum for medical and dental staff.

All Trust policies are available on the intranet for colleagues, including the extensive range of HR policies, many of which are about services available directly in support of colleagues. Examples include: Special Leave, Flexible Working, Managing Attendance, Health and Wellbeing policies, Freedom to Speak Up (Raising Concerns) and Shared Parental Leave.

The Trust recognises that valuing and celebrating the achievements of the workforce is essential to enable the future growth and development of the organisation and the individuals who are part of it. This was demonstrated when specific events were arranged to support: Innovation Week, Values Week and PROUD Week culminating in an awards ceremony for colleagues held on 01 December 2017.

Health & Safety and Occupational Health

A fourth consecutive gold award was received by the Trust for preventing accidents on its hospital and community sites from the Royal Society for the Prevention of Accidents (RoSPA), as part of their RoSPA Occupational Health and Safety Awards 2017/18. Only organisations able to maintain continued high standards in health and safety achieve the gold award.

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

During 2017/18 the WH&WB service continued to deliver high quality interventions to all employees, supporting a healthier, fitter workforce and supporting the Trust's objective to reduce sickness absence.

Countering fraud, bribery and corruption

The Trust's Chief Executive and Director of Finance are jointly responsible for ensuring adherence to the NHS Counter Fraud Authority (NHSCFA) Anti-Crime Strategy for countering fraud, bribery and corruption. The NHSCFA is responsible for ensuring the quality of measures to counter fraud, bribery and corruption within NHS Foundation Trusts.

Service condition 24.2 of the NHS Standard Contract 2017 to 2019 sets out the Trust's obligations, to safeguard NHS funds and resources through compliance with 24 standards for countering fraud, bribery and corruption:

Strategic Governance (7 standards). Covers standards in relation to the Trust's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

Inform and Involve (4 standards). Covers requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of fraud, bribery and corruption against the NHS.

Prevent and Deter (6 standards). Covers the requirements in relation to discouraging individuals who may be tempted to commit fraud against the NHS and ensuring that opportunities for crime to occur are minimised.

Hold to Account (7 standards). Sets out the requirements in relation to detecting and investigating economic crime, obtaining sanctions and seeking redress.

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

During 2017/18, counter fraud activity has focussed on activities to ensure compliance with NHSCFA standards and to address areas of heightened risk including:

- Cyber-crime
- Staff secondary working
- Bank and Agency Staff
- Mandate Fraud
- Declarations of interests
- Overseas Visitors

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

Where fraud is identified or reported it is robustly investigated in accordance with the Trust's Fraud, Bribery and Corruption policy. During 2017/18, 7 referrals of suspected fraud, bribery or corruption were made to the CFS, demonstrating a good awareness and understanding of the Fraud, Bribery and Corruption policy.

Staff Survey – Commentary Colleague Engagement

A wealth of evidence shows that organisation performance is critically dependent on the health and wellbeing of the staff employed. Many studies have identified an association between many factors such as staff satisfaction, management practice, workload and engagement. The net result, in particularly, colleague engagement (measures of advocacy, involvement and motivation) are imperatives of good performance and can be intrinsically linked to patient satisfaction, patient mortality and measures of good performance.

The Board of Directors is committed to supporting the organisation to be a high performing Trust. In line with our core values our ambition is to be in the top 20% of NHS Trusts according to the National Staff Survey results.

The Trust continues in its ambition to continuously improve and supports staff engagement in setting high standards, learning from staff experience, and working together in line with our core values – ambitious, caring, together.

Key to successfully engaging with colleagues we continue to deliver the Together We Can programme. Throughout the year 14 clinical and non-clinical teams have utilised Together We Can (TWC) methodology to successfully support and deliver organisational change. TWC puts colleagues at the heart of change using the 'Five Factors to Success' methodology. Each team was able to demonstrate the improvements achieved and this was shared with colleagues to inspire others to be ambitious and promote grass roots changes.

The Trust works to engage with staff on the information disseminated and seeks to gain feedback and intelligence on matters relating to working within the organisation.

Every quarter the Friends and Family Test for Staff 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.

Team Brief is a monthly opportunity for 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 cascaded throughout the organisation via the divisional structure.

Summary of performance – Results from the NHS staff survey

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.

The 2017 Trust National Staff Survey was facilitated through the Picker Institute Europe in Quarter 3. The Picker Institute was commissioned by 20 NHS organisations classified as Acute Community Trusts. The Trust undertook a full census of eligible employees, achieving a 41.5 % response rate (an increase from last year); a mixed census 50:50 online/ paper survey was undertaken to maximise front-line participation.

The overall colleagues' engagement score shows a small decline from last year in line with many other trusts. The Trust recognises the importance of having an organisation where its workforce feels engaged and is committed to taking specific improvement activities and plans dependent on service feedback.

The areas of improvement from the prior year and deterioration

Key areas of improvement

- Fewer experiences of harassment, bullying and abuse have gone unreported
- More adequate adjustment(s) are made to enable disabled employees to carry out their work
- Fewer staff work additional paid hours per week for the organisation
- Fewer staff experience harassment, bullying or abuse from managers
- More immediate managers are supportive in a personal crisis

Areas of Deterioration

Our overall staff engagement score has identified a slight decline from last year; whilst this is not desirable, the national overall engagement score has also seen a small decline.

From the staff survey benchmarking analysis out of the 32 key findings 8 have improved, 5 have maintained and 19 have deteriorated.

	2016/17 (previous year)	2017/18 (current year)		Trust improvement / deterioration
	Trust	Trust	Benchmarking group (trust type) average	
Response rate	40.8%	41.5%	43.0%	Improvement

Top 5 ranking scores				
	2016/17 (previous year)	2017/18 (current year)		Trust improvement / deterioration
	Trust	Trust	Benchmarking group (trust type) average	
Percentage of staff appraised in the last 12 months	93%	94%	86%	Improvement
Percentage of staff working extra hours	68%	65%	71%	Improvement
Percentage of staff experiencing discrimination at work in the last 12 months	9%	8%	10%	Improvement
Percentage of staff witnessing potentially harmful error, near misses or incidents in last month	24%	25%	29%	Deterioration
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	20%	24%	27%	Deterioration

Bottom 5 ranking scores				
	2016/17 (previous year)	2017/18 (current year)		Trust improvement / deterioration
	Trust	Trust	Benchmarking group (trust type) average	
Staff motivation at work*	3.82	3.80	3.91	Deterioration
Percentage of staff agreeing that their role makes a difference to patients/service users	89%	86%	90%	Deterioration
Percentage of staff reporting good communication between senior management and staff	28%	24%	33%	Deterioration
Quality of appraisals*	2.98	2.90	3.11	Deterioration
Effective team working*	3.76	3.65	3.74	Deterioration

* Scale summary score out of 5 (1 = poor, 5 = high)

Areas of Concern and Action Plans to Address

The Trust will focus on the following as a priority:

- Colleagues being happy with the standard of care if a relative or friend needed treatment
- Staff always recommending the organisation as a place to work
- Care of patients/service uses being the organisation's top priority
- Communication between senior management and staff always being effective
- Treating staff involved with errors fairly
- Improve the quality of appraisals
- Develop, standardise and embed divisional communication cascade to include actions resulting from NSS results and associated improvements
- Review our approach to departmental visits (Board to Floor)
- NSS agenda items to be standard in senior divisional meetings including performance meetings and corporate meetings

Future Priorities and Targets – Statement of Key Priorities

Our key priorities remain putting colleagues at the heart of decision making and service transformation to ensure opportunities to learn from colleagues' experience and knowledge is harnessed.

Performance against priority areas

Whilst we embarked on the implementation of new appraisal documentation it is clear that we still need to undertake appropriate training to staff groups where the quality of appraisal has dipped.

We need to review and improve our engagement strategy to represent the views of colleagues as detailed in the National Staff Survey and build on the Together We Can methodology.

Future priorities and how they will be measured

Performance will be monitored through the Committee structures in place including the Operational Workforce Committee and the Strategic Workforce Committee and ultimately the Board.
Where we undertook deep dive analysis of services RAG rated red improvements in engagement were developing however where service redesign has resulted in staff consultation the improving performance has dipped.

Locally, each division will develop key focus areas based on the National Staff Survey findings driven by the HR Business Partners. The wider engagement activities will be monitored through the Operational Workforce Committee, chaired by the Executive Director of Workforce. The action of this committee and any associated work plans will provide the appropriate assurance to the Strategic Workforce Committee members.

Equality Reporting

Workforce Race Equality Standard (WRES) and Public Sector Equality Duty (PSED) data, staff survey data, data from NHS jobs and census data all provide assurance in this area. The implementation of the Workforce Disability Equality Standard (WDES) during 2018 will further strengthen the Trust's approach to equality; ensuring that the organisation remains a fully inclusive one offering opportunities to all colleagues and the community as a whole.

Alongside WRES and WDES, the Trust continues to use the Equality and Diversity Systems (EDS2) to assist in discussions with local partners including local populations and review and improve performance for people with characteristics protected by the Equality Act 2010. By using the EDS2 and the WRES, the Trust is able to deliver on the Public Sector Equality Duty.

All recruitment campaigns are managed in line with the Trust's policy, this policy has been impact assessed and identifies no immediate issues. As part of the WRES implementation the Trust identified an improvement opportunity in relation to how the organisation records equality data for training and development: collection of this data will allow an improved grade to be considered.

Feedback in relation to the application process for dual sensory loss applicants indicates that further work is required in this area and also that further work could be undertaken to encourage and support applications from applicants with learning difficulties. These will be areas for priority action in the new financial year and will be progressed by the Trust's Equality & Diversity Steering Group which reports to the Operational Workforce Committee.

Training is available for all colleagues and covers all protected groups with bespoke training available for gender reassignment. This training allows middle managers to support colleagues in creating and maintaining a culturally competent work environment which is ultimately free from discrimination.

Expenditure on Consultancy

Consultancy costs during 2017/18 were £1.137m. These include £1.017m of costs related to external support for transformation and efficiency programmes. This represents the Trust's commitment to improving its efficiency and effectiveness via changes to ways of working

Staff Exit Packages

The table below summarises the total number of exit packages agreed during the year. Included within these are compulsory redundancies and other schemes including MARS (Mutually Agreed Resignation Scheme) applications. The table opposite shows packages agreed in year, irrespective of the actual date of accrual or payment.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this table are the full costs of departures agreed in the year. Where The Rotherham NHS Foundation Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Exit package cost band	Number of compulsory redundancies		Number of other non-compulsory departures agreed		Total number of exit packages by cost band	
	2017/18	2016/17	2017/18	2016/17	2017/18	2016/17
<£10,000	0	1	19	0	19	1
£10,000 – £25,000	1	1	3	0	4	1
£25,001 – £50,000	0	2	0	0	0	2
£50,001 – £100,000	1	0	0	0	1	0
£100,001 – £150,000	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	2	4	22	0	24	4
Total resource cost £000s	83	101	94	0	177	101

Analysis of non-compulsory departure payments

The table below discloses non-compulsory departures and values of associated payments by individual type. The table shows packages agreed in year, irrespective of the actual date of accrual or payment. As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number below will not necessarily match the total numbers in the Exit Packages table above which will be the number of individuals.

	Number of Agreements		Total Value of Agreements £000	
	2017/18	2016/17	2017/18	2016/17
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice*	22	1	94	31
Exit payments following employment tribunals or court orders	0	1	0	1
Non-contractual payments requiring HMT approval**	0	0	0	0
Total	22	2	94	32
of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

*Any non-contractual payments in lieu of notice is disclosed under "non-contractual payments requiring HMT approval" above.

*Includes any non-contractual severance payment made following judicial mediation and amounts relating to non-contractual payments in lieu of notice. The Remuneration Report includes exit payments payable to individuals named in that Report where applicable.

Off Payroll Engagements

The decision to appoint Board members or senior officials with significant financial responsibility through an off-payroll arrangement is made at a very senior level for exceptional operational reasons.

The standard process during 2017/18 was to seek assurance for all off payroll workers that they were compliant with IR35 and that all relevant taxes were being paid.

Table 1: For all off - payroll engagements as of 31st March 2018, for more than £245 per day and that last for longer than six months.

Number of existing engagements as of 31 Mar 2018	**0**
Of which:	
Number that have existed for less than one year at time of reporting.	0
Number that have existed between one and two years at time of reporting.	0
Number that have existed between two and three years at time of reporting.	0
Number that have existed between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

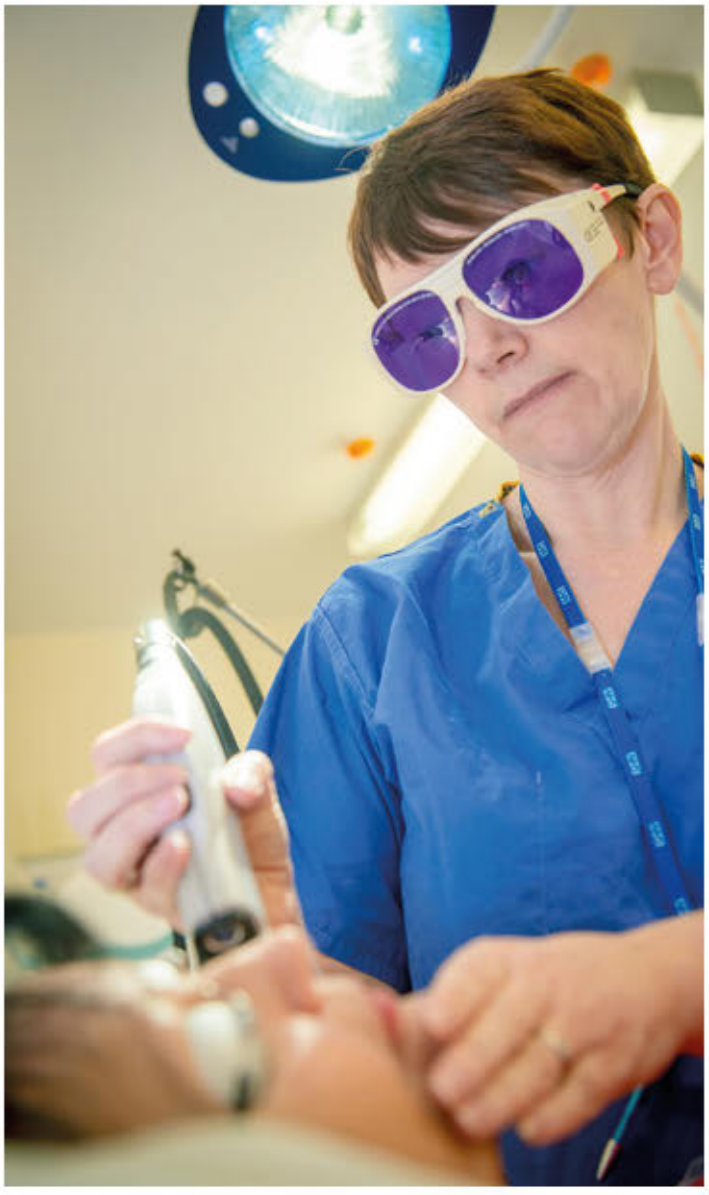
Table 2: for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	**0**
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on- payroll engagements.*	8

* There are 7 Board member posts. In year there have been two Chief Nurses.



Governance and Organisational Structure

Board of Directors

The Board of Directors 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. It uses best practice standards as part of its governance framework.

The Board of Directors ('the Board') is legally accountable for the services provided by the Trust, and its key responsibilities include:

- Setting the strategic direction (having taken into account the Council of Governors' views)
- Ensuring that adequate systems and processes are maintained to deliver the Trust's annual Operational Plan
- Ensuring that its services provide safe, clean, high quality and professional care for patients
- Ensuring robust governance arrangements are in place supported by an effective assurance framework which supports sound systems of internal control including the appointment and dismissal of Board Committees
- Ensuring rigorous performance management which enables the Trust to continue to achieve local and national targets
- Seeking continuous improvement and innovation
- Measuring and monitoring the Trust's effectiveness and efficiency
- Approving proposed expenditure above specified financial limits
- Ensuring that the Trust, at all times, remains compliant with its Licence, as issued by NHS Improvement
- Exercising the powers of the Trust established under statute, as described within the Trust's Constitution

The Board is also responsible for establishing the values and standards of conduct of the Trust and its 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' which encapsulate the ethical standards expected of individuals who hold public office)[10]. During 2017/18 this included ensuring the Trust's systems were compliant with NHS England's Conflicts of Interest guidance which came into force in June 2017.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the *Matters Reserved for the Board and Scheme of Delegation*.

