The Rotherham NHS Foundation Trust

Annual Report and Accounts

2016/17

Ambitious Caring Together

Together we can

NHS
The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2016/17

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

Contents

Together we can

OUR MISSION

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

OUR VISION

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

Welcome from the Chairman

Welcome to The Rotherham NHS Foundation Trust's Annual Report and Accounts for the year 2016/17. It sets out how the Trust performed over the year. Thank you for your continued support

Like many other NHS trusts, we have faced a challenging year financially. In 2016/17, we had originally planned to achieve a £6.6m surplus with £6.5m from the Sustainability and Transformation Fund (STF). However, we ended the year with a deficit of £6.5m (being only able to draw down £3.25m from the STF).

The financial position of the Trust continues to overshadow some significant improvements and developments in patient care and improving the financial sustainability of the Trust continues to be a focus.

Whilst we continue to face significant challenges we believe we have firm foundations on which to build for the future. We have made considerable progress as an organisation this year; however we are still formally subject to the NHS Improvement enforcement and licence conditions in relation to financial and strategic planning (see our Annual Governance Statement for further details).

We have, however, achieved £9.8m of Cost Improvement Programme (CIP) savings. Whilst we did not quite achieve our planned CIP of £10.5m, which equated to 5% of the Trust's controllable costs, the CIP we delivered far exceeded the efficiency level of 2% which was built into the national tariff for 2016/17.

During 2016/17, we have also continued to build on the progress of previous years and we are particularly pleased that the improvements we have made have been recognised by the Care Quality Commission (CQC) following their re-inspection in September 2016. A number of areas of outstanding practice were identified, including in community in-patients at Breathing Space and Oakwood Community Unit.

We aim to be a sustainable, thriving Trust providing excellent healthcare at home, in our community and in hospital. We have been working together with partners in South Yorkshire & Bassetlaw, and collectively we submitted a Sustainable Transformation Plan (STP) in October 2016. During the year we have also been working with our Rotherham partners in developing a very exciting Rotherham Place Plan.

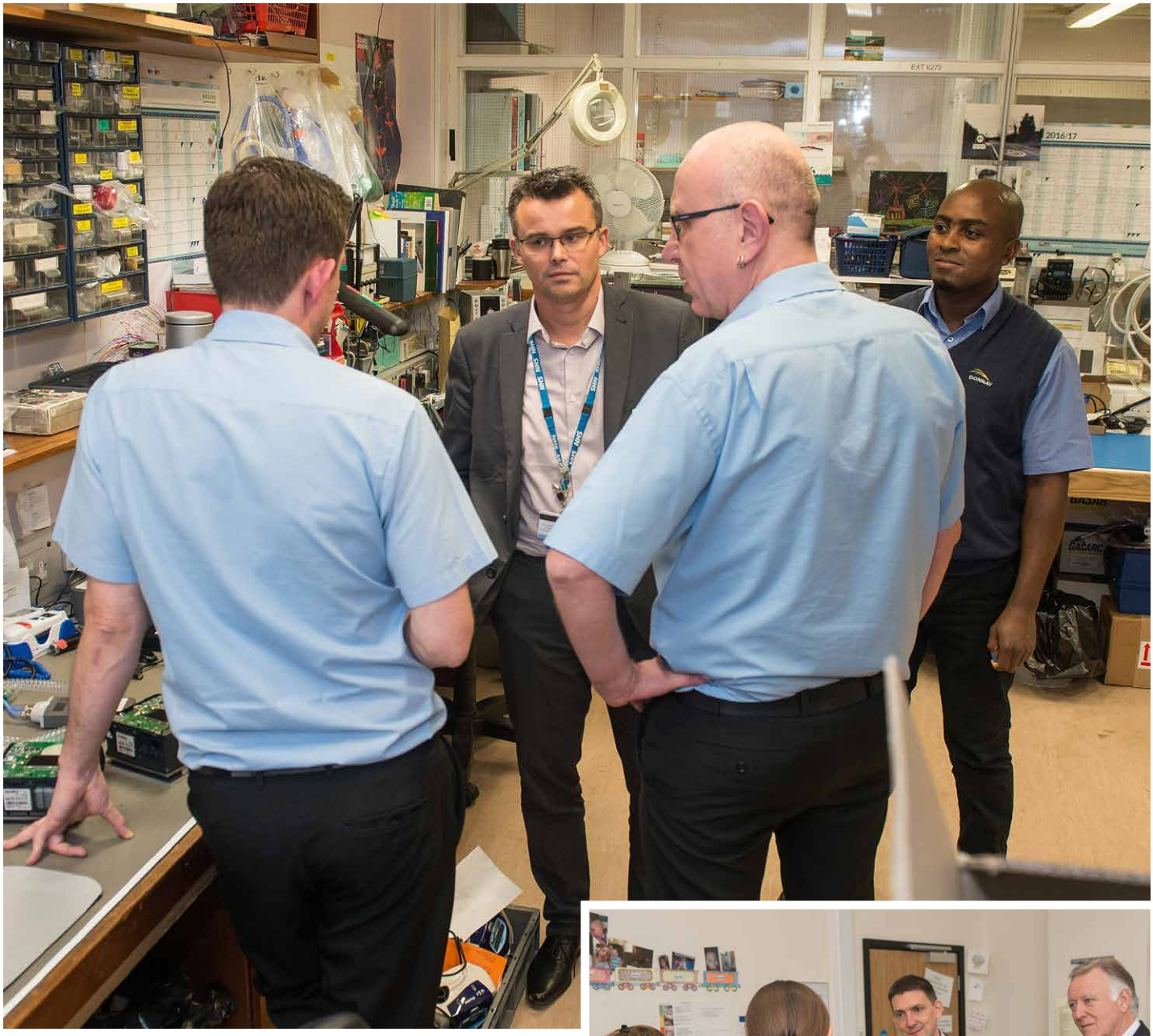
Our national staff survey results showed an improvement in how we engage with our colleagues across the Trust and we introduced a new Colleague Forum to further improve how we listen to, and act on, colleagues' concerns and ideas. We continue to engage and optimise the commitment of colleagues across the Trust and have this year launched our new engagement methodology 'Together we can'. This brings together a wide variety of engagement activities which will empower our colleagues to make positive changes on behalf of patients.

Among the highlights of the year was our integrated IT portal Sepia winning a Health Service Journal national award for making a difference to how health care professionals share information about patients to improve care.

This year we have agreed our five year strategy which is our response to how it is we can support the NHS Five Year Forward View. The strategy clearly sets out our priorities for the Trust and we have also progressed in our work to transform services, including launching the integrated locality pilot, creating a clinical strategy and beginning work to transform children's and young people's services.

We are committed to delivering our vision to be an outstanding trust, providing excellent healthcare at home, in our community and in hospital which involves every member of the Trust and we believe we are well on the way in our journey of improvement on behalf of our patients and the people of Rotherham.

Martin Havenhand
Chairman



"I have worked in the organisation for a very long period of time and feel extremely loyal and feel valued"

Staff survey feedback

Performance Report
Overview of Performance

This section provides an overview of performance for the Trust during 2016/17.

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, we are regulated by the sector regulator, NHS Improvement, and our 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 to be a leading healthcare provider to patients in the hospital, community and home settings.

The health of people in Rotherham is varied compared with the England average. Deprivation is higher than average and about 22.8% (11,300) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham than in the least deprived areas. Black and minority ethic residents make up 6.5% of the population, within which the largest group are those identifying as Asian / Asian British (4.1%) of total population. Rotherham is in the most deprived quintile within the Index of Multiple Deprivation.

The Trust has 403 inpatient beds, and circa 4,000 members of staff providing a comprehensive range of services to the population of Rotherham, as well as specialist services across the South Yorkshire region and nationally.

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, but the Trust also provides services at Breathing Space, Park Rehabilitation Centre, Rotherham Community Health Centre, Rotherham Intermediate Care Centre, and at The Flying Scotsman Centre in Doncaster

The Rotherham NHS Foundation Trust has a divisional management structure to co-ordinate and deliver healthcare services. On 1 April 2017, the Trust revised the structure of the Clinical Divisions by merging those of Emergency Care and Medicine to create a single Integrated Medicine Division comprising the Emergency Department, the Acute Medical Unit, all medical specialties and adult inpatient medical wards as well as all adult community services. As a result the Divisional structure now includes four Divisions: Integrated Medicine, Family Health, Surgery and Clinical Support Services.

National healthcare strategies

The UK Government's Five Year Forward View challenges the traditional divide between primary care, community services and hospitals. It highlights the importance of managing systems rather than organisations, and recognises the importance of out-of-hospital care and the need to integrate services around the needs of the patient.