The Board receives monthly updates on performance and delegates management, through the Chief Executive to the Executive Directors, for the overall performance of the organisation which is conducted principally through the setting of clear objectives and ensuring that the organisation is managed efficiently and to the highest standards in keeping with its values.

Composition of the Board of Directors

The Board of Directors is composed of both full-time Executive and part-time Non-Executive Directors. The Non-Executive Directors are appointed by the Governors from the Trust's membership and are chosen for their broad business, clinical or other experience.

The Non-Executive Directors include individuals specifically appointed due to their financial and/or commercial experience, existing knowledge of the NHS, educational backgrounds, voluntary and charitable sector experience.

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

The Board's mixture of skills, knowledge and experience is considered appropriate, balanced and complete for the challenges facing its Directors. 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 and objective setting for the Chairman is undertaken jointly by the Senior Independent Director and the Lead Governor. The performance appraisal for the Non-Executive Directors is undertaken by the Chairman in conjunction with the Lead Governor. Both appraisal processes are informed by a collective view on each individual Non-Executive Director's performance provided by the Executive Directors.

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

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

The Board Assurance Framework, which has undergone further development throughout 2017/18, provides a comprehensive review of the performance of the Trust against the agreed plans and strategic objectives. It is also the mechanism through which the risks to the achievement of the Trust's strategic objectives are identified, mitigated and managed.

[10] https://www.gov.uk/government/publications/the-7-principles-of-public-life

Martin Havenhand
Chairman

Louise Barnett
Chief Executive

Lynn Hagger
Non-Executive Director / Vice Chair

Mark Edgell
Non-Executive Director

Gabrielle Atmarow
Non-Executive Director / Senior Independent Director

Joe Barnes
Non-Executive Director

David Hannah
Non-Executive Director

Barry Mellor
Non-Executive Director

Heather Craven
Non-Executive Director

Chris Holt
Deputy Chief Executive / Director of Strategy and Transformation

Conrad Wareham
Medical Director

Chris Morley
Chief Nurse

Simon Sheppard
Director of Finance

Cheryl Clements
Director of Workforce


THE LARYNX
NURSING

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. Details provided for those in post as at 31 March 2018.

Non-Executive Directors

All Non-Executive Directors on the Board of Directors are considered to be independent. The Trust's policy in relation to Non-Executive 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 serve up to 6 consecutive years on the Board of Directors. A Non-Executive Director may, in exceptional circumstances, serve longer than six years; however, this arrangement is subject to annual review in accordance with the *Code of Governance for NHS Foundation Trusts.*

Martin Havenhand
Chairman

Martin is a very experienced Chairman and Non-Executive Director. He has a wealth of Executive and Non-Executive experience from both the public and private sectors and is knowledgeable and experienced in regulated industries.

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

The Council of Governors re-appointed Martin as Chairman at their meeting in July 2016 for a further three-year term effective from February 2017.

As Chairman Martin chairs the Board of Directors, the Board Nominations Committee, and the Strategy and Transformation Committee. He is also the Chair of the Council of Governors' meetings and the Chair of the Governors' Nominations Committee.

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 on page 185.

Gabrielle Atmarow
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 at the Department of Health. She has a strong commitment to the achievement of the highest standards for the patient experience wherever care is delivered.

From 2009 to 2016 she was a member of the Board of Governors of Leeds Beckett University.

Gabrielle was appointed as a Justice of the Peace in 2008 and serves as a Magistrate on the Leeds Adult Bench and is also a Family Justice. She views this responsibility as both humbling and a privilege.

Once a Non-Executive Director has served for six years, the NHS Foundation Trust Code of Governance states that Non-Executive Directors should be subject to annual re-appointment following a rigorous review. Having served six years as a Non- Executive Director of the Trust such a review was undertaken by the Council of Governors' Nomination Committee in June 2016. As a result, the Council of Governors re-appointed Gabrielle at their meeting in July 2016 for a further one-year term of office from April 2017 to provide a clinical perspective through to the completion of the Emergency Centre in 2017. At the Council of Governors meeting in April 2018 it was agreed that due to exceptional circumstances in the increase of the Board composition, Gabrielle should be appointed for a further one-year term of office from April 2018.

During 2017/18 Gabrielle was the Trust's Senior Independent Director. She was also Chair of the Charitable Funds Committee (The Rotherham Hospital and Community Charity), Vice Chair of the Finance and Performance Committee, the Vice Chair of the Quality Assurance Committee and a member of the Remuneration Committee.

Gabrielle became Chair of the Strategic Workforce Committee, remained as Vice-Chair of the Finance & Performance Committee, continued as a member of the Remuneration Committee and stepped down from her position as Chair of the Charitable Funds Committee whilst continuing as a member of this Committee.

Heather Craven
Non-Executive Director

Heather is a Chartered Accountant who trained with KPMG and has spent most of her career working across a wide spectrum of industries at director levels including FTSE and AIM listed companies.

Since 2006 she has helped a number of organisations to identify operational and financial issues and weaknesses and has delivered solutions to resolve those problems. Heather is committed to using her skills and experience to assist the Trust in meeting the challenges it faces in delivering a quality healthcare service.

Heather joined the Trust in February 2017. During 2017/18 she was Chair of the Finance and Performance Committee, a member of the Quality Assurance Committee, and the Remuneration Committee.

From 1 April 2018 Heather remained as Chair of the Finance & Performance Committee, became a member of the Strategic Workforce Committee and continued as a member of the Remuneration Committee.

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. He spent most of his career with British Coal and the Coal Pension Funds and he is a qualified accountant.

In July 2016 the Council of Governors re-appointed Joe for a further three-year term of office from September 2016.

During 2017/18 Joe was the Chair of the Audit Committee and a member of the Finance and Performance Committee.

From 1 April 2018 Joe became the Trust's Senior Independent Director.

He continued as Chair of the Audit Committee and as a member of the Finance & Performance Committee. He became Vice-Chair of the Remuneration Committee.

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.

Through his role at the Trust and his passion for ensuring local people enjoy high quality public services that effectively meet their needs, Mark will seek to help The Rotherham NHS Foundation Trust meet its challenges, both now and in the future.

During 2017/18 Mark was Chair of the Quality Assurance Committee and member of the Strategy and Transformation Assurance Committee and Vice Chair of the Board's Nomination Committee.

From 1 April 2018 Mark continued as Chair of the Quality Assurance Committee and member of the Strategy & Transformation Committee. He stepped down from his position as Vice-Chair of the Board's Nomination Committee and continued to serve as a member of this Committee.

Once a Non-Executive Director has served for six years at the Trust the NHS Foundation Trust Code of Governance states that Non-Executive Directors should be subject to annual re-appointment following a rigorous review.

Having served six years as a Non-Executive Director of the Trust such a review was undertaken for Mark by the Council of Governors' Nomination Committee in September 2017. As a result, the Council of Governors re-appointed Mark at their meeting in October 2017 for a further two-year term of office from 01 June 2018, subject to annual review, to maintain continuity on the Quality Assurance Committee which is chaired by Mark.

Lynn Hagger
Non-Executive Director and Vice-Chair

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

Lynn has published extensively in this area including two books: T*he Child as Vulnerable Patient: Protection and Empowerment* and *A Good Death: Law and Ethics in Practice*. In parallel with these activities, Lynn has been involved in the NHS for over 25 years, mostly as a Non-Executive Director of acute hospital boards, and including as Chair of Sheffield Children's NHS Foundation Trust and Non-Executive Director at Leeds Teaching NHS Trust.

During 2017/18 Lynn was Chair of the Strategic Workforce Committee, a member of the Audit Committee, and Vice Chair of the Remuneration Committee. From 1 March 2017 Lynn also became Vice Chair of the Board of Directors.

From 1 April 2018 Lynn became Vice-Chair of the Strategy & Transformation Committee, the Board's Nomination Committee and the Charitable Funds Committee and joined the Quality Assurance Committee as a member.

The Council of Governors re-appointed Lynn for a further three-year term of office with effect from October 2016 at their meeting in July 2016.

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, 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. After NHS Logistics, Barry was Commercial Director for Sheffield City Council and as Chair of the Yorkshire & Humber Strategic Procurement Group has worked closely with Rotherham Council.

For part of the year, Barry was also a Non-Executive Director of Derbyshire Healthcare NHS Foundation Trust, a mental health organisation, but stepped down from this role on 31 December 2017.

During 2017/18 Barry was Chair of the Remuneration Committee, Vice Chair of the Strategic Workforce Committee and a member of the Strategy and Transformation Assurance Committee.

From 1 April 2018 Barry continued as Chair of the Remuneration Committee and became Vice-Chair of both the Audit Committee and the Strategic Workforce Committee. He also took over the Chairmanship of the Charitable Funds Committee. Barry is also Chair of the Organ Donation Committee.

David Hannah
Non-Executive Director (from 11 January 2018)

David is a recently retired GP, having completed 30 years as a GP principal in a large practice north of Nottingham, with a similar a socioeconomic demographic to Rotherham.

As a GP he was actively involved in commissioning health services and was a founder member of the Nottingham Total Commissioning Project. He was particularly involved in commissioning children's and young people's services in Nottinghamshire, an interest which resulted in him becoming the GP representative on the Nottinghamshire County Council Children's Trust Board.

David has always been motivated by the vision to provide the best possible health care for his patients and those in the wider locality. He hopes to bring his skills and experience from a background in Primary Care and CCG work to The Rotherham NHS Foundation Trust and to add a new diversity to the Board of Directors' composition.

David is Vice-Chair of the Quality Assurance Committee. He is also a member of the Audit Committee, Strategy & Transformation Committee and the Board's Nominations Committee.

Executive Directors

Louise Barnett
Chief Executive

Louise Barnett is Chief Executive of The Rotherham NHS Foundation Trust. She joined the Trust as interim Chief Executive in October 2013, prior to being appointed to the substantive position in April 2014.

Louise has a wealth of experience, having worked at a senior level in both the public and private sectors.

Louise has held a number of NHS board positions, including Non-Executive Director at Sherwood Forrest Hospitals NHS Foundation Trust, and Interim Chief Executive at Peterborough and Stamford Hospitals NHS Foundation Trust.

Louise is a Chartered Fellow of the Chartered Institute of Personnel and Development, a Fellow of the Chartered Management Institute and Chair of the Yorkshire and Humber Regional Leadership Council.

Chris Holt
Director of Strategy & Transformation and Deputy Chief Executive

Chris Holt joined the Trust in October 2014 as Chief Operating Officer with responsibility for ensuring the safe and effective day-to-day operational performance of the organisation. Prior to joining The Rotherham NHS Foundation Trust, Chris spent 3 years at Mid Staffordshire NHS Foundation Trust as Deputy / Chief Operating Officer following the Francis inquiry and supported the organisation through the administration process.

Before taking the decision to join the NHS, Chris spent a number of years working with healthcare organisations across both primary and secondary care in England and Scotland as well as roles across the private and public sectors (working for KPMG / Atos) and 10 years working for Alstom Transport in the UK and across Europe.

Chris is passionate about improving the health and wellbeing of the local population. He is a strong believer in the closer integration of the health and social care agenda and in providing strong community based care services to ensure that the Trust continues to deliver excellent services and a safe and first class experience for all.

In February 2017 Chris became the Director of Strategy and Transformation and Deputy Chief Executive.

Cheryl Clements
Director of Workforce

Cheryl Clements is the Trust's Director of Workforce and joined the organisation in April 2016. She began her NHS career as an adult and children's nurse, training in Sheffield. She worked in Rotherham at the hospital, as a Staff Nurse in the 1980's, a Ward Sister in Doncaster, Head of Education in Chesterfield and has general management and teaching experience. She is committed to supporting and developing staff to provide excellent health care.

Cheryl has held Director posts in a variety of provider and commissioning organisations, acute care, PCTs, Community care, Mental Health and Learning Disability Services. She joins the Trust from Coventry and Warwickshire Partnership Trust.

Maxine Dennis
Acting Chief Operating Officer (from 20 December 2017)

Maxine is a dually qualified nurse being qualified in both adult and paediatric nursing. The majority of her clinical nursing career was in Leeds, working in a number of adult and paediatric critical care environments. Maxine became a Nurse Manager at the Leeds Teaching Hospitals NHS Trust and whilst there successfully completed the Institute of Health Service Management Diploma and an MA in Health Service Studies.

Maxine came to Rotherham in 1999, initially as the General Manager / Senior Nurse for Child Health, but subsequently held several different posts at the Trust culminating in the Director of Operations role. She was the Acting Chief Operating Officer from December 2017 up until her retirement on 31 March 2018.

Chris Morley
Chief Nurse (from 2 October 2017)

Chris joined the Trust in October 2017 from Sheffield Teaching Hospitals NHS Foundation Trust where he held the role of Deputy Chief Nurse.

He has previously held a number of leadership roles in healthcare governance, patient safety and nursing management. Chris possesses a BMedSci in Professional Nursing Studies from the University of Sheffield and an MSc in Health and Social Care Leadership from Sheffield Hallam University.

He was the Chair of the Association of United Kingdom University Hospitals Deputy Nurse Director Group between September 2016 and October 2017.

Simon Sheppard
Director of Finance

Simon Sheppard joined the Trust in November 2014 from the University Hospitals of Leicester NHS Trust where he was Acting Director of Finance and, before that, Deputy Director of Finance and Procurement.

Simon started in the NHS on the Graduate Management Training Scheme and has over 20 years' experience at a senior level in large acute teaching hospitals including the Nottingham University Hospitals NHS Trust.

Conrad Wareham
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.

Attendance at Board of Directors' Meetings 2017/18

	Martin Havehand (Chair)	Gabrielle Atmarow	Joe Barnes	Heather Craven	Mark Edgell	Lynn Hagger	David Hannah	Barry Mellor	Paul Smith		Louise Barnett	Cheryl Clements	Maxine Dennis	Chris Holt	Ellie Monkhouse	Chris Morley	Simon Sheppard	Conrad Wareham
2017																		
25 April	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y		Y	Y		Y	Y
23 May	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y		Y	N		Y	Y
26 May (extra)	Y	N	N	Y	Y	N		N	N		Y	N		N	Y		Y	N
27 June	Y	Y	Y	Y	N	Y		Y	Y		Y	Y		Y	Y		Y	Y
14 July (extra)	Y	N	Y	N	N	N		N	Y		Y	N		Y	N		Y	N
25 July	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y		Y	Y		Y	Y
29 August	Y	Y	Y	N	Y	Y		Y	Y		Y	Y		N	Y		Y	N
26 September	Y	Y	N	Y	Y	Y		Y	Y		Y	Y		Y	Y		Y	Y
31 October	Y	Y	Y	Y	N	Y		Y	Y		Y	N		Y		Y	Y	Y
28 November	Y	Y	Y	Y	Y	Y		Y	Y		Y	N		Y		Y	Y	N
19 December	Y	N	Y	Y	Y	Y		Y			Y	Y		Y		Y	Y	N
2018																		
12 January (extra)	Y	Y	Y	N	N	Y		Y			Y	Y	Y	Y		N	Y	Y
30 January	Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	N	Y		Y	Y	Y
27 February	Y	Y	Y	N	Y	Y	Y	Y			Y	Y	N	Y		Y	Y	Y
7 March (extra)	Y	Y	Y	N	Y	Y	Y	Y			Y	N		Y		Y	Y	Y
27 March	Y	Y	Y	N	Y	Y	Y	Y			Y	Y		Y		Y	N	Y
Attendance	16/16	13/16	14/16	10/16	12/16	14/16	4/4	14/16	9/10		16/16	11/16	1/3	14/16	6/8	7/8	15/16	11/16

Directors' Register of Interests

The Directors' Register of Interests is available to view on the Trust's website (http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Our_Board_of_Directors/) or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec, Company Secretary,
General Management Department, Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

The contact details above may be used by Members who wish to communicate with Directors.

Register of Staff Interests including those of members of the Board of Directors

In accordance with NHS England's Conflicts of Interest guidance which was implemented on 1 June 2017, the Trust also maintains a register of the interests declared by colleagues who are not members of the Board of Directors. This register is updated on a six monthly basis and is located on the Trust's website:
(http://www.therotherhamft.nhs.uk/key_documents/)

Committees of the Board

The Board of Directors has the following statutory Committees of the Board:

- Audit Committee
- Nominations Committee
- Remuneration Committee

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

For details regarding the work of the Remuneration Committee during 2017/18 please see the Remuneration Report section of this Annual Report.

Audit Committee

The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA) and the Department of Health and Social Care.

The Committee was chaired throughout the year by Joe Barnes, a Non-Executive Director with relevant financial experience. Three of the Non-Executive Directors are members of the Audit Committee, all of whom are considered to be independent. The Trust's Chairman is neither the Chair nor a member of the Audit Committee. The Director of Finance and Company Secretary attend every meeting, and in addition, other Executive or Operational Directors attend meetings as required. Since January 2014 two members of the Council of Governors have been invited as observers to the Audit Committee.

Attendance at Audit Committee Meetings 2017/18

	Joe Barnes (Chair)	Lynn Hagger	Paul Smith	David Hannah
2017				
19 April	Y	Y	Y	
19 May	Y	Y	Y	
25 May	Y	N	Y	
05 July	Y	Y	Y	
20 October	Y	Y	Y	
2018				
07 February	Y	Y		Y
Attendance	6/6	5/6	5/5	1/1

From 1 April 2018 the membership of the Audit Committee changed. Whilst Joe Barnes continued to chair the Committee and David Hannah continued as a member, Barry Mellor became the Vice-Chair of the committee replacing Lynn Hagger.

The following areas were the significant issues considered by the Audit Committee during 2017/18:

- Annual Governance Statement 2016/17
- Annual Report and Accounts 2016/17
- Quality Account and Report 2016/17
- Head of Internal Audit Opinion 2016/17
- External Audit ISA 260 review 2016/17 (PwC)
- Draft Internal Audit (TIAA) annual work plan 2018/19
- Counter Fraud (provided by 360 Assurance) annual work plan 2017/18 and risk assessment for 2017/18
- External Audit (PwC) annual work plan 2017/18
- Board Assurance Framework 2017/18
- Trust's Risk Register (scores of 16 and above)
- Annual assurance on the processes for managing serious incidents
- Annual Review of Standards of Business Conduct
- Annual Report of the Audit Committee
- Annual review of governance arrangements for any additional audit work undertaken by the External Auditors (PwC)
- Freedom to Speak up Guardian Annual Update
- Changes to Accounting Policies 2017/18

Exceptional items considered where:

- Use of External Consultants
- Data Quality

Review of:
Internal Auditor effectiveness
External Auditor effectiveness

The significant risks identified in the External Auditor's (PwC) audit plan for 2017/18 were:

- Risk of fraud in revenue recognition
- Risk of fraud in expenditure recognition
- Risk of management override of controls
- Financial sustainability

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

Internal Auditors

During the financial year 2017/18 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*.

The contract for the Trust's External Auditors was renewed during the previous financial year (2016/17) and commenced on 1 October 2016. The contract will end on 30 September 2019 (it is a 3-year contract with an option to extend for one plus one year). The total value of the contract for three years is £187,320 (£62,440 pa).

Nominations Committee

The Trust has two Nominations Committees. The Board of Directors' Nominations Committee has responsibility for the appointment of Executive Directors and the Council of Governors' Nominations Committee has responsibility for the appointment of Non-Executive Directors. The Trust's Chairman chairs both of the Nomination Committees.

Executive Director Appointments

The Nominations Committee identifies suitable candidates to fill Executive Director vacancies as they arise. The Committee makes recommendations to the Chairman, the other Non-Executive Directors and the Chief Executive (except in the case of the appointment of a Chief Executive).

Before recommending a candidate for appointment, the Committee has regard to the balance of qualifications, skills, knowledge and experience required on the Board of Directors as a whole. The Nominations Committee annually reviews the size, composition and structure of the Board of Directors to ensure it remains appropriate to deliver its statutory responsibilities.

Attendance at Nominations Committee (Executive Director appointments) 2017/18

	Martin Havenhand (Chair)	Paul Smith	Mark Edgell	Louise Barnett	David Hannah
2017					
27 June	Y	Y	N	Y	
18 August	Cancelled				
10 October	Y	Y	Y	Y	
8 December	Y	Y	Y	Y	
19 December	Y		Y	N	
2018					
12 January	Cancelled				
19 January	Y		Y	N	
22 February	Y		N	Y	Y
Attendance	6/6	3/3	4/6	4/6	1/1

From 1 April 2018 the membership of the Nominations Committee changed. Martin Havenhand continued as Chair of the Committee, Lynn Hagger replaced Mark Edgell as Vice-Chair, David Hannah joined the committee and Mark Edgell continued as a member.

Performance Appraisal Processes

The performance appraisal of the Chief Executive is undertaken by the Chairman and the performance appraisals of the Executive Directors are undertaken by the Chief Executive.

The recruitment process undertaken to appoint a new Chief Nurse following a previously unsuccessful recruitment campaign in April 2017 was as follows:

- Meeting of the Nominations Committee to discuss the requirements for the post and timelines;
- Applications invited by external search agency;
- Shortlisting took place, with approval for shortlisted applicants by Nominations Committee members;
- A comprehensive selection process took place in June 2017 which resulted in the appointment of a new Chief Nurse with effect from October 2017.

Non-Executive Directors Appointments

The Governors' 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.

The Committee met on six occasions during 2017/18.

In early 2017/18 the Committee undertook the annual review of the remuneration, allowances and other terms and conditions of office of the Chairman and other Non-Executive Directors. In April 2017 the Council of Governors approved the recommendation that Non-Executive remuneration should increase by 1% during 2017/18. At that same meeting the revised terms and conditions documents for the Non-Executive Directors were approved as recommended by the Committee.

The Chair and Non-Executive Directors' annual appraisal and objective setting process was considered at the second meeting during the year. 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 and the Council of Governors.

The third meeting of 2017/18 considered the reappointment of one Non-Executive Director for a further two-year term of office above the maximum six-year term, subject to annual confirmation. This meeting also considered the skills and composition of the Board and commenced the succession planning process through open recruitment.

The recruitment process undertaken to appoint one Non-Executive Director in 2017/18 was as follows:

- Applications invited by External Search Agency / advertising in National and Local Media
- Lead and Deputy Lead Governor met with the Trust Chair to short-list the applicants
- Informal sessions undertaken with a small panel of Governors and Non-Executive Directors with the shortlisted candidates

- Candidates offered the opportunity to meet with the Chief Executive and Medical Director
- Formal interviews undertaken by Appointments Panel comprising the Trust Chair and three Governors
- Governors' Nomination Committee made a recommendation to the Council of Governors in January 2018 to approve the appointment of the successful applicant

During the year the Committee considered and supported the appointment of a new Senior Independent Director with effect from 1 April 2018, which was supported by the Council of Governors at its October 2017 meeting.

The Committee's Terms of Reference underwent their annual review and were approved by the Council of Governors in October 2017.

Non-statutory Committees of the Board of Directors

Quality Assurance Committee
Finance & Performance Committee
Strategic Workforce Committee
Strategy & Transformation Committee

In the summer of 2017 feedback from Board committee members on the effectiveness of all of the Board Committees was sought ahead of a formal review of each committee's effectiveness.

This effectiveness review led to the revision of the Terms of Reference of the Board Committees approved by the Board of Directors in August and October 2017.

Council of Governors

The Council of Governors is responsible for making decisions regarding the appointment or removal of the Chairman, the Non-Executive Directors and the Trust's auditors; and the terms and conditions of office of the Non-Executive Directors in addition to approving the appointment of the Chief Executive. The Council of Governors is also consulted by the Board of Directors and its views taken into consideration when formulating the Trust's forward plans.

The Council also considers the Trust's annual accounts and the External Auditor's report on them as well as representing the interests of members and partnership organisations in the governance of the Trust, regularly feeding back information about the Trust to the constituency it represents.

Other statutory duties of the Council of Governors include providing their views to the Board of Directors on the Trust's strategy, to respond to the Board of Directors when consulted and to undertake functions as requested by the Board of Directors; and to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

Should any disagreements between the Board of Directors and the Council of Governors arise the manner in which these would be resolved is described in Annex 3 of the Trust's Constitution which is available on the Trust's internet site.

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

During 2017/18 the members of the Council of Governors were:

Constituency	Name	Term of Office
Public Governors (elected):		
Wentworth North (Covering the electoral wards of Hoober, Swinton, Wath)	Mr Tyrone Lee Finney	01.06.2016 to 31.05.2019 Stood down 25.04.2017
	Mrs Lynn Flather	01.06.2016 to 31.05.2019 Stood down 31.05.2017
	Vacancy (x2)	01.06.2017 to 31.03.2018
	Vacancy (x1)	01.04.2017 to 31.05.2017
Wentworth South (Covering the electoral wards of Rawmarsh, Silverwood, Valley)	Lt Col Robert McPherson	01.06.2017 to 31.05.2020
	Mr Leslie Hayhurst	01.06.2014 to 31.05.2017 Re-elected: 01.06.2017 to 31.05.2020
	Mr Nicholas Ward	01.06.2016 to 31.05.2019 Resigned: 21.08.2017
Wentworth Valley (Covering the electoral wards of Hellaby, Maltby, Wickersley)	Vacancy (x1)	21.08.2017 to 31.03.2018
	Mr Graham Barry Jenkinson	01.06.2014 to 31.05.2017 Re-elected: 01.06.2017 to 31.05.2020
Rotherham South (Covering the electoral wards of Boston Castle, Rotherham East, Sitwell)	Ms Beverly Bennett	01.06.2016 to 31.05.2019
	Mrs Jo Brookes	01.06.2016 to 31.05.2019
Rotherham North (Covering the electoral wards of Keppel, Rotherham West, Wingfield)	Mrs Valerie Lindsay	01.06.2016 to 31.05.2019
	Vacancy (x1)	01.04.2017 to 31.03.2018
	Mrs Bridget Dixon	01.06.2014 to 31.05.2017
Rother Valley South (Covering the electoral wards of Anston & Woodsetts, Dinnington, Wales)	Mrs Judy Dalton	01.06.2017 to 31.05.2020
	Mr Gavin Rimmer	01.06.2014 to 31.05.2017 Re-elected: 01.06.2017 to 31.05.2020
	Vacancy (x1)	01.04.2017 to 31.05.2017
Rother Valley West (Covering the electoral wards of Brinsworth & Catcliffe, Holderness, Rother Vale)	Mrs Hilda Littlewood	01.06.2017 to 31.05.2020
	Mr Dennis Wray **Lead Governor from June 2015**	01.06.2014 to 31.05.2017 Re-elected: 01.06.2017 to 31.05.2018 (one year)
	Ms Jan Frith	01.06.2015 to 31.05.2018
Rest of England (Covering those who live outside the borough)	Mr Bryn Kinsey	01.06.2016 to 31.05.2019 Resigned 09.10.2017
	Vacancy (x1)	09.10.2017 to 31.03.2018

Constituency	Name	Term of Office
Staff Governors (elected):		
Professional Nurses and Midwives	Vacancy (x1)	01.04.2017 to 11.01.2018
	Mrs June Lovett	Co-opted 11.01.2018 to 31.03.2018
Other Health Professionals	Mrs Catherine Ripley	01.06.2016 to 31.05.2019
Medical and Dental	Dr Firas Al-Modaris	01.06.2014 to 31.05.2017
	Vacancy (x1)	01.06.2017 to 31.03.2018
Other Directly Employed Staff	Mrs Sandra Lewis	01.06.2016 to 31.05.2019
Support Staff to Health Professionals	Mrs Tina Senior	01.06.2014 to 31.05.2017
	Vacancy (x1)	01.06.2017 to 31.03.2018
Partner Governor Organisations (nominated/appointed):		
Sheffield Hallam University	Dr Christopher Low	01.08.2015 to 31.07.2018
Sheffield University	Prof Arshad Majid	14.11.2016 to 13.11.2019
Rotherham Partnership	Mrs Carole Haywood	01.09.2016 to 31.08.2019
Voluntary Action Rotherham	Mrs Janet Wheatley	01.06.2016 to 31.05.2017
	Mrs Jean Flanagan	01.09.2017 to 31.08.2020
Rotherham Metropolitan Borough Council	Cllr Patricia Jarvis	06.02.2017 to 05.02.2020
Barnsley and Rotherham Chamber of Commerce	Mr John Silker	21.04.2017 to 20.04.2020 Died 20.08.2017
Rotherham Ethnic Minority Alliance	Vacancy (x1)	01.04.2017 to 31.03.2018

All Governors, both elected and appointed, hold office for a term of three years. They are eligible for re-election or re-appointment at the end of that period and serve a maximum of three terms (nine years in total). The Trust Constitution outlines that a Governor is eligible to continue in the role subject to annual re-election up to a maximum of 12 years.

All elections for public and staff governor positions are conducted under the auspices of the Electoral Reform Service in accordance with the requirements of the Trust's Constitution.

There were four scheduled meetings of the Council of Governors during 2016/17 with attendance as detailed in the table below:

Attendance 2016/17

Council of Governors meeting	Number of meetings held during tenure	Number of meetings attended
Dr Firas Al-Modaris	1	1
Ms Beverly Bennett	4	4
Mrs Jo Brookes	4	4
Mrs Judy Dalton	3	3
Mrs Bridget Dixon	1	1
Mrs Jean Flanagan	2	2
Mr Tyrone Finney	1	0
Mrs Lynn Flather	1	0
Miss Jan Frith	4	4
Mr Leslie Hayhurst	4	4
Mrs Carole Haywood	4	2
Cllr Patricia Jarvis	4	3
Mr Graham Barry Jenkinson	4	4
Mr Bryn Kinsey	2	0
Mrs Sandra Lewis	4	3
Mrs Hilda Littlewood	3	3
Mrs Valerie Lindsay	4	4
Dr Christopher Low	4	2
Lt Col Robert McPherson	3	3
Prof Arshad Majid	4	1
Mr Gavin Rimmer	4	3
Mrs Catherine Ripley	4	3
Mrs Tina Senior	1	0
Mr Nicholas Ward	2	1
Mrs Janet Wheatley	1	0
Mr Dennis Wray	4	4

In order to ensure that members of the Board of Directors (particularly the Non-Executive Directors) have developed an understanding of the views of Governors and Members about the Trust they have attended Council of Governors meetings, Governors Forum sessions and Governor Development sessions throughout the year. In addition, the Governors have invited both Executive and Non-Executive Directors to attend their quarterly Council of Governors meetings where their input is required in relation to the agenda.

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 Governors' interests is available to view on the Trust's website (www.therotherhamft.nhs.uk) or by requesting a copy from the Company Secretary.

Ms Anna Milanec, 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 2017/18 there were over 16,440 Members of The Rotherham NHS Foundation Trust (TRFT), which includes public and staff members.

The Trust has two membership constituencies:

A 'public constituency'
A 'staff constituency'

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 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.

Boundaries for public membership

Rotherham South (Boston castle, Rotherham East & Sitwell)
Rotherham North (Keppel, Rotherham West, Wingfield)
Wentworth South (Rawmarsh, Silverwood, Valley)
Wentworth North (Hoober, Swinton, Wath)
Wentworth Valley (Hellaby, Maltby, Wickersley)
Rother Valley West (Brinsworth, Catcliffe, Holderness, Rother Vale)
Rother Valley South (Anston and Woodsetts, Dinnington, Wales)
Rest of England (covers all areas not within RMBC boundaries)

The Rotherham NHS Foundation Trust constituency boundaries reflect the Rotherham Metropolitan Borough Council area assembly boundaries.

Membership composition to 31 March 2018

Public	
Rotherham South	2,010
Rotherham North	1,513
Wentworth South	1,670
Wentworth North	1,189
Wentworth Valley	1,690
Rother Valley West	1,305
Rother Valley South	1,034
Rest of England	1,547
Out of trust area	0
Total	11,958
Staff	
Medical and Dental	259
Professional Nurses and Midwives	1,400
Other Health Professionals	579
Support Staff to Health Professionals	910
Other Directly Employed NHS Staff	1,334
Total	4,482

Total Trust Membership: 16,440

Public Members are able to contact their local Governor by sending an e-mail to: public.governors@rothgen.nhs.uk indicating the name of the Governor they wish to contact in the subject line of the e-mail.