Against this environment, the Trust's Vision is 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 work with patients, the public and partners to make a positive difference to health and wellbeing of the people of Rotherham and the wider catchments which the Trust serves, and seeks to continue to serve, in the provision of high quality services. 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 Sustainability and Transformation Plan (STP), Working Together Programme (WTP) and Acute Care Collaboration Vanguard, brings together in various configurations, Health and Social Care partners across South Yorkshire, Bassetlaw and North Derbyshire, with the aim of providing sustainable health services for not only Rotherham, but the wider population. These programmes provide the mechanism through which we will continue to explore and progress steps to improve resilience and sustainability of services.

Our strategic themes

Patients
Excellence in healthcare

Colleagues
Engaged, accountable colleagues

Governance
Trusted, open governance

Finances
Strong financial foundations

Partners
Securing the future together

"...Nursing/medical staff are a credit to the hospital. Today I saw a nurse feeding an elderly lady with care and compassion. Staff friendly, informative and efficient. Full marks! A+"

Friends and Family patient feedback
Acute Medical Unit

Our strategic themes were agreed in 2014/15 and have remained constant.
A number of key operational priorities supported their delivery during 2016/17:

Patients

1 Improve the quality of admission to discharge care planning
- Reduce non clinical ward moves

2 Improve rates of harm free care and expand use of safety thermometer
- Recognising and responding to the deteriorating patient
- Reduce the incidence of medication errors
- Prevent missed or delayed diagnosis

3 Improve mortality rates (reduce HMSR and SHMI)
- Improve responsiveness to complaints
- Improve our engagement with patients and families and use feedback to support service transformation

4 Improve patient experience of our clinical administration systems (e.g. outpatient booking systems)

5 Develop new models of care supported by the Trust's clinical strategy, and consistent with the STP and Vanguard
- Removal of unnecessary clinical variation to support the Trust's strategy

6 Clinically led estates plan and strategy in place to support Trust's strategy

7 Clinically led IT plan and strategy in place to support Trust's strategy

Colleagues

8 Implement demand and capacity led job planning
- Improved short and long term workforce planning
- Attract, recruit and retain the right colleagues to provide the capability and capacity to deliver the operational plan and strategy
- Right colleagues in the right place at the right time (E-rostering and roster management)

9 Improve medical engagement
- To create a culture where our colleagues are engaged and accountable
- To improve the health and wellbeing of our workforce - to be happy, healthy and here

10 Provide training, education and development for colleagues
- Develop senior leadership development programmes

Governance

11 Implement effective emergency preparedness and business resilience planning

12 Work with regulator regarding outstanding enforcement actions and address where possible
- Implementation of audit recommendations – none outstanding over 3 months old, with 90% completed within original deadline. Non-compliance reported to TMC and Audit Committee, alongside "lessons learnt" actions
- Delivery of annual audit plan to agreed timescales

13 Strengthen risk management
- Enhance governance arrangements from ward to board
- Strengthen the BAF

14 Develop board leadership development programmes
- Increased transparency and board visibility
- Enhance Stakeholder governance

15 Improve compliance with IG Toolkit
- Improve IG compliance culture / awareness

16 Effective use of business intelligence and performance management frameworks
- Improve data quality

Finance

17 Deliver the 2016/17 financial plan
- 2016/17 Capital programme approved by the board of directors
- Reduce the underlying deficit within the 2016/17 financial year and then subsequent years

18 Supporting colleagues in innovation and continuous improvement
- Deliver the 2016/17 CIP programme
- Draft CIP plans for 2017/18 to come to TMC/F&P from October onwards
- Engagement in the Lord Carter Productivity Programme (monthly updates to TMC-T 1/4ly F&P)
- Improve utilisation and efficiency of theatres and maximise use of day case services
- Reduction of premium pay

19 Monthly cash balance in line with the 2016/17 annual plan
- Improved aged profile of debtors

20 Implementation of PLICs including 1/4ly SLR reports
- Financial training implemented across TRFT to all budget holders (face to face and e-learning
- Consultant finance and business sessions – 100 % to be offered sessions by Q1, with 30% delivered by Q2 (to support medical engagement programme)

Partners

22 Extend the scale and pace of transformation across both adult, and children and young people's services consistent with the principles of 7 day working and effective governance
- Supporting closer health and social care integration
- To develop a shared vision of services across the Rotherham Place and the South Yorkshire & Bassetlaw Sustainability & transformation Plan including the acute care collaboration vanguard.


Big Smiles
Extra dwarf variety up to 37cm (15") tall.

Progress against the priorities has been reported to the Board of Directors on a monthly basis, and, in conjunction with the Board Assurance Framework, has provided the Board with oversight and timely review of the Trust's progress against strategic objectives.

Chief Executive's Statement

Overall, the Trust had mixed performance against national healthcare standards; details are provided in the Quality Report from page 31. However some specific headlines are provided below.

National focus remained on the A&E 4-hour access standard, with the Trust's performance deteriorating during the second half of the year. One of the key challenges faced during the year was that the department continued to be run out of a former ward which, as a physical environment, presents significant challenges around space. This has been necessary in order to accommodate the construction of the new Urgent and Emergency Care Centre (UECC), which is due to open in July 2017.

In November 2016, the Trust also implemented a new IT system in A&E, which was an essential and planned improvement in readiness for working with a new service model as part of the UECC. As with any major IT implementation, it was anticipated that the new system would provide some operational challenges during the early phases of 'go-live' and as a result, it was agreed with the regulator and the local CCG that the Trust would suspend reporting of the A&E 4-hour access target until the new system was suitably embedded. This period was anticipated to be 2 to 4 weeks and was extended for a total of 6 weeks, and therefore between the 4 November 2016 and 19 December 2016, the Trust did not formally report against the A&E 4-hour access target.

Throughout this period, alternative controls were put in place to oversee patient waiting times and care, and whilst this caused some disruption at the time, the system is now fully operational within the department.

The Trust remains committed to continuing to improve data quality and is focused on taking actions to strengthen this to provide a sound platform of information and reporting to inform decision-making. This will remain a key priority throughout 2017/18.

By the end of the 2016/17 financial year, which included a nationally challenging winter period, the Trust finished with performance against the A&E 4-hour access target of 86.43% against the national standard of 95%. Whilst this is very disappointing, and is a significant drop on performance over previous years, the Trust has agreed an improvement trajectory with NHSI to improve performance to at least 90% by September 2017 and 95% by March 2018.

The Trust's performance against the 18-week referral-to-treatment incomplete waiting time standard of 92%, remained very strong, with compliance being achieved for every month during 2016/17. This was against a national picture of monthly non-compliance in performance over the same period. We anticipate that this good performance will be maintained going forward into 2017/18.

The Trust also has an excellent reputation for timely treatment of cancer, and the performance figures throughout the year reflect this. Quarterly performance against both the 2 week-wait from GP referral and the 62-day wait from GP referral, has been achieved in every quarter since 2014/15, and is the result of robust tracking and waiting list management. It is therefore disappointing that performance in Q4 against the 62-day referral standard was not achieved. The 2-week

wait standard remains compliant, and the Trust has also reported upper quartile performance against another 5 of the main cancer standards. However, the reasons for non-compliance in Q4 are understood and the Trust is confident that performance will be back on track going forward into 2017/18.

Performance against clodistrium difficile trajectory of 26 for the year set by the regulator was strong, with 18 occurrences (+1 community acquired infection) being reported. More details can be found in the quality report on page 84.

HSMR deteriorated during the year, and by year end, stood at 107 (source, CHKS). Data also showed that weekend mortality was generally higher than observed on other days of the week. SHMI, which is reported 6 monthly, was at 102 at year end, but had risen to 109.63 in April 2017 after having also been rebased during that month. The Trust has an action plan in place to ensure timely review of all deaths and their causes, and the Board's Quality Assurance Committee and Board of Directors receive monthly reports regarding the position.

The CQC re-inspected the Trust in September 2016, which followed their initial inspection in February 2015. The regulator acknowledged some areas of great improvement since the previous visit. However, the Trust was served with regulation notices relating to Regulation 11 HSCA (RA) Regulations 2014: Need for Consent, Regulation 17, HSCA (RA) Regulations 2014: Governance, and Regulation 18 HSCA (RA) Regulations 2014: Staffing. More details can be found in the Quality Report on page 55.

Disappointingly, four Never Events were reported by the Trust during 2016/17. Two were retrospective, identified through a review of incidents and relating to wrong route administration of medication. The third incident related to a retained foreign object post-procedure, and the fourth related to an overdose of insulin due to the use of an incorrect device.

All of the incidents were subject to extensive investigation and report, and both NHSI and the CQC were advised with action plans having been created which helped to address any arising issues. The Trust reviewed and reissued its Incident and Serious Incident Management Policy in August 2016, and a new weekly Serious Incident Weekly Review Group was sent up and attended by the Chief Nurse and Medical Director. No severe harm was caused to any of the patients involved in the four incidents.

The Trust has a culture where reporting of incidents is encouraged, and this is reflected in the details that appear on our DATIX reporting system. During the financial year, a total of 10,253 incidents were reported, as indicated on the table below.

1st April 2016 to 31st March 2017

Incident Type	TRFT - Community Rotherham	TRFT - Acute	TRFT - Woodside	Patient Home	Other NHS Trust	Nursing / Residential Home	Off Site	Total
Incidents affecting patients	1119	6490	23	637	90	307	48	8714
Incidents affecting visitors/public	8	49	0	0	0	0	4	61
Incidents affecting staff/contractors	160	576	4	11	3	4	9	767
Trust Incidents (Excluding Fire and Security)	95	476	7	0	2	0	7	587
Security and Fire Incidents	21	92	3	0	0	0	8	124
Total	1403	7683	37	648	95	311	76	10253

"The Matron service has really helped, don't know what we'd have done without them."

Friends and Family patient feedback
Community Matrons

Whilst colleagues feel able to report incidents, there is still some way to go in using the information from these incidents so that the Trust can learn more fully when things go wrong. This is something that will considered during an external Quality Governance review that the Trust will carry out in 2017/18.

Compliance with Level 2 of the Information Governance Toolkit was submitted at the end of March 2017. This was an improvement on the previous year where lack of numbers taking up IG training had meant that the Trust was not able to pass the required Level 2. Details of the scores against individual standards for 2016/17 is provided below.

Standard	Overall score 2014/15	Overall score 2015/16	Overall score 2016/17	Grade
Information Governance Management	60%	86%	86%	Satisfactory
Confidentiality and Data Protection Assurance	66%	75%	75%	Satisfactory
Information Security Assurance	60%	71%	68%	Satisfactory
Clinical Information Assurance	66%	66%	73%	Satisfactory
Secondary Uses Assurance	62%	66%	66%	Satisfactory
Corporate Information Assurance	55%	77%	77%	Satisfactory
Overall	62%	72%	72%	Satisfactory

The Trust reported one information governance breach through SIRI which involved personal identifiable information being taken from a locked vehicle. This breach was reported and investigated as a serious incident and was reported to the attention of the Information Commissioner. The Information Commissioner's Office commenced their own investigation into the breach, and was satisfied with the actions taken by the Trust, and the controls and policies in place, in response to this incident and took no action against the Trust.

The 2016/17 financial plan (control total) was a very challenging £6.6M surplus, and reflected £6.5M of Sustainability and Transformation funding (STF). Whilst the Trust did deliver against the STF targets in Quarters 1 and 2 of the financial year, performance deteriorated in the final half of the year resulting in non-receipt of STF in these quarters.

In January 2017, the Trust submitted a risk-assessed, stretching revised year-end forecast to the regulator of £9.7M deficit. Whilst we made savings and invested in our estate and new models of care, our deficit for the year ending 31 March 2017 was a deficit of £6.5M which was £13.1M adverse to plan (£3.25M linked to STF).

Cost Improvement Plans delivered £9.8M of savings in 2016/17 against a plan of £10.5M, with the full year effect of identified schemes being £12.7M which represented approximately 5% of controllable costs, and was in excess of the inbuilt implied efficiency level within the 2016/17 national tariff of 2%.

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

Quality of care:

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.

The main focus for the Trust will be the ongoing development and implementation of actions following the CQC's re-inspection as part of the Quality Improvement Plan (QIP) for 2017/18. The Trust recognises that its quality governance framework could be more robust, and it is anticipated that the outcomes of the QIP, coupled with an external quality governance review during 2017/18, will support improvement in services.

Workforce:

Leadership capacity and capability, failure to recruit to significant posts, sickness absence, productivity, and the modernising of the workforce to ensure the optimum workforce shape and size to meet clinical future needs and support improved clinically financial sustainability.

The Trust has a significant and persistent issue with recruitment for some key positions. The areas of staffing where there are shortages represent national staffing challenges but nonetheless impact on the Trust's ability to deliver a sustainable, robust, effective and cost effective service. Extensive work has and is continuing to support recruitment and there have been some notable successes but long standing recruitment gaps still exist in some areas.

Regulatory Risk:
Breach of NHS Improvement's Single Oversight Framework and the Trust's Provider Licence, CQC and association legislation, and Information Commissioner's Office requirements.

Finance:
Increasing cost pressures predominately linked to agency staffing, significant capital and revenue investment is required to address backlog maintenance and to support transformation of services, liquidity, and the requirement for improved information and reporting.

Operational delivery:
Failure to achieve quality and operational targets, leading to increased financial penalties with a possibility of failing to deliver transformation at a reasonable pace. Failure to deliver robust action plans to achieve performance against the operational objectives.

External environment:
Changing regulatory regime and new collaborative working arrangements, increased reliance on partners and shared governance through new working relationships.

These risks are referenced in more detail in the Annual Governance Statement, beginning on page 198.

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.

In 2017/18 the Trust Board has agreed a £13.6m deficit plan, to allow the Trust to meet its liabilities as they fall due. The Trust will require additional financial support from the Department of Health over this period which will be agreed on a monthly basis. Currently the nature or amount of funding that will be required is unknown.

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 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 2017/18 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 214 and the report from the Audit Committee detailing the significant issues considered by the Committee in relation to the financial statements as required by the Foundation Trust Code of Governance (provision C.3.9) in the Governance and Organisational Structure section of this Annual Report.

"I was very poorly when I came. I had 24 hour care and cannot fault anyone or anything. Excellent care!"

Friends and Family patient feedback
Breathing Space

Performance Analysis

Development and Performance of the Trust during the Year

76,383	Emergency Attendances
4,949	Electives
6,206	Excess Bed Days
8,360	Ambulatory attendances
19,707	Non-Elective attendances
32,084	Day Cases
55,425	Outpatient Procedures
75,118	Outpatient First attendances
155,428	Outpatient Follow Up attendances

4 Never Events

Financial Risk Rating score being 4 (against a plan of 2)

£6.5m	deficit for the year ending 31 March 2017
£8.8m	deficit
£12.5m	agency and locum spending gainst a plan of £10.6M
£9.8m	of savings delivered through Cost Improvement Plans in 2016/17 against a plan of £10.5M, plan = 5% of controllable costs

The Trust uses an integrated performance dashboard which gives oversight to over 170 key performance indicators at the monthly Board of Directors' meetings. These indicators cover a full range of domains including quality, operational, governance, workforce and financial performance. This is replicated across the Trust's clinical divisions and clinical service units and forms part of the monthly performance meetings between each clinical division and the Executive Directors.

A detailed analysis of some of the metrics against which the Trust reports, can be found on pages 105-106 of the Quality Report.

The CQC Report into its September 2016 re-inspection of the Trust, assessed Urgent and Emergency services as 'requires improvement'. This was reflected by the Trust's overall pe rformance against the A&E 4-hour access standard at year end of 86.43% against the national standard of 95%.

In order to improve the performance against this standard, a series of improvements were made within the A&E department itself and also out in the wider clinical areas. Within the A&E department, changes have seen the introduction of 'Manchester Triage', the establishment of a primary care stream which aims to ensure more patients are seen by the GP within A&E, the use of regular staffing huddles, as well as looking at the use of alternative clinical roles, such as the use of Advanced Nurse Practitioners and Emergency Department Practitioners.

The Trust also experienced difficulties around the availability of a substantive A&E medical workforce (consultants and middle-grade doctors), leading to a higher than planned usage of locum doctors. This very much reflects the national picture and the difficulties experienced in other parts of the country.

We have been more successful in the recruitment of a nursing workforce within the A&E department, and following a series of successful recruitment events during early 2017, have been able to attract a number of new, experienced nurses - with the new U&ECC being one of the key attractions.

Also, as well as a primary care 'stream', and following successful trials, additional GPs also regularly worked in the A&E department during the winter period to help triage patients appropriately and identify alternative pathways for patients.

In order to support the plans to improve performance in the A&E department, the Trust has hosted visits from a number of external bodies, including the NHS Improvement Intensive Support Team, and a joint team from the Local Government Association, and an acute trust. These reviews have confirmed that a great deal of positive improvements have, and continue to be made, but that further work is required to embed the principles of the SAFER care bundle, which aims, amongst a number of things, to ensure patients who are medically fit and safe to leave hospital, do so earlier in the day. Attention also needs to continue on increasing the number of discharges at weekends, as well as regularly reviewing patients who have an extended length of stay within the hospital.

Considerable work has also continued during 2016/17 to improve the performance of patient pathways within the hospital setting. This has seen an increased focus on ambulatory assessments, a reconfiguration of some of the assessment and admitting units, as well as the function of multi-disciplinary working on the wards to ensure patient's plans are reviewed and progressed daily.