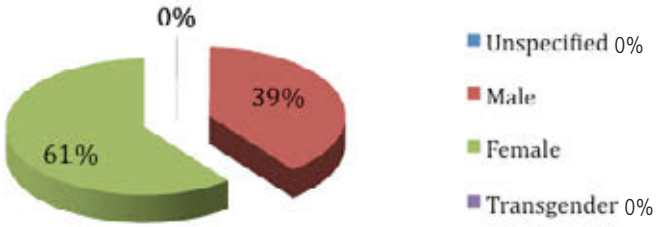
In a similar manner, staff members are able to contact their Governor by sending an e-mail to: staffgovernors@rothgen.nhs.uk also including the name of the governor in the subject line of the e-mail.

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

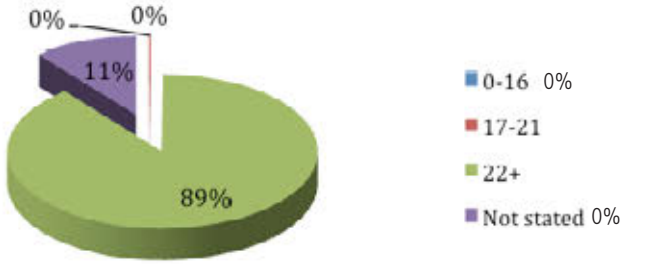
The Trust values the continued support and engagement of its Membership and recognises the importance of a Membership that is representative of all the communities it serves. The Trust strives to ensure that its Membership is as representative of the population as possible.

The Board of Directors monitors the extent to which the Trust's membership is representative of the population it serves.
As at 31 March 2018 the Trust's membership was composed as follows:

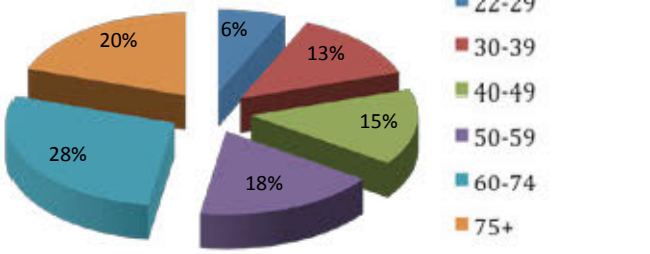
Public Member Gender chart



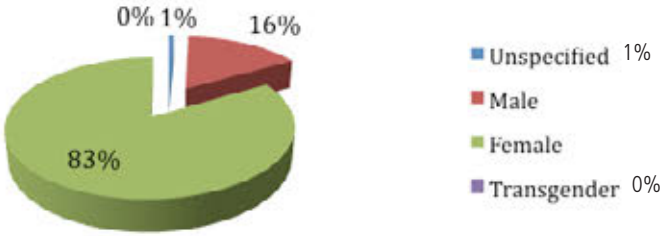
Public Member Age Range chart



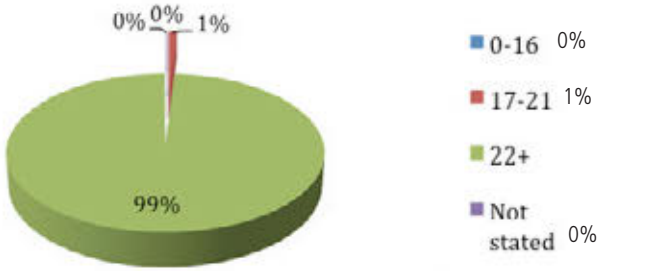
Public Members 22+



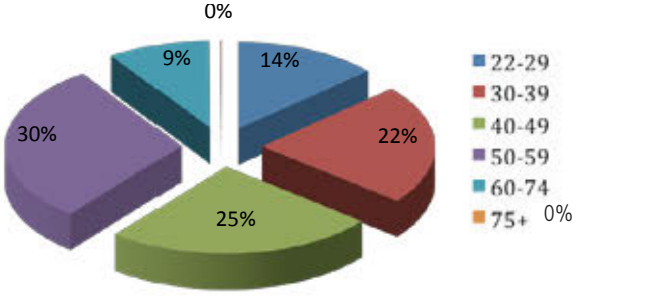
Staff Member Gender chart



Staff Member Age Range chart



Staff Members Age 22+ chart



Membership Breakdown	Public	Staff	Total
Ethnicity. Breakdown below	11,958	4,482	16,440
White - English, Welsh, Scottish, Northern Irish, British	4,122	3,161	7,283
White - Irish	16	11	27
White - Gypsy or Irish Traveller	0	0	0
White - Other	14	32	46
Mixed - White and Black Caribbean	2	5	7
Mixed - White and Black African	1	3	4
Mixed - White and Asian	1	11	12
Mixed - Other Mixed	8	5	13
Asian or Asian British - Indian	34	57	91
Asian or Asian British - Pakistani	172	31	203
Asian or Asian British - Bangladeshi	3	2	5
Asian or Asian British - Chinese	6	8	14
Asian or Asian British - Other Asian	20	21	41
Black or Black British – African	23	26	49
Black or Black British - Caribbean	5	8	13
Black or Black British - Other Black	13	5	18
Other Ethnic Group – Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	68	30	98
Not stated	7,450	1,066	8516

In recent years the membership strategy has been to shift the focus from improving the visibility of Membership to building on the service offered to Members through more accessible engagement; and to continue to raise the profile of the Trust and its Membership base within the local community.

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 sustained, two-way communication plans.

The annual edition of the 'Your Choice' magazine continues to be the traditional method of communication with the entire Membership base. Produced in February or March each year it provides information on service developments, Proud Awards for colleagues (which include a Public Recognition category) and the Rotherham Hospital & Community Charity. Its publication is timed to showcase the role of Governors and announce the forthcoming annual Council of Governor Elections, encouraging Members to stand as Governors and to vote in the Governor elections.

The Trust continues to hold quarterly 'Governors' Surgeries' at the Rotherham Hospital site and at Rotherham Community Health Centre. These Surgeries provide an opportunity for our Members to speak with our Governors, giving their views on services and to ask questions of our Governors. The feedback from these sessions is seen by the senior management within the Trust to ensure opportunities for quality improvements in patient care and experience are acted upon.

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

The Rotherham NHS Foundation Trust has applied the principles of the *NHS Foundation Trust Code of Governance* on a 'comply or explain' basis. *The NHS Foundation Trust Code of Governance*, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Disclosures:

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Partly compliant: A statement describing how any disagreements between the Council of Governors and Board of Directors would be resolved, appears in annex 3 of the Trust's Constitution. Summary statements included in the Accountability Report.
2: Disclose	Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration[11] committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 7.25 as part of the directors' report.	Compliant. Included in the Annual Report as follows: in the Director's report, Remuneration Report and Governance & Organisational Structure section (Audit Committee, Nominations Committee)
2: Disclose	Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Compliant. Included in the Governance & Organisational Structure section (Council of Governors Section)
Additional requirement of FT ARM	Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Compliant. Included in Governance & Organisational Structure section (Council of Governors Section)
2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each Non- Executive director it considers to be independent, with reasons where necessary.	Compliant. Included in the Governance & Organisational Structure section (Composition of the Board of Directors section)
2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Compliant. Included in the Governance & Organisational Structure section (Composition of the Board of Directors and Meet the Board of Directors section)
Additional requirement of FT ARM	Board	n/a	The annual report should include a brief description of the length of appointments of the Non-Executive directors, and how they may be terminated	Compliant. Included in the Director's report (Meet the Board of Directors section)

[11] This requirement is also contained in paragraph 7.45 as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Compliant. Included in Governance & Organisational Structure section (Nominations Committee section)
Additional requirement of FT ARM	Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or Non-Executive director.	Compliant. Included in Governance & Organisational Structure section (Nominations Committee section)
2: Disclose	Chair / Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Compliant. Included in the Governance & Organisational Structure section (Board of Directors section in the Chairman's biography)
2: Disclose	Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Compliant. The Governors canvassed the opinion of members and the public on the Trust's forward plan for 2018/19 including its objectives, priorities and strategy via the Council of Governors meeting in January 2018 and their Governors' Surgeries. Forum meetings and their views have been communicated to the Board of Directors.
Additional requirement of FT ARM	Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Compliant. During 2017/18 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. (In Disclosures as set out in the NHS Foundation Trust Code of Governance section)
2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Compliant. Included in Governance & Organisational Structure section (Composition of the Board of Directors section) for committee evaluation and Board members' evaluation and in Non-statutory Committees of the Board of Directors section. At the end of every Board of Directors' meeting one of the Executive or Non-Executive Directors provides feedback evaluation of the meeting.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board	B.6.2	Where there has been external evaluation of the board and/ or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	During the year the Trust commissioned an external review of clinical governance processes at corporate and divisional level and received a report on this during March 2018. The review was carried out by KPMG which does not have any other connection to the Trust.
2: Disclose	Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 7.92.	Compliant. Included in the Director's report and Annual Governance Statement section
2: Disclose	Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Compliant. Included in the Annual Governance Statement section
2: Disclose	Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Compliant. Included in Governance & Organisational Structure section (Audit Committee section)
2: Disclose	Audit Committee / Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable.
2: Disclose	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Compliant. • Included in Governance & Organisational Structure section (Audit Committee section) • Included in Governance & Organisational Structure section (Audit Committee section) • Not applicable: no non-audit services provided in year by PwC. Included in Disclosures as set out in the NHS Foundation Trust Code of Governance section

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board / Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a Non-Executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Compliant. None of the Trust's Executive Directors were released, for example to serve as a Non-Executive Director elsewhere. during 2017/18
2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Website: Compliant Annual Report: Compliant, included in Governance & Organisational Structure section (Council of Governors section, Foundation Trust membership section and Board of Directors section)
2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the Non-Executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face- to-face contact, surveys of members' opinions and consultations.	Compliant. Included in the Council of Governors section of Governance & Organisational Structure section
2: Disclose	Board / Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Compliant. Included in Foundation Trust Membership section of Governance & Organisational Structure section.
Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Compliant. Included in Foundation Trust Membership section of Governance & Organisational Structure section
Additional requirement of FT ARM (based on FReM requirement	Board / Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 0 as directors' report requirement.	Compliant. Included in Governance & Organisational Structure section: • Board of Directors section • At end of Council of Governors section.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery	Compliant.
6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	Compliant.
6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.	Compliant.
6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions.	Compliant.
6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life	Compliant.
6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	Compliant.
6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Compliant.
6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	Compliant
6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent Non-Executive directors to be the senior independent director	Compliant.
6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the Non-Executive directors without the executives present.	Compliant.
6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Compliant.
6: Comply or explain	Council of Governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.	Compliant.
6: Comply or explain	Council of Governors	A.5.2	The council of governors should not be so large as to be unwieldy.	Compliant.
6: Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.	Compliant.
6: Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.	Compliant.
6: Comply or explain	Council of Governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Council of Governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Compliant.
6: Comply or explain	Council of Governors	A.5.8	The council should only exercise its power to remove the chairperson or any Non-Executive directors after exhausting all means of engagement with the board.	Compliant.
6: Comply or explain	Council of Governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Compliant.
6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise Non-Executive directors determined by the board to be independent.	Compliant as at 31/3/18
6: Comply or explain	Board / Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and Non-Executive directors.	Compliant.
6: Comply or explain	Board / Council of Governors	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.4	The chairperson or an independent Non-Executive director should chair the nominations committee(s).	Compliant.
6: Comply or explain	Nomination Committee(s) / CoG	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and Non-Executive directors.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of Non-Executive directors should consist of a majority of governors.	Compliant.
6: Comply or explain	Council of Governors	B.2.7	When considering the appointment of Non-Executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	Compliant.
6: Comply or explain	Council of Governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and Non-Executive directors.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	Compliant.
6: Comply or explain	Board	B.3.3	The board should not agree to a full- time executive director taking on more than one Non-Executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.	Compliant.
6: Comply or explain	Board / Council of Governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Compliant.
6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Compliant.
6: Comply or explain	Council of Governors / Remuneration Committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a Non- Executive.	Compliant. The Council of Governors did not consult external professional advisors to market-test the remuneration levels of the Chairman and/or other Non-Executive Directors in year. However, external datza provided by the NHS Providers' annual salary report has been considered and informed the Governors' decision on Non-Executive Director remuneration for 2017/18.
6: Comply or explain	Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Compliant.
6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	Compliant.
6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	Compliant.
6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Board	B.5.2	The board and in particular Non- Executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis	Compliant.
6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially Non-Executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Compliant.
6: Comply or explain	Board / Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Compliant.
6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.	Compliant.
6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for Non-Executive directors relevant to their duties as board members.	Compliant.
6: Comply or explain	Chair / Council of Governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	To be undertaken in Q1 2018/19 and results presented in Q2
6: Comply or explain	Council of Governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Compliant.
6: Comply or explain	Board / Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Compliant.
6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 7.15.	Compliant.
6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Board	C.1.4	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	Compliant – verified by Board, Council and Committee minutes throughout the year
6: Comply or explain	Board / Audit Committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent Non-Executive directors.	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Compliant.
6: Comply or explain	Council of Governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Compliant.
6: Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Compliant.
6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Compliant.
6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other Non-Executive directors should reflect the time commitment and responsibilities of their roles.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Compliant.
6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Compliant.
6: Comply or explain	Council of Governors / Remuneration Committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the Chairperson and other Non-Executives at least once every three years and when they intend to make a material change to the remuneration of a Non-Executive.	Compliant The Council of Governors did not consult external professional advisors to market-test the remuneration levels of the Chairman and/or other Non-Executive Directors in year. However, external data provided by the NHS Providers' annual salary report has been considered and informed the Governors' decision on Non-Executive Director remuneration for 2017/18.
6: Comply or explain	Board	E.1.2	The board should **clarify in writing** how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Compliant
6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	Compliant.
6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	Compliant
6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	Compliant

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach, or suspected breach, of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17.

Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for Annual Reports.

Segmentation

The Rotherham NHS Foundation Trust is in segment 3. This means that the Trust has been in receipt of mandated support from NHS Improvement.

This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score.

Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed does not reflect the overall finance score here.

During 2017/18, breaches remained in place against the Trust's Licence, which resulted from Enforcement Action taken by Monitor against the Trust in April 2013. 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.

During the 2014/15 financial year the two breaches relating to governance and electronic patient records system were lifted as it was deemed by NHS Improvement (then, Monitor) that the Trust had taken all the required actions.

Progress was also made in relation to the outstanding financial and strategic planning breaches with regard to the Trust evidencing its compliance with the required actions.

In view of the extensive changes that have taken place across the NHS since the requirements were enforced, and in recognition of its financial position, the Trust has not yet formally submitted this to the regulator. Hence, breaches 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) remained in place throughout 2017/18.

The allocation of a segment 3 sector rating by NHSI in October 2016, reflected the Trust's regulatory position at that time.

Area	Metric	2017/18 Scores				2016/17 Scores	
		Q1	Q2	Q3	Q4	Q4	Q3
Financial Sustainability	Capital service capacity	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4
Financial Efficiency	I&E margin	4	4	4	4	4	4
Financial Controls	Distance from financial plan	2	4	4	4	4	4
	Agency spend	2	2	2	2	2	2
Overall Scoring		3	4	4	4	4	4

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of The Rotherham NHS Foundation Trust NHS Foundation Trust.

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Rotherham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Rotherham NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Signed:

Louise Barnett
Chief Executive
23 May 2018

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 2018 and up to the date of approval of the Annual Report and Accounts.

Capacity to Handle Risk

The Board of Directors is collectively and individually responsible for ensuring sound risk management systems are in place in the organisation, and is supported by a number of formal committees which oversee the effectiveness of risk management, internal control and assurance arrangements.

Each member of the executive team has an area of responsibility for risk management, in accordance with their portfolios and as reflected in their role descriptions, which supports me in my role as Accounting Officer.

The Chief Nurse is responsible for ensuring that an appropriate Trust wide risk management framework is in place that aligns with the Board of Director's approved risk management strategy. He is responsible for ensuring that the Trust's risk management framework is complied with, and together with his 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 operational finance issues, cost and efficiency improvement and financial sustainability and contracting, procurement and commissioning issues.

The Medical Director is responsible for clinical and, in conjunction with the Chief Nurse, for the management of risk relating to quality of care.

The Director of Workforce is responsible for issues relating to workforce, including recruitment and retention, workforce productivity, pay efficiencies, health and wellbeing.

Operational performance was largely overseen by the Deputy Chief Executive / Director of Strategy and Transformation. In order to increase focus on the transformation agenda and operational delivery, an interim Chief Operating Officer Executive Director role was established during Q4, with the appointment of a substantive Chief Operating Officer taking up post on 1 April 2018.

The Senior Information Risk Owner (SIRO) is responsible for leading the area of information governance.

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. Refreshed risk management training was provided throughout the year as a mandatory subject for all colleagues of band 7 and above, including members of the Board of Directors.

The corporate induction programme that all colleagues and volunteers undertake, ensures that everyone is provided with details of the Trust's risk management systems and processes, and this is augmented by local induction organised by line managers. We recognise the importance of training colleagues to be able to recognise and manage key risks in the organisation such as fire safety, health and safety, manual handling, resuscitation, infection control and safeguarding.

Internal audit and clinical audit programmes are also used to provide assurance against internal controls, and recommendations are made where improvements may be appropriate.

The Board has regard to the requirements of the 'developmental reviews of leadership and governance using the well led framework' guidance, and started to prepare for its external review, which will take place during 2018/19.

The risk and control framework

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

Each Division and CSU is required to identify, manage and control local risks, in order to provide a safe environment for patients and colleagues and to reduce unnecessary expenditure. Local risk registers hold details of risks identified though day-to-day business activities, as well as those 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 risk management policy, approved by the Board, sets out the organisation's approach to risk, the Executive and Non-Executive director responsibilities, and the framework in place for the management of risk throughout the organisation. Risk appetite is determined by the Board and is reviewed on a regular basis. The policy also includes details of the role of Board Committees in providing assurance that risks are being managed effectively. A copy of the policy is available to all colleagues on the Trust intranet.

The Chief Nurse began a review of the risk management structure during quarter 4 2017/18. The outcome of that review, together with a programme of work to be undertaken during the first half of 2018/19, was presented to the Board of Directors, in April 2018.

During 2017/18, the Trust's Risk Management Committee provided a process through which older low level risks were reviewed in a timely manner. All risks scoring 16 and above are reviewed by the Committee on a regular basis.

The Trust's quality priorities are set out in the Quality Report (page 29) and reference the three domains of quality, and the CQC's five key lines of enquiry.

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, with assurance being provided to the Quality Assurance Committee.

Key performance indicators are presented on a monthly basis to Board assurance committees, and the Board itself. These include progress against targets and standards, internal safety measures, process measures and other clinical quality indicators.

The Board regularly receives reports on quality information (such as complaints, incidents and reports from specific quality functions). A significant improvement has been seen during the year relating to agreed timescales for responses to complaints, which remained at 100% during Q4.

We recognised that, to further strengthen the quality assurance framework, our clinical and quality governance frameworks could be more robust, and we commissioned an external review during 2017/18. A number of recommendations arose from the review which were presented to the Board of Directors in March 2018 and an action plan is in place to enact the recommendations.

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.

All Trust colleagues are subject to a code of confidentiality, and access to data held on IT systems is restricted to authorised users. The Trust's IT department maintain up-to-date technical security measures to minimise the threat to Trust network resources from outside threats and inappropriate access.

On the 12 May 2017, the Trust was made aware of the emerging cyber-attack that was underway, that affected a number of NHS organisations. Immediately, inbound and outbound e-mail access was disconnected as well as access to web-based e-mails. We also undertook internal communications and supported the national response. The response from the Trust's Health Informatics team was prompt, and support from clinical areas was positive where disruption was experienced as a result of systems and servers being temporarily disabled. Teams then continued to work over that weekend to ensure that appropriate 'patches' were deployed and systems and devices rebooted to mitigate against any potential risk. The Trust did not

experience any virus infection in any of its systems. Further work has taken place since that time with systems being further updated to protect against similar attacks.

The Trust 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 and information security breaches 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.

In March 2018, the Board received information relating to the 2017/18 Data Security and Protection Toolkit (DSP Toolkit) Requirements, which has replaced the Information Governance Toolkit (IG Toolkit).

In-year risks:

The major risks faced by the Trust during 2017/18, were:

Quality of care:

This relates to the failure to deliver high quality patient care, leading to poor patient experience, avoidable harm and poor clinical outcomes. Regarding mortality rates, the Trust began the financial year with a HSMR of 108.5. Although not statistically significant, this placed the Trust into the upper quartile (poorest performance) of hospitals. A Hospital Mortality Steering Group was established to oversee, monitor and take action on investigations carried out throughout the year. The Board of Directors were presented with reports on a monthly basis, and by year-end, the HSMR rate had reduced to 96.

Despite excellent results from the Friends and Family Test throughout the year, the Trust received disappointing results from the national maternity survey, which had been facilitated by the CQC. The Chief Nurse immediately carried out a review, and took immediate actions to put in place a plan for improvement. Whilst this has provided the opportunity to improve patient experience, the survey results were issued late in the year.

Workforce:

We have worked extremely hard to redesign, support and retain our workforce, whilst also recruiting to vacant posts in order to reduce agency spending. Monthly agency costs decreased in year by 8%. However, even after adjusting for directly engaged staff (medical and dental locums) expenditure still exceeded the annual agency cap set by NHS Improvement by 3%.

We have ongoing recruitment initiatives in place for clinical, nursing and technical staff, but nationwide shortages of qualified colleagues continue, and the difficulty in recruiting substantively to some key roles, remains.

Operational delivery:

Until July 2017, the Trust provided its Accident and Emergency services from a former in-patient ward area before moving to its purpose built Urgent and Emergency Care Centre. Whilst it has taken time for new processes to embed as a result of the move, the new facility now provides quality 24/7 emergency care for the population of Rotherham. The Trust continues to face challenges in consistently meeting the A&E four-hour access target, but has also experienced days of excellent performance. Work is ongoing to ensure sustainable, high quality care is provided to our patients.

The Trust encountered challenges in meeting its cancer performance targets during Q4 of 2017/18, and into Q1 of 2018/19. Work has been undertaken to ensure that no patients have detrimentally suffered as a result of potential delays to treatment.

Detailed recovery plans have been put in place to restore formerly strong performance and external support has been sought from the Cancer Alliance and the Trust is working with external stakeholders in order to ensure a joined up approach across Yorkshire and Bassetlaw.

Finances:

The Trust did not deliver its £13.6M deficit plan for 2017/18, and ended the financial year with a £22.3M deficit, £8.7M adverse to plan.

The Trust was unable to deliver sufficient levels of efficiency improvements to compensate for the increased costs associated with a number of service changes, and difficulties in recruiting to key medical positions led to higher than expected agency costs and unexpected financial consequences of moving to the new payment system (HRG4+).

A number of measures have been put into place to mitigate the risk of the issues re-occurring in 2018/19 (see page 13 of the Chief Executive's report for more details).

External Environment:

The Trust continues to support development of the South Yorkshire and Bassetlaw Integrated Care System and the Rotherham Integrated Care Partnership, whilst also recognising the Trust's duty under its licence.

Future Risks

- Standards and quality of care are not achieved
- Workforce vacancies cannot be filled, costs cannot be reduced
- Business resilience is not sufficiently robust; increased risk of cyber attack
- Working with local and regional partners impedes agreement on integrated service models leading to failure to improve sustainability of services
- Inability to deliver the forecast £20.3M deficit 2018/19 financial plan, resulting from:
  - o Inability to deliver planned efficiency improvement;
  - o Continued staff agency costs resulting from recruitment delays in filling substantive posts; and
- Uncertainty over the following publication of the Hospital Services Review report.

During the year, the Trust retained breaches against its Licence, resulting from Enforcement Action taken by Monitor against the Trust in April 2013. Outstanding financial planning breaches, i.e. those relating to Licence conditions FT4(5)(a), FT4(5)(b), FT4(5)(d), FT4(5)(e), FT4(5)(f), FT4(5)(g) and CoS3(1), remain in place.
The allocation of a segment 3 sector rating by NHSI in October 2016, reflects the regulatory position.

The Trust reviews its compliance with the NHS Foundation Trust licence condition 4(8) (b) on an ongoing basis. A monthly governance report, prepared by the Company Secretary, is provided to the Board, and highlights 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 Board and committee structure is reviewed on a regular basis for its effectiveness, and to ensure clarity of reporting lines and accountabilities. An internal review took place at the end of Q4 2017/18, with an external review planned to take place by the end of Q2.

The Board Assurance Framework and Risk Management

The Trust's strategic and operational objectives are reviewed during the Board of Directors' annual cycle of business, and the annual operational and financial plans provide the framework through which to achieve those objectives.

The Board Assurance Framework (BAF) evidences the 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.

In addition, the Board recognises the need to horizon scan for emerging risks and to review low probability / high impact risks to ensure that contingency plans are in place.

The Trust learns from the outcomes of external 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 Board, on a monthly basis, against specific priorities that have been identified as areas for improvement or potential risk to achievement of the strategic objectives. Key priorities have an implementation plan that indicates required milestones, KPIs and outcomes. The Board committees also seek more detailed assurance that milestones are being achieved, KPIs are being met and that outcomes are as anticipated. The Board also receives, on a monthly basis, an Integrated Performance Report ("IPR"), containing information on an extensive range of performance related KPIs, national priority indicators, statutory and regulatory requirements and local priorities.

Operational committees report through the monthly Trust Management Committee (TMC) which is attended by all Trust's senior leadership team which includes all Executive Directors.

Well established and effective arrangements are in place for working with key public stakeholders across the local health economy, including:

- Rotherham Clinical Commissioning Group
- Rotherham Metropolitan Borough Council Health Select Commission (RMBC)
- HealthWatch Rotherham
- Rotherham and Barnsley Chamber of Commerce
- Rotherham College / University College Rotherham
- Rotherham Place Board
- Voluntary Action Rotherham
- Yorkshire Ambulance Service
- South Yorkshire Police
- South Yorkshire Fire and Rescue Services
- South Yorkshire and Bassetlaw Integrated Care System
- NHS England
- NHS Improvement
- The Trust's Council of Governors, Trust members, and members of the public

The 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

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

During the year, the Audit Committee receives a number of internal audit reports, in line with an agreed work plan, that aims to test the economy, efficiency and effectiveness of a range of Trust systems and controls.

The internal audit plan is reviewed and agreed by the Committee, and helps to provide assurance that a control environment is in place which supports delivery of the Trust's strategic objectives. Reports from both Internal and External Auditors are received by the Committee.

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

The Trust annually produces detailed annual plans which reflect the Trust strategic and operational objectives. Clinical and corporate Divisions are responsible for the delivery of financial and other performance targets via a performance management framework incorporating monthly reviews for each of the clinical divisions, by the Executive team.

The in-year use of resources is monitored by the Board and its committees. Through the performance management framework, a series of detailed monthly reports cover finance, activity, performance, quality, workforce and risk. These documents are a consolidation of detailed reports that are provided at Divisional and department basis to allow active management of resources at an operational level.

The External Auditors, through their audit of the Annual Report and Accounts, also provide assurance to the Audit Committee and Board that financial control systems are robust.

Information Governance

On the basis of the reporting requirements, one Serious Incident Requiring Investigation (SIRI) report was made during the year where confidential information had been disclosed in error.

The Information Commissioner's 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 breach, 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.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Quality Report 2017/18 has been developed in line with relevant national guidance and is supported internally through the Board Assurance Framework. The Chief Nurse is the executive lead for quality improvements in the organisation and is 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 mandatory indicators and comments from Trust stakeholders, is subject to review 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, the Audit Committee, and Risk Management Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the organisation in achieving its objectives, have been reviewed.

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 (PWC).

The Trust's Internal Auditors' annual audit plan, agreed by the Audit Committee, is risk based and covers risk management, governance, and internal control processes, both financial and non-financial, across the Trust. The work includes identifying and evaluating controls and testing their effectiveness.

Eighteen internal audits have taken place as part of the 2017/18 audit programme, with three being rated as having provided substantial assurance (Claims Process, Safeguarding, Board Assurance Framework).

The audit work found that there was insufficient evidence that the controls were working effectively during the 'Ward Rounds' audit, which sought to provide assurance over compliance in respect of completion of ward rounds within medical wards. Eight recommendations were made from the audit, two of which were urgent and included the provision of a documented ward rounds policy and standard operating procedures, which, at the time of writing, was out for consultation. Auditors also recommended that Consultants be reminded of the need to complete the pro-forma ward round sheets.

The Internal Auditors also provided a limited assurance report on the ICT Cyber Security Audit. This was partly because there were a number of outstanding matters to address since the last health check report, including two urgent recommendations and it is expected that the first, relating to implementation of critical items on the previous health check report, will be completed by June 2018. A second urgent recommendation, will be completed by March 2019. Actions have been agreed and are being implemented.

Progress against the recommendations is followed in an audit action tracker which is presented to each Audit Committee meeting by the Director of Finance.

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 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. Actions have been identified and tracked to ensure such weaknesses are addressed in a timely manner.

The 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 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 Board through an embedded process.

The Audit Committee ensures that a system of controls is in place to support the organisation operating effectively and to meet its statutory and strategic objectives, providing 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 assurance regarding the in-year financial position of the Trust and the delivery of strategic objectives relating to financial and operational 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.

The Strategy and Transformation Committee oversees progress against the Trust's five-year strategy and transformation agenda.

My review is also informed by:

- External Audit opinion
- Ongoing reviews of compliance with the CQC's Fundamental Standards for regulated activities across all locations as part of the registration process
- Consideration of performance against national and local healthcare targets
- Assessment against the information governance toolkit
- Investigation reports and action plans following Serious Incidents
- Results of national patient surveys, and other means of patient feedback, including complaints, compliments, surveys, Friends and Family Test outcomes
- Staff satisfaction levels, evidenced by local engagement, and the National Staff Survey
- External reviews, inspections and accreditations by Royal Colleges and similar bodies.

Conclusion

The Board has in place, extensive governance assurance processes which enable the identification and control of risks reported through the Assurance Framework.

Other than the issues noted above, there are no issues of significant internal control.

Signed:

Louise Barnett
Chief Executive
23 May 2018

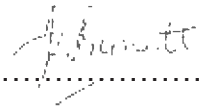
The Rotherham NHS Foundation Trust

Annual Accounts for the year ended 31 March 2018

Foreword to the accounts

The Rotherham NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by The Rotherham NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.
The Accounts of The Rotherham NHS Foundation Trust for the period ending 31 March 2018 follow. The four primary statements; the Statement of Comprehensive Income (SOCI), the Statement of Financial Position (SOFP), the Statement of Changes in Taxpayers' Equity (SOCITE), and the Statement of Cashflows (SCF) are presented first. These are followed by the supporting notes to the accounts.
Note 1 outlines the Foundation Trust's accounting policies. Subsequent notes provide further detail on the four primary statements and are cross referenced accordingly.
The financial statements (Accounts) were approved by the Board on 23rd May 2018 and signed on its behalf by:

Signed 

Name **Louise Barnett**
Job title **Chief Executive**
Date **23rd May 2018**

Statement of Comprehensive Income for year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	**218,174**	224,236
Other operating income	4	**23,930**	24,086
Total operating income from continuing operations		**242,104**	248,322
Operating expenses	5-9	**(264,650)**	(251,873)
Operating surplus/(deficit) from continuing operations		**(22,546)**	(3,551)
Finance income	10	**27**	25
Finance expenses	11	**(1,343)**	(809)
PDC dividends payable		**(1,833)**	(2,168)
Net finance costs		**(3,149)**	(2,952)
Surplus/(deficit) for the year from continuing operations		**(25,695)**	(6,503)
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		**-**	-
Surplus/(deficit) for the year		**(25,695)**	(6,503)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	**(2,122)**	-
Revaluations and impairments of property, plant and equipment	15	**15,306**	-
Other recognised gains and losses		**(1,743)**	-
Total comprehensive income/(expense) for the period		**(14,254)**	(6,503)
Allocation of profits / (losses) for the period:			
Surplus / (Deficit) for the year attributable to the Foundation Trust		**(25,695)**	(6,503)
Total comprehensive income (expense) for the year attributable to the Foundation Trust.		**(14,254)**	(6,503)

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	**9,746**	10,352
Property, plant and equipment	13	**118,725**	110,838
Trade and other receivables	21	**30**	43
Total non-current assets		**128,501**	121,233
Current assets			
Inventories	20	**3,652**	3,184
Trade and other receivables	21	**11,521**	12,727
Cash and cash equivalents	22	**1,400**	1,503
Total current assets		**16,573**	17,414
Current liabilities			
Trade and other payables	23	**(22,475)**	(24,524)
Borrowings	26	**(3,403)**	(3,406)
Provisions	28	**(205)**	(79)
Other liabilities	25	**(1,224)**	(1,420)
Total current liabilities		**(27,307)**	(29,429)
Total assets less current liabilities		**117,767**	109,218
Non-current liabilities			
Trade and other payables	23	**-**	-
Borrowings	25/26	**(59,829)**	(34,983)
Provisions	28	**(958)**	(1,159)
Other liabilities	25	**-**	(1,842)
Total non-current liabilities		**(60,787)**	(37,984)
Total assets employed		**56,980**	71,234
Financed by			
Public dividend capital		**73,403**	73,403
Revaluation reserve		**32,945**	19,668
Income and expenditure reserve		**(49,368)**	(21,837)
Total taxpayers' equity		**56,980**	71,234

The following notes 1 - 35 form part of these accounts.