To support increased patient need over the winter period, the Trust increased the bed capacity throughout the winter months through the opening of a 'winter ward'. An additional twelve beds were also opened in the community by working with partner organisations. This helped relieve some of the bed pressures that were experienced over January and February, although it was still a challenging period. As in previous years, a planned reduction of elective activity during the busiest winter months, but without delaying cancer operations, was planned to assist overall flow.

Whilst the Trust placed significant focus on these internal challenges, we continued to work with partner organisations and we continue to work closely with health and social care partners in Rotherham; the development of the locality based working is another of the successful developments throughout 2016/17.

The integration of district nursing, community matrons, mental health nurses, therapists and social workers into a single multi-disciplinary team in one of the seven localities, has also contributed to the reduction in hospital admissions, as well as improvements in the length of stay for patients. The further development of the locality based working is a key objective for 2017/18 and to build upon the positive changes that have already been made.

18 Week Referral to Treatment Waiting Times

The Trust is proud of its delivery of the 18-week referral-to-treatment incomplete waiting time target, and the Trust has been amongst the strongest NHS performers in the country against this particular outcome measure.

However, in January 2017 the contract that the Trust had held for over 10 years to provide ophthalmology services to the residents of Barnsley, was re-tendered by Barnsley CCG. The Trust was disappointed at not being successful in securing the contract, which was won by Barnsley Hospital NHS Foundation Trust.

As part of the transition of the contractual arrangements at the end of 2016/17, it was found that some of the patient waiting lists required further validation. On completing this exercise, a number of patient pathways were found to have remained open for over 12 months.

All patients were immediately contacted and clinically assessed; this action confirmed that there was no patient harm identified as a result of the waits.

All of the patients were then either seen or had their pathway closed following a discussion. This therefore resulted in the Trust having to report 10 x 52 week wait breaches against the 18 week RTT standard. These breaches are allocated to the Trust's March 2017 return.

Cancer Waiting Times

The Trust achieved the 2016/17 national cancer performance standard for all metrics and is particularly proud to be consistently performing in the top quartile (best 25%) of NHS providers for five of the nine cancer standards including;

- Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer
- Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected
- Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis
- Percentage of patients receiving subsequent treatment for cancer within 31-days from the decision to treat date - where that treatment is Surgery
- Percentage of patients receiving subsequent treatment for cancer within 31-days from the decision to treat date - where that treatment is an Anti-Cancer Drug Regime

"Friendly and approachable staff - good bedside manner of all doctors throughout care given. All help fully appreciated and nurses are extremely helpful."

Friends and Family patient feedback
Acute Medical Unit


NHS

Diagnostic Waiting Times

The Trust has traditionally delivered strong performance against the 6 week wait diagnostic standard. Disappointingly the performance average for 2016/17 indicates that 2.24% of patients waited longer than six weeks for their diagnostic test, this is against a national standard of no more than 1% of patients.

This underachievement can be attributed to two main areas;

- capacity available within certain modalities; and
- securing staff to meet the service requirements

On a positive note, once the challenges around staffing were fully realised, a recovery plan was established and through working differently with teams internally as well as working with partner providers, compliance with the standard was achieved in both February and March 2017. During this time the Trust was also one of the joint top performing Trusts in the country.

Compliance with Sustainability and Transformation Fund trajectories for 2016/17 for the healthcare standards already outlined, is provided in the table below:

		Q1	Q2	Q3	Q4	16/17
4hr access	TRFT	91.6%	92.2%	83.5%	85.2%	88.4%
	STP	87%	91.8%	91.8%	92.1%	90.7%
Cancer	TRFT	92.5%	85.4%	85.3%		
	STP	86%	85.2%	85.1%	85.3%	85.4%
RTT	TRFT	95.4%	93.9%	94.6%	94.4%	94.6%
	STP	93.9%	93.8%	93.6%	93.7%	93.8%
6 week wait	TRFT	1.1%	1.9%	4.4%	1.9%	2.3%
	STP	0.9%	0.8%	0.6%	0.6%	0.7%

The 2016/17 financial plan (control total) was a very challenging £6.6M surplus, and reflected £6.5M of Sustainability and Transformation funding (STF). This funding would only be received on successful delivery of quarterly operational and financial targets. Whilst the Trust did deliver against these targets in Quarters 1 and 2 of the financial year, performance deteriorated in the final half of the year resulting in non-receipt of STF in these quarters.

In January 2017, the Trust submitted a risk-assessed, stretching revised year-end forecast to the regulator of £9.7M deficit. Substantial risks to achievement of this target were highlighted; a reduction in agency spend, delivery of CQUIN/acute and community indicators, and receipt of all clinical income for work undertaken was required.

Whilst we made savings and invested in our estate and new models of care, our deficit for the year ending 31 March 2017 was a deficit of £6.5M which was £13.1M adverse to plan (£3.25M linked to STF), and resulted in the Trust's Financial Risk Rating score being 4 (against a plan of 2). This was compared with ending the previous year with a £8.8M deficit which was £6.9M adverse to plan.

The Trust was set a target by NHSI to reduce overall agency expenditure by 35% below levels experienced in the last financial year. This represented an overall reduction in annual expenditure of circa £5.5M. By the end of Q1, the Trust was performing £133K better than forecast. However, by year end, agency and locum spending had risen to £12.5M, against a plan of £10.6M; this was significantly due to medical workforce challenges, particularly in the emergency department, dermatology and gastroenterology.

Cost Improvement Plans delivered £9.8M of savings in 2016/17 against a plan of £10.5M, with the full year effect of identified schemes being £12.7M. This compared with 2015/16 where plans delivered £12.6M of savings against a plan of £12.9M. The 2016/17 CIP target of £10.5M represented approximately 5% of controllable costs. This was far in excess of the inbuilt implied efficiency level within the 2016/17 national tariff of 2%. This stretched target reflects the Trust's plan to manage and reduce its ongoing underlying deficit position.

The Commissioning for Quality and Innovation (CQUIN) scheme, £3.6m, includes nationally mandated and locally agreed goals for improving quality of patient care. The schemes agreed with Rotherham Clinical Commissioning Group and our forecast year-end position is detailed below:

Indicator Status National (N) Local (L)	Indicator Description	Forecast Year-end Position
N	Introduction of staff health & wellbeing initiatives	Achieved
N	Development of an implementation plan and implementation of a healthy food & drink offer	Achieved
N	Improving the up-take of flu vaccinations for frontline clinical staff	Achieved
N	Timely identification and treatment for sepsis in A&E and inpatient settings	Partial Achievement
N	Reduction in antibiotic consumption per 1,000 admissions	Partial Achievement
N	Empiric review of antibiotic prescriptions	Partial Achievement
L	Improving quality &timeliness of clinic letters from secondary care to primary care (outpatients)	Achieved
L	Improving quality &timeliness of discharge letters from secondary care to primary care including intermediate care and handover plans (inpatients)	Partial Achievement
L	Engagement in Clinical Referrals Management Committee/System Resilience Group including audits	Achieved
L	Clinical engagement in other CCG priorities	Achieved
L	Embed the SAFER Care Bundle and support 7 day working across inpatient wards	Partial Achievement

In addition to the above, the Trust monitors progress against delivery of an extended range of hospital services 7 days per week as well as a range of community schemes aimed at supporting admission avoidance and early discharge.

In 2016/17 the Trust demonstrated significant improvement in the following quality indicators:

- Significantly improved performance and compliance with National Stroke Indicators with the Trust achieving Level B standard
- Cancer Two Week Waits – most patients being seen within seven days of referral (top quartile performance nationally)
- Percentage of patients with a fractured neck of femur meeting best practice targets has increased significantly from 61% to 93%

We actively engage with Public Health both at RMBC and NHS England in supporting health awareness messaging and in addition work with the voluntary sector to provide support where appropriate. Without the commitment of our partners across health and social care, Voluntary Action Rotherham, Age UK Rotherham, Yorkshire MESMAC, we would not have been able to achieve the progress that we have made in improving our services for patients. We are grateful for the continued support from our patients, families, partner organisations and members of the community.

After being awarded preferred bidder status to deliver 0-19s and Integrated Sexual Health services following a formal procurement exercise, the Trust worked closely with Rotherham Metropolitan Borough Council (RMBC) to jointly agree implementation and mobilisation plans in preparation for the 1 April 2017 commencement date. The revised service models will streamline systems and processes to improve patient experience and enhance service delivery.

In addition, the Trust and RMBC continue to work jointly 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.

Workforce, Equality and Human Rights

The Trust continues to improve its performance with a strengthened focus on equality and increased engagement in order to meet its requirements with regard to the Equality Duty and the Equality Act 2010.