Signed .....

Name **Louise Barnett**
Position **Chief Executive**
Date **23rd May 2018**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2018

	Public dividend capital £000	**Revaluation reserve £000**	**Income and expenditure reserve £000**	**Total £000**
Taxpayers' and others' equity at 1 April 2017 - brought forward	73,403	19,668	(21,837)	**71,234**
Surplus/(deficit) for the year			(25,695)	**(25,695)**
Other transfers between reserves		(133)	133	**-**
Net Impairments		(2,122)		**(2,122)**
Revaluations - PPE		15,306		**15,306**
Revaluations - Intangible assets		-		**-**
Transfer to retained earnings on disposal of assets		-	-	**-**
Other recognised gains and losses		(1,743)	-	**(1,743)**
Other reserve movements	-	1,969	(1,969)	**-**
Taxpayers' and others' equity at 31 March 2018	**73,403**	**32,945**	**(49,368)**	**56,980**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	73,403	19,700	(15,366)	77,737
Surplus/(deficit) for the year			(6,503)	(6,503)
Other transfers between reserves		(32)	32	-
Taxpayers' and others' equity at 31 March 2017	73,403	19,668	(21,837)	71,234

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 For the Year Ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**(22,546)**	(3,551)
Non-cash income and expense:			
Depreciation and amortisation	5.1	**6,690**	6,096
Impairments and reversals	6	**3,367**	-
(Increase)/decrease in receivables and other receivables		**887**	846
(Increase)/decrease in inventories		**(468)**	(83)
Increase/(decrease) in trade and other payables		**(1,728)**	1,416
Increase/(decrease) in other liabilities		**(1,070)**	(229)
Increase/(decrease) in provisions		**(76)**	(793)
Other movements in operating cash flows		**(48)**	(96)
Net cash generated from/(used in) operating activities		**(14,992)**	3,606
Cash flows from investing activities			
Interest received		**27**	25
Purchase and sale of financial assets		**-**	-
Purchase of intangible assets		**(480)**	(1,815)
Sales of intangible assets		**-**	-
Purchase of property, plant, equipment and investment property		**(4,529)**	(9,881)
Net cash generated from/(used in) investing activities		**(4,982)**	(11,671)
Cash flows from financing activities			
Movement on loans from the Department of Health		**22,210**	9,406
Capital element of finance lease rental payments		**(31)**	(142)
Interest paid		**(1,148)**	(797)
Interest element of finance lease		**(3)**	(12)
PDC dividend (paid)/refunded		**(1,157)**	(2,496)
Net cash generated from/(used in) financing activities		**19,871**	5,959
Increase/(decrease) in cash and cash equivalents		**(103)**	(2,107)
Cash and cash equivalents at 1 April		**1,503**	3,609
Cash and cash equivalents at 31 March	22	**1,400**	1,502

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Rotherham NHS Foundation Trust ('the Trust') is a public benefit corporation authorised, in England, by Monitor (trading as NHS Improvement) in accordance with the National Health Service Act 2006. The Trust provides healthcare mainly to the region. The address of the Trust is Moorgate Road, Rotherham, S60 2UD.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

The Rotherham NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust has delivered a financial outturn for 2017/18 of £25,695k deficit against a planned deficit of £18,603k, showing an adverse variance of £7,092k, the performance in the year required working capital loan financing support to be provided of £25,585k.

The Board of Directors has approved a deficit financial plan of £20,345k deficit for 2018/19, which will require further financial loan support to be provided to enable the Trust to meet its debts as they fall due over the foreseeable future, which is defined as the period of 12 months from the date the accounts are signed. Plans are in place to draw down additional funding which is built into the 2018/19 plan and notified to NHSI and the Department of Health and Social Care, although these are agreed on a monthly basis.

As with any financial plan, there are potential risks to its delivery, although the Board is confident that these can be successfully mitigated via use of earmarked reserves and contingencies.

Having considered the material uncertainties and the Trusts financial plans, together with the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare these accounts on a going concern basis. The accounts do not include any adjustments that would result if the Trust was unable to continue as a going concern.

1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of The Rotherham NHS Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.2.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying The Rotherham NHS Foundation Trust's accounting policies and that have the most significant affect on the amounts recognised in the financial statements:

- Management make judgements in determining when substantially all the significant risks and rewards of ownership of financial assets and lease assets are transferred to other entities.

1.2.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Income estimates
In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year. Included in the income figure is an estimate for open spells, patients undergoing treatment that is only partially complete at twelve midnight on 31 March. The number of open spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which belongs to the current year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense accruals
In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Impairment of property, plant and equipment
The Trust has undertaken an annual impairment exercise of its Property, Plant and Equipment. Following a professional valuation carried out at 31 March 2018, the Trust has considered items such as; indices movements, deterioration of assets and its further estates plans to support its impairment assessment. It is the judgement of management following this review that there is not an indication of impairment.

Recoverability of receivables
In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for credit losses.

Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

Note 1.3 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within The Rotherham NHS Foundation Trust.

Note 1.4 Income

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.

At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Note 1.5 Expenditure on Employee Benefits

1.5.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.5.2 Retirement Benefit Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as at 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers. The 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 employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

NEST Pension Scheme

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where;

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably, and either
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
• items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring it back into use and where there are no restrictions preventing access to the market at the reporting date, is valued at fair value under IFRS 13, if it does not meet the requirements of IAS40 of IFRS 5.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

• Land and non-specialised buildings - market value for existing use
• Specialised buildings - depreciated replacement cost, modern equivalent asset basis

Where applicable, assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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 DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met;

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued except where 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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

Assets held by the Trust have useful lives within the following ranges. Lives are re-evaluated annually and during each revaluation to ensure they continue to be appropriate for the assets held. 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	75
Dwellings	-	-
Plant & machinery	5	15
Transport equipment	7	9
Information technology	5	20
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 1.8 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment.

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

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 of 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

	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 1.10 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of [the entity]'s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 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 above/below.

All other financial assets and liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

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".

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

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 transactions 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.

Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of “other comprehensive income”. When items classified as “available-for-sale” are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in “finance costs” in 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.

The Trust has reviewed all its main contracts and concluded that any derivatives the contracts may have are 'closely related' and therefore do not warrant separate disclosure or accounting.

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.

Note 1.14 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is 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.

Contingent rents are recognised as an expense in the period in which they are incurred.

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 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

Clinical negligence costs
NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within the Trust's Accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital
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.

At any time the Secretary of State can issue new PDC to, and requirement repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the 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 Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.18 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of Income and Capital Gains within categories covered by this but the Trust is potentially within the scope of Corporation Tax in respect of activities where income is received from a Non Public Sector source.

However, the Trust has evaluated that it is has no Corporation Tax Liability, as all activities are either ancillary to healthcare or below the de minimis level of profit at which tax becomes payable.

Note 1.20 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s FReM.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the Trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity’s accounts are preserved on recognition in the Trust’s accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers’ equity.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The Trust has considered the above new standards, interpretation and amendments to published standards that are not yet effective and concluded that they are currently either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures. This conforms with the FT ARM 2017/18, which requires that any amendments to standards are applied in accordance with the applicable timetable, with early adoption not permitted.

Note 2 Operating Segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Trust revenue derives within the UK. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust Board of Directors, which includes non-executive directors. The Board of Directors review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with graphical line charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		**Total**	
	2017/18 000s	2016/17 000s	**2017/18 000s**	2016/17 000s
Income	**242,104**	**248,322**	**242,104**	248,322
Retained Deficit	**(25,695)**	**(6,503)**	**(25,695)**	(6,503)
Segment net assets	**56,980**	**71,234**	**56,980**	71,234

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18 £000	Restated* 2016/17 £000
Acute services		
Elective income	**33,065**	34,457
Non elective income	**53,621**	52,344
First outpatient income	**18,784**	19,983
Follow up outpatient income	**13,415**	17,124
A & E income	**9,472**	8,709
High cost drugs income from commissioners	**10,308**	11,747
Other NHS clinical income	**34,127**	37,442
Community services		
Community services income from CCGs and NHS England*	**43,373**	41,031
Community services income from other commissioners	**971**	1,156
All services		
Private patient income	**35**	61
Other clinical income	**1,003**	182
Total income from activities	**218,174**	224,236

** Income streams re-categorised in 2017/18 have been re-categorised similarly in 2016/17. A movement of £1,156k between 'Community Services income- CCGS & NHSE' and 'Community Services income from other commissioners' is therefore shown in prior year figures. This does not effect the total income for Community Services, nor overall.*

Note 3.2 Income from patient care activities (by source)

	2017/18 £000	Restated* 2016/17 £000
Income from patient care activities received from:		
NHS England*	**17,626**	16,818
CCGs	**188,239**	194,457
Local authorities	**9,216**	9,957
NHS trusts	**29**	1
NHS other	**20**	735
Non-NHS: private patients	**35**	61
Non-NHS: overseas patients (chargeable to patient)	**34**	54
NHS injury scheme (was RTA)**	**825**	4
Non NHS: other	**2,150**	2,149
Total income from activities	**218,174**	224,236
Of which:		
Related to continuing operations	***218,174***	*224,236*
Related to discontinued operations	**-**	-

**NHS England income is now shown separately in 2017/18. 2016/17 is restated to show the equivalent NHS England prior year income.*

***NHS injury scheme income is subject to a provision for doubtful debts of 22.94% in 2017/18 (21.99% in 2016/17) to reflect expected rates of collection.*

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS Trust)

	2017/18 £000	2016/17 £000
Income recognised this year	**34**	54
Cash payments received in-year	**15**	-
Amounts added to provision for impairment of receivables	**19**	-
Amounts written off in-year	**-**	-

Note 4 Other operating income

Note 4.1 Other operating income by nature

	2017/18 £000	Restated* 2016/17 £000
Research and development	**329**	360
Education and training	**7,100**	6,618
Charitable and other contributions to expenditure	**5**	5
Non-patient care services to other bodies	**4,162**	2,979
Sustainability and Transformation Fund income	**-**	3,250
Rental revenue from operating leases	**427**	384
Rental revenue from finance leases	**48**	96
Income in respect of staff costs where accounted on gross basis	**1,602**	1,147
Other income	**10,257**	9,247
Total other operating income	**23,930**	24,086
Of which:		
Related to continuing operations	***23,930***	*24,086*
Related to discontinued operations	**-**	-

Further analysis of other Operating Revenue - 'Other income'

Car Parking	**957**	912
Estates Recharges (external)	**99**	447
IT Recharges (external)	**513**	222
Pharmacy Sales	**353**	843
Clinical Tests	**787**	742
Staff Accommodation Rentals	**284**	58
Staff Contributions to Employee Benefit Schemes	**364**	286
Property Rentals	**656**	698
Other income not already covered	**6,244**	5,039
	10,257	9,247

** Income streams re-categorised in 2017/18 have been re-categorised similarly in 2016/17. A movement of £1,147k between 'Other income not already covered' and 'Income in respect of staff costs were accounted for on a gross basis' is therefore shown in prior year figures along with a movement of £346k between 'Staff contributions to Employee Benefit Schemes' and 'Car Parking'. This does not affect the total income in this note.*

Note 4.2 Fees and Charges

In 2017/18 the Rotherham NHS Foundation Trust had no fees or charges where the scheme individually had a cost exceeding £1,000k.

Note 4.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18 £000	2016/17 £000
Income from services designated (or grandfathered) as commissioner requested services	**217,136**	223,993
Income from services not designated as commissioner requested services	**24,968**	24,329
Total	**242,104**	248,322

Note 4.4 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of any land or buildings assets in year used in the provision of commissioner requested services.

Note 5.1 Operating expenses

	2017/18	Restated* 2016/17
	£000	£000
Staff Costs		
Employee expenses - staff and executive directors	**172,814**	167,362
Research and development - Staff Costs	**240**	242
Remuneration of non-executive directors	**179**	164
Redundancy	**83**	-
Early retirements	**-**	-
Premises and Establishment		
Premises	**11,195**	10,657
Premises (Business rates)	**1,162**	930
Establishment	**1,843**	1,745
Rentals under operating leases	**2,858**	3,452
Transport (business travel only)	**662**	747
Transport- other (including patient travel)	**818**	792
Depreciation on property, plant and equipment	**5,604**	5,144
Amortisation on intangible assets	**1,086**	952
Net impairments	**3,367**	-
Supplies		
Supplies and services - clinical	**28,427**	26,807
Supplies and services - general	**4,033**	3,981
Drug costs	**16,843**	18,761
Inventories written down	**24**	-
Other Costs		
Clinical negligence	**9,308**	8,462
Consultancy costs	**1,137**	145
Research and development	**36**	35
Increase/(decrease) in provision for impairment of receivables	**(16)**	(405)
Change in provisions discount rate(s)	**10**	161
Audit fees payable to the external auditor		
audit services- statutory audit	**70**	72
other auditor remuneration (external auditor only)	**8**	8
Legal fees	**97**	131
Internal audit costs	**94**	94
Training, courses and conferences	**344**	350
Hospitality	**-**	4
Insurance	**210**	231
Other services, eg external payroll	**1,331**	763
Losses, ex gratia & special payments	**87**	12
Other	**696**	74
Total	**264,650**	251,873
Of which:		
Related to continuing operations	***264,650***	*251,873*
Related to discontinued operations	**-**	-

*Operating lease expenditure is restated in 2016/17 to reflect leases identified in 2017/18. Research and Development expenditure is now also separately identified, and prior year comparatives updated to reflect this split.

Note 5.2 Other auditor remuneration

The Council of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the 3 year period commencing 1 October 2016, with the option to extend for a further two years commencing 1 April 2020. The audit fee for the statutory audit is included in note 5.1.

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	**8**	8
Total	**8**	8

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1,000k (2016/17: £1,000k).

Note 6 Impairment of assets

In 2017/18 The Rotherham NHS FT completed work on its new Urgent and Emergency Care Centre, which opened on 7th July 2017. At the date of completion the asset was revalued. Costs incurred in developing the existing and new build exceed its current value, and an impairment of £5,493k was recognised. The net charge to operating costs is £3,521k. Additionally the Trust's previously impaired Mortuary was revalued upwards in the Trust's full revaluation at 31st March 2018, resulting in an impairment reversal to operating costs of £154k.

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	**3,367**	-
Total net impairments charged to operating surplus / deficit	**3,367**	-
Impairments charged to the revaluation reserve	**2,122**	-
Total net impairments	**5,489**	-

Note 7 Employee benefits

	2017/18 £000	2016/17 £000
Salaries and wages	**133,325**	127,501
Social security costs	**12,842**	12,928
Apprentice Levy	**633**	-
Employer's contributions to NHS pensions	**15,848**	15,284
Pension cost - other	**19**	25
Termination benefits	**83**	-
Temporary staff - agency/contract	**10,453**	12,518
Total gross staff costs	**173,203**	168,256
Recoveries in respect of seconded staff netted off expenditure	**-**	-
Total staff costs	**173,203**	168,256
Of which		
Costs capitalised as part of assets	*67*	*652*
Operating expenditure analysed as:		
Employee expenses	**172,814**	167,362
Research and Development	**240**	242
Redundancy	**83**	-
Total staff costs excluding capitalised costs.	**173,137**	167,604

Note 7.1 Retirements due to ill-health

During 2017/18 there were 3 early retirements from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £123k (£185k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration and other benefits

The requirements under section 412 of the Companies Act 2006 to disclose information on directors' remuneration are considered to be satisfied by the disclosures made in the notes to the accounts above and in the Remuneration Report. Director's other benefits, where relevant, are set out here.

In 2017/18 no advances or credits were granted by the Trust to any of the directors of the Trust. No guarantees were entered into on behalf of the directors of the Trust.

Note 8 Pension costs

The default scheme is the NHS pension scheme, however some employees are not eligible to join and therefore to meet auto enrolment legislation an alternative pension scheme must be provided. Like most NHS providers this Trust procured the government backed, defined contribution, National Employment Savings Trust ("NEST") as the alternative pension scheme. Pension costs for defined contribution schemes are disclosed in Note 7.

Note 9 Operating leases

Note 9.1 The Rotherham NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor. The Trust has a lease agreement with Rotherham, Doncaster & South Humber NHS FT for use at Woodlands which expires in 2108. Future lease receipts due at 31st March 2018 therefore capture this future commitment. This lease has been similalry re-categorised as an operating lease, from Premises costs, in 2016/17 comparatives.

	2017/18	Restated 2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	**427**	384
Total	**427**	384

	31 March 2018	Restated 31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	**397**	384
- later than one year and not later than five years;	**1,410**	1,053
- later than five years.	**6,875**	6,302
Total	**8,682**	7,739

Note 9.2 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	**2,858**	3,452
Total	**2,858**	3,452

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**2,844**	2,140
- later than one year and not later than five years;	**1,417**	1,074
- later than five years.	**2,274**	841
Total	**6,535**	4,055
Future minimum sublease payments to be received	**-**	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18 £000	2016/17 £000
Interest on bank accounts	**25**	22
Interest on loans and receivables	**2**	3
Total	**27**	25

Note 11 Finance Expense

Note 11.1 Loans and interest

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health	**1,337**	795
Finance leases	**4**	12
Interest on late payment of commercial debt	**1**	2
Total interest expense	**1,342**	809
Unwinding of discount on provisions	**1**	-
Other finance costs	**-**	-
Total	**1,343**	809

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2017/18 £000	2016/17 £000
Amounts included within interest payable arising from claims made under this legislation	**1**	2
Compensation paid to cover debt recovery costs under this legislation	**-**	-

Note 12.1 Intangible assets - 2017/18

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/Gross cost at 1 April 2017 - brought forward	**18,811**	**1,187**	**19,998**
Additions	343	137	**480**
Reclassifications	1,006	(1,006)	**-**
Disposals / derecognition	**-**	**-**	**-**
Gross cost at 31 March 2018	**20,160**	**318**	**20,478**
Amortisation at 1 April 2017 - brought forward	9,646	-	9,646
Provided during the year	1,086	-	1,086
Disposals / derecognition	-	-	-
Amortisation at 31 March 2018	**10,732**	**-**	**10,732**
Net book value at 31 March 2018	**9,428**	**318**	**9,746**
Net book value at 1 April 2017	**9,165**	**1,187**	**10,352**

Note 12.2 Intangible assets - 2016/17

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2016 - as previously stated	17,689	494	18,183
Additions	1,122	693	1,815
Valuation/gross cost at 31 March 2017	18,811	1,187	19,998
Amortisation at 1 April 2016 - as previously stated	8,694	-	8,694
Provided during the year	952	-	952
Amortisation at 31 March 2017	9,646	-	9,646
Net book value at 31 March 2017	9,165	1,187	10,352
Net book value at 1 April 2016	8,995	494	9,489

Note 13.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	**6,450**	**87,296**	**1,908**	**15,383**	**29,458**	**216**	**4,030**	**180**	**144,921**
Additions	-	1,346	-	1,698	245	-	385	-	**3,674**
Impairments	(150)	(5,493)	-	-	-	-	-	-	**(5,643)**
Reversals of impairments	-	154	-	-	-	-	-	-	**154**
Reclassifications	-	18,376	(1,908)	(17,081)	-	-	613	-	**-**
Revaluations	150	3,797	-	-	-	-	-	-	**3,947**
Disposals / derecognition	-	-	-	-	(3,798)	-	-	-	**(3,798)**
Valuation/gross cost at 31 March 2018	**6,450**	**105,476**	**-**	**-**	**25,905**	**216**	**5,028**	**180**	**143,255**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**7,651**	**639**	**-**	**22,768**	**172**	**2,834**	**19**	**34,083**
Provided during the year	-	3,785	34	-	1,199	15	554	17	**5,604**
Revaluations	-	(11,359)	-	-	-	-	-	-	**(11,359)**
Disposals/ derecognition	-	-	-	-	(3,798)	-	-	-	**(3,798)**
Accumulated depreciation at 31 March 2018	**-**	**750**	**-**	**-**	**20,169**	**187**	**3,388**	**36**	**24,530**
Net book value at 31 March 2018	**6,450**	**104,726**	**-**	**-**	**5,736**	**29**	**1,640**	**144**	**118,725**
Net book value at 1 April 2017	**6,450**	**79,645**	**1,269**	**15,383**	**6,690**	**44**	**1,196**	**161**	**110,838**

Contractual capital commitments not otherwise disclosed in the Accounts are disclosed in Note 30.

Note 13.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - as previously stated	6,450	85,880	1,908	7,211	29,097	202	3,841	180	134,769
Additions	-	1,416	-	8,172	361	14	189	-	10,152
Valuation/gross cost at 31 March 2017	6,450	87,296	1,908	15,383	29,458	216	4,030	180	144,921
Accumulated depreciation at 1 April 2016 - as previously stated	-	4,308	571	-	21,690	153	2,217	-	28,939
Provided during the year	-	3,343	68	-	1,078	19	617	19	5,144
Accumulated depreciation at 31 March 2017	-	7,651	639	-	22,768	172	2,834	19	34,083
Net book value at 31 March 2017	6,450	79,645	1,269	15,383	6,690	44	1,196	161	110,838
Net book value at 1 April 2016	6,450	81,572	1,337	7,211	7,407	49	1,624	180	105,830

Contractual capital commitments not otherwise disclosed in the Accounts are disclosed in Note 30.

Note 13.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018	**6,450**	**104,726**	**-**	**-**	**5,736**	**29**	**1,640**	**144**	**118,725**
Owned	6,450	101,463	-	-	5,646	29	1,640	144	**115,372**
Finance leased	-	2,514	-	-	10	-	-	-	**2,524**
Donated*	-	749	-	-	80	-	-	-	**829**
NBV total at 31 March 2018	**6,450**	**104,726**	**-**	**-**	**5,736**	**29**	**1,640**	**144**	**118,725**

**Donated asset NBV is now shown separately in 2017/18. 2016/17 is restated to show the equivalent donated asset values.*

Note 13.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017	6,450	79,645	1,269	15,383	6,690	44	1,196	161	110,838
Owned	6,450	78,038	-	15,383	6,544	44	1,195	161	107,815
Finance leased	-	1,159	1,269	-	36	-	-	-	2,464
Donated*	-	448	-	-	110	-	1	-	559
NBV total at 31 March 2017	6,450	79,645	1,269	15,383	6,690	44	1,196	161	110,838

**Donated asset NBV is now shown separately in 2017/18. 2016/17 is restated to show the equivalent donated asset values.*

Note 14 Donations of property, plant and equipment

The Rotherham NHS Foundation Trust has received no new donations of property, plant and equipment in the financial year.

Note 15 Revaluations of property, plant and equipment

During 2017/18 and in line with IAS16, the Trust's land and buildings were revalued as at 31st March 2018 by an independent valuer. The previous revaluation was undertaken as at the 31 March 2015. Between valuations management review and asset verification exercises have assessed the need for impairments.

The valuation was carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. Non operational property, including land was valued to market value.

In order to meet the underlying objectives established by International Financial Reporting Standards and the application of IAS 16 changes, those buildings which qualify as specialised operational assets and therefore, fall to be assessed using the depreciated replacement cost approach have been valued on a modern substitute basis i.e. the valuation approach assumed that the existing asset will be replaced by an asset of modern design and size which is suitable for delivering those services currently being provided where appropriate. Therefore, we have continued to assume that the modern equivalent asset does not require a site as extensive as the actual Rotherham Hospital site. We have recognised that an 8 hectare site is sufficient and the modern equivalent development is in a more appropriate location closer to the M1 and M18 motorway interchange. This approach is consistent with the last 2015 valuation methodology.

Changes in-year include the derecognition of lease accounting arrangements for the Staff Residencies buildings, which transferred back into Trust ownership from 1st October 2017, and the establishment of Finance Lease accounting for the lease of Park Rehabilitation Centre.

Note 16 Investment Property

In 2017/18 an assessment of the property portfolio during the revaluation process identified assets which are rented to other organisations and are not held for primary healthcare provision purposes. These were however deemed to support service provision and as such have not been categorised as Investment Property. They are The Lodge, the Creche and the former staff residencies.

Note 17 Investments in associates and joint ventures

In 2017/18 The Rotherham NHS Foundation Trust have no investments in associates and joint ventures.

Note 18 Other investments / financial assets (non-current)

In 2017/18 The Rotherham NHS Foundation Trust have no other investments or financial assets.

Note 19 Disclosure of interests in other entities

The Rotherham Hospital & Community Charity

The Trust has considered the need to consolidate Charitable Funds (The Rotherham Hospital & Community Charity) within the main Trust accounts and concluded, although the Trust continues to meet the criteria within the accounting standard, the value of the Charitable Funds is not material and will not therefore be consolidated within the Trust's main accounts.

The table below summarises the Charitable Funds Statement of Financial Activities and Balance sheet.

	31 March 2018 £000	31 March 2017 £000
Total incoming resources	**173**	107
Resources expended	**(200)**	(177)
(Losses)/Gains on revaluation and disposals	**(8)**	(16)
Net movement in funds	**(35)**	(86)
Total Assets	**373**	403
Total Liabilities	**(11)**	(6)
Total Charitable Funds	**362**	397

The 2017/18 Charitable Funds accounts have not yet been subject to independent review. The 2016/17 Charitable Funds accounts were finalised in January 2018.

Note 20 Inventories

	Drugs £000	**Consumables £000**	**Energy £000**	**Total £000**
Carrying value at 1 April 2017	**523**	**2,530**	**131**	**3,184**
Additions	14,511	11,536	22	**26,069**
Consumed	(14,188)	(11,346)	(43)	**(25,577)**
Write-downs	(24)	-	-	**(24)**
Carrying value at 31 March 2018	**822**	**2,720**	**110**	**3,652**
Carrying value at 1 April 2016	684	2,285	132	3,101
Additions	12,951	245	(1)	13,195
Consumed	(13,112)	-	-	(13,112)
Write-downs	-	-	-	-
Carrying value at 31 March 2017	523	2,530	131	3,184

Note 21.1 Trade and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables due from NHS bodies*	**4,391**	2,408
Trade receivables due from related WGA parties	**359**	2,526
Trade receivables due from non-WGA bodies	**332**	-
Provision for impaired receivables	**(613)**	(656)
Prepayments (non-PFI)	**2,357**	2,878
Accrued income	**4,260**	4,083
PDC dividend receivable	**-**	332
VAT receivable	**365**	642
Other receivables	**70**	514
Total current trade and other receivables	**11,521**	12,727
Non-current		
Other receivables	**30**	43
Total non-current trade and other receivables	**30**	43

*Where the Trust has received contractual income for activity but has performed less activity than planned to 31st March 2018, the reduction in income is accounted for as an advance and transferred to Payables. The equal and opposite value appears in the Payables note as Receipts in Advance.

Note 21.2 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April as previously stated	**656**	1,308
Increase in provision	**(16)**	(405)
Amounts utilised	**(27)**	(247)
Unused amounts reversed	**-**	-
At 31 March	**613**	656

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; for example, Injury Cost Recovery Scheme debts are provided for at 22.94% per the national guidance.

Note 21.3 Analysis of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables £000	**Investments & Other financial assets £000**	Trade and other receivables £000	Investments & Other financial assets £000
Ageing of impaired financial assets				
0 - 30 days	**4**	**-**	0	-
30 - 60 Days	**1**	**-**	12	-
60 - 90 days	**1**	**-**	1	-
90 - 180 days	**52**	**-**	37	-
Over 180 days	**78**	**-**	606	-
Total	**136**	**-**	656	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	**440**	**-**	281	-
30 - 60 Days	**178**	**-**	430	-
60 - 90 days	**199**	**-**	104	-
90 - 180 days	**373**	**-**	225	-
Over 180 days	**956**	**-**	271	-
Total	**2,146**	**-**	1,311	-

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.

The Trust holds no other assets or finance lease receivables than those already detailed.

Note 22 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.

	2017/18	2016/17
	£000	£000
At 1 April	**1,503**	3,609
Net change in year	**(103)**	(2,106)
At 31 March	**1,400**	1,503
Breakdown of cash and cash equivalents		
Cash at commercial banks and in hand	**252**	119
Cash with the Government Banking Service	**1,148**	1,384
Total cash and cash equivalents as in SoFP	**1,400**	1,503
Bank overdrafts (GBS and commercial banks)	**-**	-
Drawdown in committed facility	**-**	-
Total cash and cash equivalents as in SoCF	**1,400**	1,503

The Trust's cash balances are largely held in the Government Banking Service Royal Bank of Scotland account and also a HSBC account, both of which are considered low risk institutions.

Note 22.1 Third party assets held by the Trust

At 31st March the Trust held no cash or cash equivalents which relate to monies held on behalf of patients or other parties.

Note 23 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Receipts in advance*	**895**	820
NHS trade payables	**2,563**	1,295
Amounts due to other related parties	**136**	2,085
Other trade payables	**6,043**	5,010
Capital payables	**489**	1,344
Social security costs	**1,846**	1,763
VAT payable	**48**	95
Other taxes payable	**1,425**	1,350
Accrued interest on DHSC loans	**349**	158
Other payables	**-**	(87)
Accruals	**8,337**	10,691
PDC dividend payable	**344**	-
Total current trade and other payables	**22,475**	**24,524**
Total non-current trade and other payables	**-**	**-**

** Where income has been received in advance of service provision, the negative receivable is reclassified as a payable at the 31st March. These relate to activity with CCGs and NHSE. The opposite entry appears in the Receivables note.*

Note 24 Other financial liabilities

The Trust holds no other financial liabilities. In 2016/17 £96,000 current and £1,842,000 non-current liabilities were classified as 'Other Financial Liabilities'. This is restated in this year's accounts to appropriately reflect their nature to 'Other Liabilities', and ensure consistency of treatment. See Note 25.

Note 25 Other liabilities

	31 March 2018 £000	Restated* 31 March 2017 £000
Current		
Deferred income*	**1,224**	1,420
Deferred grants	**-**	-
Lease incentives	**-**	-
Total other current liabilities	**1,224**	1,420
Non-current		
Deferred grants income*	**-**	1,842
Deferred grants	**-**	-
Lease incentives	**-**	-
Total other non-current liabilities	**-**	1,842

* In 2016/17 liabilities of £96,000 current and £1,842,000 non-current, that were associated with staff residencies held on-SOFP were classified as 'Other Financial Liabilities.'. These were correctly reclassified as 'Other Liabilities'. These were then de-recognised in October 2017 when the residencies were transferred back to Trust ownership.

Note 26 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health	**3,375**	3,375
Obligations under finance leases	**28**	31
Total current borrowings	**3,403**	3,406
Non-current		
Loans from the Department of Health	**57,179**	34,969
Obligations under finance leases	**2,650**	14
Total non-current borrowings	**59,829**	34,983

Note 27 Finance Leases

Obligations under finance leases where the Trust is the lessee.

In year rentals associated with a long term lease for Park Rehabilitiation Centre have been assessed and categorised as a finance lease obligation. The asset is held on the Trust's balance sheet (SOFP).