During the financial year, evidence in support of the Trust's compliance with the legislation included publishing the first annual Workforce Race Equality Standard (WRES) report, followed by the Equality Delivery System (EDS2) assessment. Both of these reports are available to view via the equality and engagement pages of TRFT's website.

Furthermore the Trust has a suite of policies and procedures in relation to the workforce in order to support colleagues in their roles which brings together the Trust's approach to equality, across all the protected interest groups, and to respecting the basic human rights of our colleagues, patients and public. An Equality Impact Assessment is required to be undertaken and completed 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 documentation ratification group which is a key part of the governance arrangements.

Social and Community Issues

In 2016/17 The Rotherham NHS Foundation Trust was recognised by several organisations for its work in the community and improving services for patients and colleagues. These included:

- UNICEF awarded the Trust's Maternity service Baby Friendly status following backing from parents.
- RoSPA[1] awarded the Trust a Gold Award in their Occupational Health and Safety Awards 2016 for the third consecutive year.
- The Health Service Journal chose the Trust's in-house clinical IT system, SEPIA, as the winner of the national 'Enhancing Care by Sharing Data and Information' award.
- The National Cancer Patient Experience Survey praised the Trust for the quality of care it offers cancer patients.
- Voluntary Action Rotherham awarded the Trust's volunteer service 'Kitemark Plus' status recognising the way the service is coordinated and managed to ensure volunteers have a rewarding experience.

Within the entrance to the Trust is the 'Community Corner' which is an area for health enquiries and promotions. Community Corner hosted 160 promotions from local organisations such as the 'Police Hate Crime'; events held there raised over £5,600 in funds for The Rotherham Hospital and Community Charity.

The Rotherham Hospital and Community Charity has worked with, and alongside, various groups in the community this year to raise funds for its Purple Butterfly Appeal.

Schools also supported the Charity, including Rotherham College, which donated artwork, and Maltby Redwood Primary school which raised money for the Children's Ward after a student spent time on the ward.

The Rotherham Hospital and Community Charity provided, inter alia:

- £20,000 to fund 11 ceiling and wall murals throughout the Trust, which when combined with specialist lighting, create a calming glow for patients to experience whilst undergoing treatment.
- A third Purple Butterfly room, located on Ward A1 / A2, for the use of patients and their families at the end of life which provides a 'home from home', has been opened thanks to generous donations and fundraising by members of the public.

Rotherham United Football Club continued to support the Trust's Charity by attending various events at the hospital and delivering gifts to the children at Christmas and attended the on-site Christmas Fair.

[1] The Royal Society for the Prevention of Accidents.


NHS

Overseas Operations
The Trust does not have any overseas operations.

Any Important Events since the End of the Financial Year Affecting the Foundation Trust
There are no events since the end of the financial year affecting the Trust.

Progress against the Sustainable Development Plan
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 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 (TRFT) 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 managing their lives in a positive way.

> *"Emergency services were quick and efficient and the hospital was caring and made me feel relaxed at what was happening to me."*
>
> **Friends and Family patient feedback**
> **Coronary Care Unit**

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 will be approving the Trust's SDMP shortly so the plans for a sustainable future will become well known within the organisation and clearly laid out.

One of the ways in which our impact as an 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, running awareness campaigns that promote the benefits of sustainability to our 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.

We have not assessed the social and environmental impacts for the Trust.

We are 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 TRFT 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 here is the sustainability comparator for our CCGs:

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 helps to explain how both the organisation and its performance on sustainability has changed over time.

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

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 £1,111,026 on energy in 2016/17, which is a 3.3% decrease on energy spend from last year:

Resource		2013/14	2014/15	2015/16	2016/17
Gas	Use (kWh)	37,433,799	36,553,450	40,577,691	3,869,144
	tCO_2e	7,941	7,669	8,492	809
Oil	Use (kWh)	175,350	0	0	0
	tCO_2e	56	0	0	0
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	11,693,036	10,895,180	10,810,127	10,872,310
	tCO_2e	2,265	1,942	756	1,556
Green Electricity	Use (kWh)	0	348,377	146,071	2,306,501
	tCO_2e	0	-21,360	-8,314	-87,850
Total Energy CO_2e		10,262	-11,749	934	-85,486
Total Energy Spend		£ 1,643,442	£ 1,462,708	£ 1,073,928	£ 1,111,026

Performance

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

However, over the last 12 months the CHP has suffered several lengthy stoppages which have impacted upon both the electricity and gas consumption on site. Even accounting for the problems encountered with the CHP a year on year energy reduction has still been achieved despite creeping growth through increased IT systems by implementing energy saving initiatives such as LED lighting, improved building controls, upgrading air handling units and increased staff engagement. 12.3% of the Trust's electricity comes from renewable sources.

Commentary

Each year energy saving / carbon reducing projects have been identified and successfully implemented via an internal Invest to Save scheme, resulting in lower energy consumption and less impact upon the environment. New technologies and innovations have been installed whenever possible when replacing unserviceable, high energy usage equipment and plant that has come to the end of its useful life. Awareness training is continually rolled out to colleagues and an Estates Newsletter has been launched to increase colleague engagement.

Travel

Local air quality can be improved as can the health of those in the community by promoting active travel – to colleagues and to the patients and public that use TRFT's services.

Every action counts and the Trust is a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We support a culture for active travel to improve colleague wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for the local population, patients, colleagues and visitors and are caused by cars, as well as other forms of transport

Category	Mode	2013/14	2014/15	2015/16	2016/17
Patient and visitor Travel	miles	410,333	0	0	0
	tCO_2e	151.61	0.00	0.00	0.00
Business Travel and fleet	miles	1,503,687	1,514,909	1,560,557	1,631,250
	tCO_2e	540.64	499.44	509.15	524.42
Colleague commute	miles	Data not collected	Data not collected	Data not collected	Data not collected
	tCO_2e	Data not collected	Data not collected	Data not collected	Data not collected

Performance

The Trust has recently commenced implementing its new Board-approved Travel Plan which sets out a range of strategies and objectives to enable colleagues, patients and visitors to take a healthier and environmentally friendly option when travelling to and from the hospital and other locations. The Trust has also participated in a discounted bus ticket scheme for colleagues along with promoting cycle to work schemes such as Dr Bike where colleagues can have their bicycles serviced free of charge. The Trust also runs a lease car scheme where colleagues are able to enter into a contract through salary deduction which allows them to have the opportunity to travel in vehicles with lower carbon emissions than they may have done previously.

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:

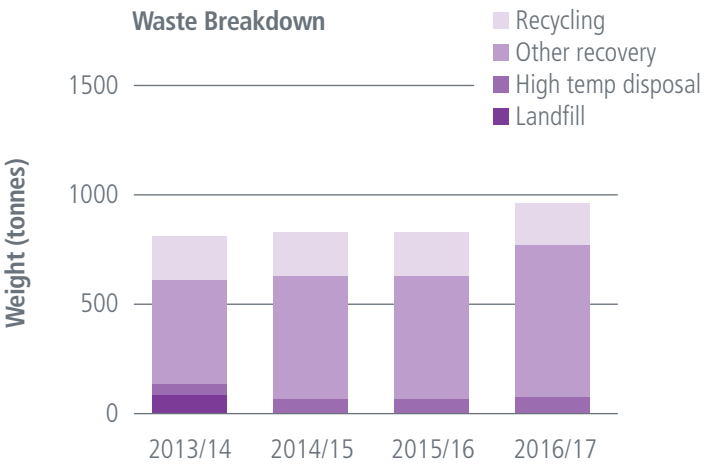
- BART an acronym for Be A Recycler Today, BART is our recycling character for plastic,
- BART's girlfriend GRACE (Go Recycle A Can Everyday) and she is our can recycling character, to conclude the family for the present
- Grandpa SETH (Segregate Everyday Trash Here) has now joined the family for the black bag waste stream.

As a result of the initiative the plastic recycling has now increased over 100% since the commencement of the initiative. We have also introduced our recycling of anaesthetic masks which are sent for shredding and re-use. This is a relatively new initiative which will further increase the plastic recycling rates.

Waste

Performance

In line with legislative requirements, none of the waste from the Trust is sent to landfill. Other recovery tonnage has increased and levelled due to the increase in the 'tiger stripe' waste stream, and an alternative disposal route found. Recycling has steadily improved and there has been a dramatic increase from 6.8 tonnes prior to the introduction of the 'BART' recycling family to last year's recorded tonnage of 15.97 tonnes over the 3 year period. Metal recycling and WEEE recycling is also up.



Due to improved waste segregation, orange bag waste has further reduced and improved segregation of paper waste has seen a reduction in the amount of confidential waste produced. The Trust's drive to increase recycling and reduce waste is detailed below:

Waste		2013/14	2014/15	2015/16	2016/17
Recycling	(tonnes)	197.00	195.00	216.00	194.00
	tCO_2e	4.14	4.10	4.32	4.07
Other recovery	(tonnes)	476.00	574.00	573.00	702.00
	tCO_2e	10.00	12.05	11.46	14.74
High Temp disposal	(tonnes)	54.00	64.00	63.00	70.50
	tCO_2e	11.88	14.08	13.80	15.51
Landfill	(tonnes)	81.00	0.00	0.00	0.00
	tCO_2e	19.80	0.00	0.00	0.00
Total Waste (tonnes)		808.00	833.00	852.00	966.50
% Recycled or Re-used		24%	23%	25%	20%
Total Waste tCO_2e		45.81	30.23	29.58	34.33

Finite resource use – Water Performance

Due to improved monitoring and trend analysis it has been possible to achieve a steady reduction in water consumption on the hospital site. A partner has been engaged to assist with consumption patterns and leak detection. The performance targets in the Trust's Sustainable Development Management Plan are on target to be achieved within the next 12 months.

Commentary

During the past 12 months several underground leaks have been detected and repaired. To date 6 underground leaks (from hydrants and valves) have been identified and repaired in addition to the repair of damage to underground pipework. A number of urinal flush controls, water saving taps and cisterns have been installed across the Trust. A colleague communication aimed at reporting dripping taps was successful and resulted in noticeable savings.

The Trust's water consumption over the past four years is contained in the table below.

Water		2013/14	2014/15	2015/16	2016/17
Mains	m^3	106,325	104,971	97,450	87,969
	tCO_2e	104	103	96	80
Water & Sewage Spend (£)		212,624	225,291	205,749	188,584

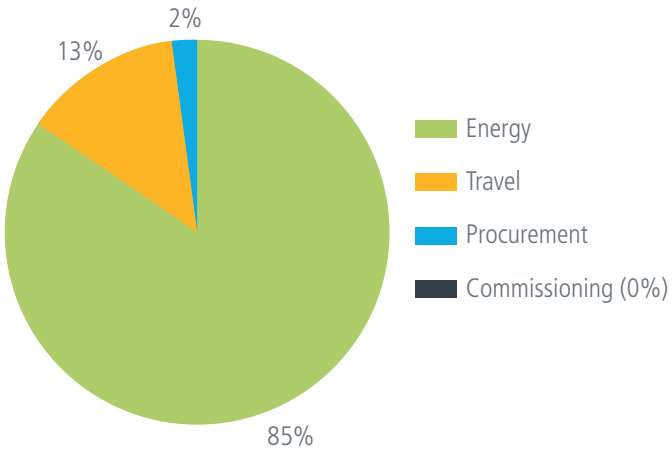
Modelled Carbon Footprint

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 our 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

The Trust's estimated total carbon footprint for 2016/17 was 8,780 tonnes of carbon dioxide equivalent emissions (tCO_2e). In 2015/16 this figure was 8,758 and in 2014/15 it was 9,232. These carbon footprint figures relate to energy and travel use only, and exclude procurement and commissioning. The organisation's carbon intensity per pound is 348.52 grams of carbon dioxide equivalent emissions per pound of operating expenditure ($gCO_2e/£$). Average emissions for the Trust's service mix is 190 per pound.

Category	% CO_2e
Energy	85%
Travel	13%
Procurement	2%
Commissioning	0%

Proportions of Carbon Footprint



"Really helped my son with getting a diagnosis and me to understand it and also he is getting help he needs at school."

Friends and Family patient feedback
Child Development Centre

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 [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.

The Rotherham NHS Foundation Trust: Looking forward

We are currently transforming the way that urgent and emergency health care is provided to local people. We will open a new state-of-the-art Urgent and Emergency Care Centre (U&ECC) in July 2017 at Rotherham Hospital. The Centre will see the town centre based walk-in centre relocate to the hospital site and will provide a better service for patients, 24 hours a day, 7 days a week, 365 days a year.

The U&ECC is being developed in partnership with NHS Rotherham CCG. However, we are also working closely with Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) to provide urgent mental health services on-site. And, together with Rotherham Metropolitan Borough Council (RMBC) and Voluntary Action Rotherham to support people who require social care support. Working in collaboration with all of these partner agencies in Rotherham has led to the development of Rotherham's Integrated Health and Social Care Place Plan ('the Place Plan') which brings together the skills of primary care with those of emergency medicine, urgent mental health services and social care.

The Place Plan focuses on improving the health and well-being gap of the community of Rotherham, through prevention, self-management, education and early intervention. It will drive transformation to close the care and quality gap through:

- Rolling out our integrated locality model – The Village;
- Opening an integrated UECC;
- Further developing the Care Coordination Centre; and
- Building a specialist re-ablement centre.

Underpinnng the urgent and emergency care portal will be appropriate, right sized assessment facilities, together with clinical pathways aimed at facilitating safe and effective treatment and discharge. We will redesign the assessment units and will use technology to provide live visibility of patients coming to and within the assessment units. The Care Coordination Centre supports referrals from primary care and other professionals to ensure alternative pathways are identified and accessed, in conjunction with the assessment unit clinical teams. The service will be extended to include mental health and social care.

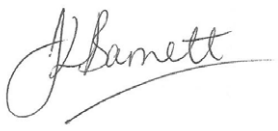
We will develop Trust wide Ambulatory Care pathways with dedicated facilities from which ambulatory services can be located. We will reconfigure our in-patient bed base so that it will support the sub-specialisms and as far as possible separate out the non-elective bed base from the elective. The medical workforce will be configured to provide appropriate levels of seniority in the right place at the right time, with the use of alternative roles and specialists to support areas where recruitment may be difficult.

Delivering sustained access to care for elective and cancer pathways in line with the constitutional standards is something that the Trust has been able to achieve with reasonable success over the last few years. We will ensure diagnostic access is timely and community based diagnostics are deployed to improve access, capacity and flexibility.

The Trust is seeking to expand its range of community rehabilitation and therapy services which are aimed at promoting independence and increasing healthy life expectancy. We recognise that there are opportunities for integration of fragmented services which will optimise physical, mental and social wellbeing of our patients.

The Trust is committed to working with health and social care and wider partners across South Yorkshire and Bassetlaw to improve the sustainability of services for the population it serves.

Performance Report signed by CEO in capacity as Accounting Officer



Louise Barnett
Accounting Officer
May 2017

Quality Report 2016/17

I have always been treated very professionally but on a friendly basis on my visits for various reasons to this hospital. This department is no exception, many thanks.

Friends and Family patient feedback
Dermatology Non Theatre

Contents

Foreword from the Chairman

Welcome to The Rotherham NHS Foundation Trust's Quality Report for 2016/17 which describes the Trust's performance against a range of national and local quality priorities. Our priorities are agreed each year with local organisations representing patients and the public we serve, our commissioners (NHS Rotherham Clinical Commissioning Group), our Governors and Trust colleagues.

The Quality Report reflects the performance and achievements of colleagues and volunteers who deliver care to our patients. It provides a description of our performance over the last year and sets out how we work to achieve our ambition of being an outstanding trust, delivering excellent care at home, in our community and in hospital.

This has been a challenging year in which the Trust has had to respond to high demand for emergency care, a CQC re-inspection and continuing financial pressures.

The Trust collaborates with our partners to ensure continued quality of care with the finances we have available. We are working with our partners through the 'Working Together' Vanguard, which places Rotherham at the forefront of developments in the NHS. However the Sustainability and Transformation Plan will lay the foundations for a long-term, sustainable approach to providing quality clinical services within a network of 25 partner organisations across South Yorkshire and Bassetlaw. The first step, a consultation on changes to Hyper-Acute Stroke Services and Children's Surgery and Anaesthesia is now complete and details about the next areas for consideration can be found at www.smybndccgs.nhs.uk

The coming year will see the opening of our new Emergency and Urgent Care Centre, an essential component for improving patient experience and raising clinical standards. The purpose-built facility will help the Trust give patients the emergency care they need and improve the flow of patients from community to hospital to home.

It is also important that we acknowledge areas where the Trust did not deliver the highest standards. During the year two 'Never Events' were reported in addition to two from the previous year identified in a review of medication incidents. We have yet to make sufficient progress on discharge planning, complaints management or reducing the incidence of pressure ulcers. There was also one breach of information governance reported to the Information Commissioner's Office. The Trust was unable to meet the emergency care target with 88.4% of patients admitted, treated or discharged within four hours over the year against a target of 95%. As an organisation we continue talk openly and honestly about these occurrences and their root causes, taking action to learn and improve.

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

It is encouraging that the results of the CQC re-inspection of September 2016 show that we have made solid progress in many areas of quality and patient care. Those areas previously deemed 'inadequate' have all been uprated and special mention is due to Oakwood Community Unit that was accorded an 'Outstanding' rating by inspectors.