	31 March 2018 £000	31 March 2017 £000
Total lease liabilities	**2,678**	45
of which liabilities are due:		
- not later than one year;	**28**	31
- later than one year and not later than five years;	**-**	14
- later than five years.	**2,650**	-
Finance charges allocated to future periods	**-**	-
Total lease liabilities	**2,678**	45
Contingent rent recognised as an expense in the period	**-**	-

Note 28.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Total £000
At 1 April 2017	**1,119**	**119**	**1,238**
Change in the discount rate	10	-	**10**
Arising during the year	76	72	**148**
Utilised during the year	(75)	(19)	**(94)**
Reversed unused	(98)	(42)	**(140)**
Unwinding of discount	1	-	**1**
At 31 March 2018	**1,033**	**130**	**1,163**
Expected timing of cash flows:			
- not later than one year;	75	130	**205**
- later than one year and not later than five years;	298	-	**298**
- later than five years.	660	-	**660**
Total	**1,033**	**130**	**1,163**

The Pensions (early departure) provision relates to the ongoing costs of making early payment of pensions. Legal claims relate to liabilities to third parties (administered by NHS Resolution). The main uncertainty in terms of the timing of the cash flows relates to the pensions provision as assumptions need to be made (in accordance with guidance) as to the estimated length of life of the pensioners and the consequent cost to the Trust. These are discounted per the guidance along with Injury Benefits provisions. At present there is no expectation that the Trust will receive any reimbursement in respect of these provisions.

Note 28.2 Clinical negligence liabilities

At 31 March 2018, £49,061k is included in the provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS FT (31 March 2017: £45,544k).

Note 29 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	**(40)**	(119)
Gross value of contingent liabilities	**(40)**	(119)
Net value of contingent assets	**-**	-

Note 30 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment*	**122**	956
Total	**122**	956

**At 31 March 2017 the Trust was committed to expenditure relating to the continued work on the new Urgent and Emergency Care Centre (UECC). Costs disclosed here were committed to under contract. At 31 March 2018 work is completed on the UECC. Capital commitments as at 31 March 2018 include smaller capital schemes where costs are committed under contract, but which are not included elsewhere in the accounts.*

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has low exposure to interest rate fluctuations as it has borrowings only from the Department of Health at fixed rates of interest.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 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 31.2 Financial assets

Assets as per SoFP as at 31 March 2018	***Loans and receivables*** **£000**	***Assets at fair value through the I&E*** **£000**	***Held to maturity*** **£000**	***Available-for-sale*** **£000**	***Total*** **£000**
Trade and other receivables excluding non financial assets	6,707				**6,707**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	1,400	-	-	-	**1,400**
Total at 31 March 2018	**8,107**	**-**	**-**	**-**	**8,107**

Restated

Assets as per SoFP as at 31 March 2017	*Loans and receivables* £000	*Assets at fair value through the I&E* £000	*Held to maturity* £000	*Available-for-sale* £000	*Total* £000
Trade and other receivables excluding non financial assets	6,608	-	-	-	6,608
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	1,503	-	-	-	1,503
Total at 31 March 2017	8,111	-	-	-	8,111

Note 31.3 Financial liabilities

Liabilities as per SoFP as at 31 March 2018	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Borrowings excluding finance lease and PFI	60,554		**60,554**
Obligations under finance leases	2,678		**2,678**
Obligations under PFI, LIFT and other service	-		**-**
Trade and other payables excluding non financial liabilities	17,917		**17,917**
Other financial liabilities	-		**-**
Provisions under contract	-		**-**
Total at 31 March 2018	**81,149**	**-**	**81,149**

Re-stated

Liabilities as per SoFP as at 31 March 2017	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Borrowings excluding finance lease and PFI	38,344		38,344
Obligations under finance leases	45		45
Obligations under PFI, LIFT and other service	-		-
Trade and other payables excluding non	20,497		20,497
Other financial liabilities	-		-
Provisions under contract	-		-
Total at 31 March 2017	58,886	-	58,886

Note 31.4 Maturity of financial liabilities

	31 March 2018 £000	Re-stated 31 March 2017 £000
In one year or less	**21,320**	28,698
In more than one year but not more than two years	**5,108**	3,375
In more than two years but not more than five years	**39,383**	12,813
In more than five years	**15,338**	14,000
Total	**81,149**	58,886

Note 32 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	**Total value of cases £000**	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	**-**	**-**	1	-
Fruitless payments	**1**	**30**	-	-
Bad debts and claims abandoned	**59**	**(5)**	5	34
Stores losses and damage to property	**3**	**25**	-	-
Total losses	**63**	**50**	6	34
Special payments				
Extra-contractual payments	**-**	**-**	-	-
Extra-statutory and extra-regulatory payments	**-**	**-**	-	-
Compensation payments	**9**	**12**	6	11
Special severence payments	**-**	**-**	-	-
Ex-gratia payments	**17**	**19**	17	9
Total special payments	**26**	**31**	23	20
Total losses and special payments	**89**	**81**	29	54
Compensation payments received		**-**		-

Note 33 Events after the reporting period

There have been no significant events after the reporting period date.

Note 35 Related parties

Note 35.1 Register of Interests

The Rotherham NHS Foundation Trust is corporate body established by order of the Secretary of State for Health.

The Trust is required, under International Accounting Standard 24 'Related Party Disclosures', to disclose any related party transactions. The objective of IAS 24 is to draw attention to the possibility that the reported financial position and results may have been affected by the existence of related parties and by material transactions with them. In the cases above, all payments shown have been made by the Trust to the organisations concerned and not to the individual officers.

During the year the Trust has had transactions with a number of organisations with which key employees/directors of the Trust have some form of relationship. Those bodies, outside the Department of Health parent body, are detailed below and are not considered material.

	31 March 2018	31 March 2017	**31 March 2018**	31 March 2017
	Receipts from Related Party £000	Receipts from Related Party £000	**Payments to Related Party £000**	Payments to Related Party £000
Leeds University	**0**	0	**10**	1
Finegreen Associates	**0**	0	**17**	1
University of West London	**1**	0	**0**	0
Total related party transactions	**1**	0	**27**	2

There was £nil owed, or due at the 31st March in respect of these transactions.

The relationships are:

- The wife of a Board member is employed by Leeds University
- the husband of a board member is also Chair of Finegreen Associates Ltd and a Professor at the University of West London.

Note 35.2 Other Related Parties

The value of the Trust's transactions with other related parties during the year is £Nil. (2016/17 £Nil)

The value of the Trust's outstanding balances with other related parties at 31 March 2018 is £Nil (31 March 2017 £Nil)

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. The Government Accounting Manual interprets this such that Department of Health and Social Care group bodies must disclose the Department of Health and Social Care as the parent department and provide a note of the main entities within the public sector with which the body has had dealings. During the year, the Trust has had a significant number of material transactions with other entities within the public sector. These entities are listed below:

- NHS Property Services
- Rotherham Metropolitan Borough Council
- Her Majesty's Revenue and Customs (HMRC)
- NHS Pension Scheme

Independent auditors' report to the Council of Governors of The Rotherham NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, The Rotherham NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts 2017/18 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Taxpayer's Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 to the financial statements (Accounting Policies) concerning the Trust's ability to continue as a going concern.

The Trust anticipates that it will receive external financial support to ensure that it is able to meet its liabilities as they fall due and provide ongoing healthcare services. However, the nature of any financial support, including whether such support will be forthcoming or sufficient is not yet known.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Explanation of material uncertainty

The current year's deficit of £25.7m compares to an original plan of £13.6m deficit. At the end of 2017/18 the Trust had a cash balance of £1.4m, largely due to the drawdown of working capital loans in the year, and the net cash outflow from operations of £15.0m.

For 2018/19 the Trust Board has agreed a financial plan that has a deficit of £20.3m. Based on the financial plan for 2018/19, the Trust will require further financial support from the Department of Health and Social Care to ensure that it is able to meet its liabilities as they fall due and provide ongoing healthcare services. At the time of approval of the financial statements the amount of and nature of the funding was unknown and will be agreed between the Trust and Department of Health and Social Care on a monthly basis.

We also note the level of external borrowing in the form of Department of Health and Social Care loans of £60.5m as at 31 March 2018, and that there is currently no realistic prospect of paying these back without additional funding beyond current levels.

In addition, the Trust's licence condition in relation to financial performance remains in place.

What audit work we performed

In considering the appropriateness of the Going Concern basis in the preparation of the financial statements we obtained the 2018/19 financial plan and cash flow forecasts, and:

- compared the assumptions within the Trust's financial plan against assumptions provided by Monitor/ NHSI and our experience in the health sector;
- understood the Trust's Cost Improvement Plan target of £9.7m;
- considered the Trust's prospects of paying back the £60.5m of Department of Health external loans as being relatively low based on current funding arrangements;
- assessed the reasonableness of the plan assumptions and carried out a sensitivity analysis over this plan; and
- considered the reliance that the Trust has on external support to deliver its 2018/19 plan, which at the time of approval of the financial statements the nature and amount had not been agreed.

Our audit approach

Context

The 2017/18 financial year is the second year that PwC has audited the Trust. In the year the Trust experienced financial pressure delivering a £25.7m deficit for the year, which was higher than the original planned deficit of £13.6m. External borrowing from the Department of Health has also risen from £38.3m to £60.5m during the year.

The licence condition placed on the Trust on 23 April 2013 by Monitor, regarding financial planning remains in force. Within the prior year the Trust received a follow up inspection from the Care Quality Commission ("CQC") which, although acknowledging the Trust's progress and improvements made, gave a rating of 'requires improvement'. These matters have been considered within our audit approach.

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Trust's operations and relative financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged, other than the Trust having undertaken a full revaluation of its estate.

Overview

- Overall materiality: £4,834,000 which represents 2% of total revenue.
- This was our second year audit of the Trust; in considering our approach we considered the Trust's financial performance and clinical performance to identify the areas of greatest risk for the audit process.
- Risk of fraud in revenue and expenditure recognition and management override of controls;
- Financial standing and sustainability;
- Valuation of Property, Plant and Equipment

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In

addition to financial sustainability and going concern, described in the Material Uncertainty relating to going concern section above, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	*How our audit addressed the Key audit matter*
Risk of fraud in revenue and expenditure recognition and management override of control *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of revenue and expenditure and notes 3 to 5 for further information.* We focussed on this area because there is a heightened risk due to: • The Trust being under increasing financial pressure: the deficit for the year is £25.7m, and whilst the Trust is actively looking at ways to maximise revenue and reduce cost, there is an incentive for management to manipulate the timing of recognition of both revenue and expenditure. • For 2018/19 the Trust Board has agreed a financial plan resulting in a deficit of £20.3m, the achievement of which will continue to place pressure on the Trust. Given the continued financial support required by the Trust over that period, there remains an increased incentive to misreport the Trusts position. Given these incentives, we considered the key areas of focus to be: • Recognition of revenue and expenditure; • Manipulation through journal postings; and • Items of income or expenditure whose value is dependent upon estimates.	*Revenue* For income and expenditure transactions close to the year-end we tested, on a sample basis that the transaction and the associated income and expenditure had been posted to the correct financial year end by tracing them to invoices or other documentary evidence. Our testing did not identify any balances which had been recorded in the incorrect period. For a sample of income contracts from NHS England and Clinical Commissioning Groups ("CCG"), we obtained and agreed the income received during the year to a signed contract with no exceptions noted. For a sample of income recognised in relation to over performance against contract (i.e. the 'the true up' income) we agreed to year end settlements with no exceptions noted. *Expenditure* For invoices received/ balances paid for a period after the year-end we tested, on a sample basis that the transactions and the associated expense had been posted to the correct financial year by tracing them to other documentary evidence or invoices. Our testing did not identify any items incorrectly recorded. We tested a sample of operating expenses through to invoice to ensure that this had been correctly accounted for. No differences were identified that required amendment within the financial statements. *Intra-NHS balances* We obtained the Trust's mismatch reports received from NHS Improvement ("NHSI"), which identified balances (debtor, creditor, income or expenditure balances) that were different with the counterparty. We checked that management had investigated all differences over £250k (based on the National Audit Office's reporting criteria). We read correspondence with the counterparties, which was consistent with these results. We then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements. Our testing identified a number of errors with the Trust's treatment of balances, and those errors identified which were individually over £250k were amended for in the financial statements. The balances that remained unadjusted do not have a material impact to the year-end financial statements of the Trust. *Manipulation through journal postings* We selected a sample of manual and automated journal transactions that had been recognised in both income and expenditure, focusing in particular on those with unusual characteristics. We traced these journal entries to supporting documentation (for example, invoices, good received notes and cash receipts and payments) to check that the transaction was valid and had been correctly accounted for within the financial statements. Our testing identified no issues that required further reporting. *Management estimates* We evaluated and tested management's accounting estimates, focussing on; accruals, provisions, deferred income; and Property, Plant and Equipment Valuation (see specific area of focus below).

Key audit matter	How our audit addressed the Key audit matter
	We evaluated and challenged the key accounting estimates on which management's estimates were based and the basis of their calculation on a sample basis by comparing the assumptions used by management in the calculation of their estimate with independent assumptions and investigating any differences. Our testing identified no matters that required amendment within the financial statements of the Trust.
Valuation of Property, Plant and Equipment *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to Property, Plant and Equipment and note 12 for further information.* We focussed on this area because Property, Plant and Equipment ('PPE') represents the largest balance in the Trust's statement of financial position. All PPE assets are measured initially at cost with Land and Buildings being subsequently measured at fair value, through full valuations every 5 years and interim valuations after three years, with interim impairment assessments being carried out by management to see if there is an indication of impairment. Based on management's decision, the Trust's external valuers have undertaken a full revaluation exercise for the purpose of the valuation of land and buildings as at 31 March 2018.	We used our valuations expertise to confirm that management's the revaluation adjustments were appropriate, and represented the Trust's specific circumstances including regional adjustments. We evaluated and challenged the assumptions and methodology in the valuation report produced by the Trust's external valuation experts and used our own valuations expertise in the health sector to: • check the valuer's qualifications and objectivity; • consider the suitability of the methodology adopted in valuing the assets; and • agreed the movement in the BCIS indexation that has been adopted in the valuation to the average BCIS movements in the area. We also checked and found that the valuation of land and buildings per the valuation report had been accurately reflected in the financial statements and that the gains and impairments have been accurately reflected in the correct area within the Statement of Comprehensive Income and reserves. We physically verified a sample of assets across land, buildings and other categories to check existence and, in doing so, assessed whether there was any indication of physical obsolescence which would indicate potential impairment. We found no issues from this testing.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the accounting processes and controls, and the environment in which the Trust operates.

In establishing our overall audit approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£4,834,000 (2017: £4,968,000)
How we determined it	2% of revenue (2017: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £242,000 (2017: £240,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 148, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of The Rotherham NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis of adverse conclusion

i) Breach of Licence

On the 23 April 2013 and subsequently amended in June 2013, September 2013 and June 2015, Monitor issued enforcement action against the Trust. This related to breaches surrounding financial planning, governance and the Electronic Patient Records System.

However, the breaches in relation to financial planning remained outstanding as of 31 March 2018, which specifically made reference to the fact that the Trust had not demonstrated that it had established and effectively implemented systems and/or processes to ensure compliance with its duty to operate economically, efficiently and efficiently.

The above issue is evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

ii) Financial performance

In the year the Trust delivered a deficit of £25.7m (£22.3m excluding impairments) which was in line with the revised plan, though £8.7m adrift of the original deficit plan of £13.6m. Cash outflow from operations was £15.0m and external borrowing with Department of Health is at £60.5m (2017: £38.3m).

The above issue is evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

iii) CQC inspection results

In September 2016, the Trust received a focussed follow up Care Quality Commission (CQC) inspection. The outcome of the inspection was received on 2 March 2017, when the Trust received a 'requires improvement' rating. We have also seen no evidence that the Trust had made sufficient improvements before the start of the year.

The above issue is evidence of a weakness in proper arrangements for planning and developing workforce to deliver strategic priorities effectively.

Adverse conclusion

As a result of these matters, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2018.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 149, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Trust's performance, business model and strategy is not materially consistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on page 185, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of

performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Ian Hooker (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Leeds
Date: 25/5/18

Acknowledgements

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