Our colleagues have done a good job and we face an exciting and challenging year ahead as we implement a further programme of change and improvement.

Martin Havenhand
Chairman
May 2016

1 Statement on Quality from the Chief Executive

Our Vision is to be 'an outstanding Trust, delivering excellent healthcare, 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'.

On 2 March 2017, the CQC published their re-inspection report for our hospital and community services. I am pleased that the CQC recognised considerable improvements across the Trust, including some areas of 'outstanding' practice and, as a result of the progress made since the last inspection in 2015, the Trust now has no areas rated as 'inadequate'. The CQC increased the number of inspection areas rated as 'good', with the number requiring improvement being reduced.

The CQC positively highlighted the 'caring' domain across the Trust, and rated it as 'good' throughout, with 'outstanding' for the caring domain at Breathing Space and Oakwood Community Centre. In line with their standard practice, the overall rating for the Trust was not reassessed and therefore remains at the 'requires improvement' level from the original full inspection in February 2015.

We welcome the CQC feedback, together with all the feedback we receive about our services from many sources. As a provider of NHS services, it is important that we put patients at the heart of what we do. Everyone has a part to play in setting and achieving high standards of care for patients and their families. Working in partnership with patients, service users, friends and family, alongside our many stakeholders is vital in shaping and delivering high quality care every day and for the future. I would like to thank everyone who has contributed to the progress we have made over the last year; their commitment and dedication is greatly valued.
Our strategic aim is to achieve good or outstanding across all our services and we know that we still have areas which need further improvement. These areas are included in the qualities priorities which we have set for 2017/18 onwards.

The Quality Report outlines the progress we have made during 2016/17 against our quality priorities. In particular, complaints management.

Harm-free care has continued to be challenging, with the Trust not achieving its overall target of 96%. The Trust achieved 92.30% harm free care compared with 94.85% in 2015/16. Whilst the number of falls with harm was at the lowest level for three years, with the total number of falls with moderate harm being 16 in comparison to 18 in 2015/16, the number of pressure ulcers being reported both in Acute and Community areas has significantly increased in comparison to the same reporting timeframe for 2015/16. As a result, there is renewed focus on reinvigorating the "stop the pressure" campaign to support improvement during 2017/18.

The Trust made improvement in reducing the number of hospital-acquired clostridium difficile from 19 in 2015/16 to 18 (plus 1 community acquired case by date but with a very recent hospital admission) in 2016/17 against the trajectory of 26 cases. However, disappointingly, we had one case of MRSA bacteraemia. The patient was effectively treated with antibiotics and was discharged when medically fit. Lessons learnt from the SI investigation have been shared with the clinical teams and with the patient's family.
We also reported four never events in year, two of which were reported retrospectively. Whilst no patients experienced permanent harm, this is nevertheless concerning and actions continue to be taken to learn from these incidents to improve practice.

This emphasises the need to ensure that we improve and strengthen quality governance, which was reflected in the CQC report and is a priority in our operational objectives for 2017/18.

In terms of patient experience, in 2016/17 we improved the responsiveness of complaints within the agreed timescale by 10% to 41% compared with 31% in 2015/16. We will continue to build on this progress, listening to feedback and embracing this to make positive changes for the benefit of patients.

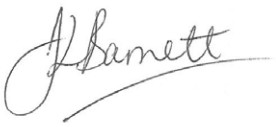
The ongoing commitment to the quality priorities compliments the significant work which is taking place to develop new models of care, which aim to address the current and future challenges faced locally and nationally across health and social care. With the support of partners across Rotherham, 2016/17 saw the introduction of a successful locality pilot, enhanced care coordination centre and the urgent and emergency care centre is due to open in July.

For 2017/18, the Trust Board has approved a Quality Improvement Plan, incorporating the Quality Report priorities and CQC feedback. Through this, we will work together with our colleagues, patients and stakeholders to shape a culture of continuous improvement and become a learning organisation.

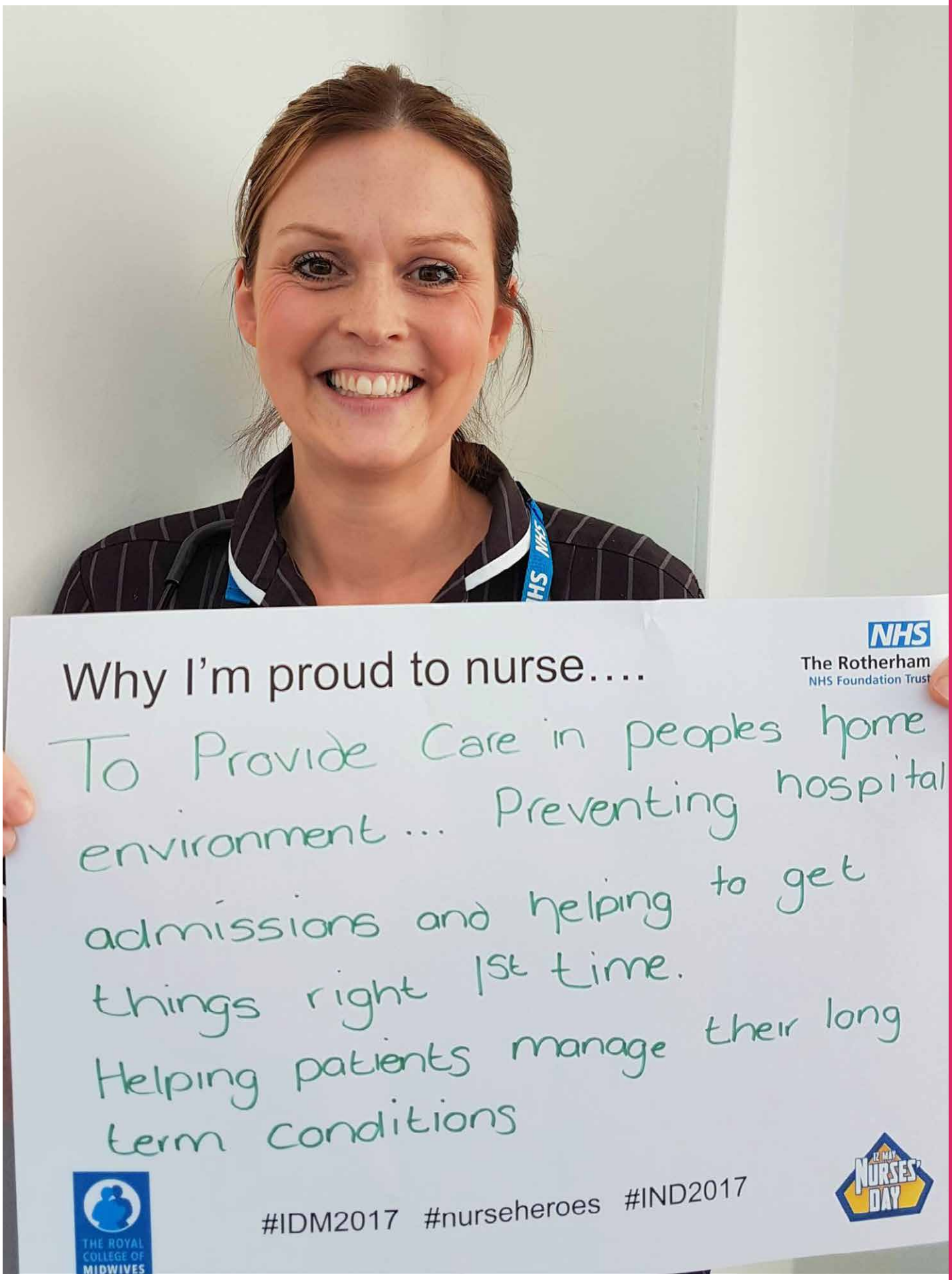
I am grateful to our Governors, Healthwatch Rotherham, the NHS Rotherham Clinical Commissioning Group and the Rotherham Health Select Commission for endorsing the priorities contained within this Quality Report.

We remain committed to ensuring that we provide excellent, high-quality care for the people of Rotherham and wider community we serve.

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



Louise Barnett
Chief Executive
26 May 2017


Why I'm proud to nurse....
NHS
The Rotherham
NHS Foundation Trust
To Provide Care in peoples home environment... Preventing hospital admissions and helping to get things right 1st time.
Helping patients manage their long term conditions
#IDM2017 #nurseheroes #IND2017
THE ROYAL COLLEGE OF MIDWIVES
NURSES' DAY


Rotherham
Simulation Suite

2

2.1 Priorities for improvement during 2017/18

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 are 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 the 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.

Our second Quality Improvement Plan describes the improvement priorities, accountability for delivery and the measures used to assess progress through the year. The plan pulls together our Quality Report priorities with the CQC requirements that emerged from the 2016 re-inspection. The plan identifies an ambitious programme of 17 areas for improvement with a 3-5 year timescale for implementation, increasing the number and range of services rated as 'good' by the care quality commission and delivering the goal of being an 'Outstanding' Trust.

For 2017/18, 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 100 colleagues, governors, patients and members of public were able to comment on a wide range of proposals and identify what matters most. One priority, Improving Compliance with the Mental Capacity Act, has been highlighted by Governors as a particular area of concern.

But a plan is nothing without the means to deliver. A new Quality Improvement Board (QIB) will therefore drive implementation by effective deployment of the skills and talents of colleagues. The QIB will use improvement work streams drawing on the Practice Development Team and others to deliver focussed improvement activity. Change will be monitored using audit, performance data and patient feedback and provide the information necessary to identify and celebrate success. Progress will be monitored through the governance structures of the Trust with quarterly updates known as Quality Accounting presented to the Board and published on the Trust website.

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, Finance and Human Resources. 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.

From 1 April 2017 a new consolidated Division of Integrated Medicine will be created to reflect the Trust's continuing strategy of developing integrated services and pathways. The Division will support the integration of emergency pathways with acute hospital services and community based services for adult medical patients and help create innovative solutions to the issues of demand and flow of patients through hospital.

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 is needed and additional areas identified where improvements are required.

The quality priorities for 2017/18 are:

Patient Experience
1. The Safe Management of Discharge from Hospital
2. End of Life Care – acute services
3. End of Life Care – community services

Patient Safety
1. Improving Medication Safety and Efficiency
2. The Deteriorating Patient
3. Increasing the Rate of Harm Free Care

Clinical Effectiveness
1. Compliance with the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
2. Compliance with the Mental Capacity Act (2005)
3. National quality requirements and clinical audit

Domain: Patient Experience

1. The safe management of discharge from hospital

Lead: Director of Operations
Operational Lead: Head of Nursing – Operations
CQC domain: Responsive

Discharge is a key element of the patient journey. If it is well-managed it will be timely and effective and will ensure that patients, families and carers are properly supported when leaving hospital and discharged to the most appropriate setting with a clear care plan in place. A problematic discharge not only creates ill-feeing but can also have a negative impact on clinical outcome, resulting for example from failure to optimally meet patients' needs as a result of being in the wrong setting or may create clinical risk should discharge be premature or poorly supported. It raises the possibility of an early re-admission to hospital that might otherwise have been avoided. Delays to discharge impact on the whole hospital.

The Trust now has a baseline for numbers of formal complaints and informal concerns over twelve months that are related to discharge; this shows a reduction in formal complaints.

This priority continues from 2016/17.
In 2017/18 the Trust aims to continue to improve the management of hospital discharge ensuring people leave hospital in a safe, timely, way.

Our objectives for 2017/18 are:

- 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

What will we do to achieve this?

SAFER care bundle role out will continue across the Division of Medicine.
Challenge routine discharge planning within wards by recording

- Audit
- Patient Outcomes
- Length of Stay
- Admission Avoidance

How will progress be monitored and reported?

Capture monthly data from Datix reports and monitored by the Operation Division and Patient Experience Group. Assurance will be given through the Clinical Governance Committee

2 and 3. End of Life Care

Executive Lead: Chief Nurse
Operational Lead: Assistant Chief Nurse (Vulnerabilities)
CQC Domain: Effective

The Trust aims to ensure all patients that are coming to the end of their life have the best possible support and care to provide a peaceful and pain free death and that they are able to die in the place of choice. In addition, we recognise the importance of ensuring that relatives and loved ones have a positive experience of care provision for patients at end of life care, understanding that this is a sad and distressing time.

There are many times that care provision has been excellent and this is demonstrated by the testimony of many letters, thank you cards and messages received. However, there are times when the Trust has not achieved the care expected by patients or relatives who are left with a lasting negative experience. There is only one chance to get this right.

The CQC Inspection in 2015 found that the Trust was inadequate in terms of the well-led quality domain in community, compared with a rating of good in the hospital setting. The Trust embraced this feedback taking considerable steps through the year to bring together multidisciplinary teams, patients and carers to further enhance and integrate care provision. As a result, in the CQC re-inspection in 2016, the Trust was rated as requires improvement in this domain in community, with improved ratings from requires improvement to good in the safe and responsive domains.

CQC ratings for Trust Hospital Services 2015 CQC Inspection

	Safe	Effective	Caring	Responsive	Well led
End of life care	Good	Requires Improvement	Good	Good	Good

CQC ratings for Trust Hospital services after 2016 re-inspection

	Safe	Effective	Caring	Responsive	Well led
End of life care	●	Requires Improvement	●	●	●

● not rated during this inspection visit

CQC ratings for Trust Community services after 2015 inspection

	Safe	Effective	Caring	Responsive	Well led
End of life care	Good	Requires Improvement	Good	Good	Good

CQC ratings for Trust Community services after 2016 re-inspection

	Safe	Effective	Caring	Responsive	Well led
End of life care	Good	Requires Improvement	Good	Good	Good

The CQC Trust re-inspection in 2016 identified a number of excellent examples of systems and process of care provision. However the re-inspection also identified the following areas that require improvement and a Requirement Notice was issued to the Trust from 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.

This is a new priority for 2017/18.
In 2017/18 the Trust aims 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.

Our objectives for 2017/18

- 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 – 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.
- Use NICE Guidance and other National EOLC Guidance to inform Trust processes and systems.
- Provide focused leadership and the best End of Life and Palliative Care across the Trust.
- 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 Group.
- Work in collaboration with Local Authorities, the Hospice and other partners to provide joined up services.
- To ensure full compliance with the DNACPR Policy and the Mental Capacity Act. (see Clinical Effectiveness 1 and 2, below)
- 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.

Deliver key priorities that are currently being addressed:

- Ensure that all relevant areas 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.
- Review arrangements to monitor the patient's preferred place of care and death.
- Review fast track discharge arrangements.
- Improve co-ordination of care with district nurses and palliative care nurses (Hospice@Home).
- Improve compliance with DNACPR and Mental Capacity Act.

What will we do to achieve this?

- All planned activity will be via the End of Life Operational Group and Governance Groups work plans and action logs
- A Task and Finish Group has been in place since 23 March 2017 and will run until 15 June 2017, in relation to compliance of the Mental Capacity Act

How will progress be monitored and reported?

- Key performance indicators agreed for end of life and palliative care services.
- Monitoring of all active action plans to ensure delivery and that changes are embedded in practice.
- To complete national audits and internal/partnership audits as required as part of a work plan to assess quality of care and documentation.
- The use of a work plan that describes key actions and deadline in order to embed the strategy.
- Progress will be monitored via the Medicine Divisional Governance Groups and The End of Life Operational Group that reports to the Patient Experience Group. EOLC is a standard agenda Item on the Patient Experience Group in relation to providing feedback from the EOLC Operational Group and is part of the Work Plan.
- All developments for end of life care in relation to partnership working are also monitored via the End of Life Care Strategic Group led by the Rotherham Clinical Commissioning Group.

Domain: Patient Safety

1. Improving medication safety and efficiency

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

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

Nothing was hard or too much trouble for staff to perform. All staff were only too willing to assist.

Friends and Family patient feedback
Stroke Unit

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 continues from 2016/17.

Our objectives for 2017/18 are:

- Reduce the level of harm caused by medication errors by 10%.
- Ensure 100% of medication administration is signed for (or a reason for non-administration recorded)
- 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
- Use benchmarking data for Pharmacy to develop pharmacy workforce and business plans

What will we do to achieve this?

- Investigation of medication incidents and review of themes through Medication Safety Group
- Quarterly medication omissions audit
- Develop effective communication e.g. medication safety newsletter, 'Stop the Shift' campaigns
- Monthly medication reconciliation rates for inpatients visible more widely across the organisation
- Contribute to and use pharmacy benchmarking data – e.g. NHS Benchmarking; Model Hospital

How will progress be monitored and reported?

Performance will be measured using:

- NHS Digital (NRLS) medication incident data
- Rate of medicines reconciliation within 24 hours of admission on AMU
- Number of medication administrations signed (or reasons for non-administration clearly recorded)

Regular reports to and discussion at:

- Quality Assurance Committee
- Clinical Governance Committee
- Patient Safety Group
- Medication Safety Group

2. The Deteriorating Patient

Executive Lead: Medical Director
Operational Lead: Associate Medical Director
CQC Domain: Safe

The new system of Modified Early Warning Scores (MEWS) was introduced last year in response to concerns regarding the identification and treatment of deteriorating patient. 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 an more timely manner to aim to prevent patient harm.

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

This priority continues from 2016/17.

Our objectives for 2017/18 are:

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 will we do to achieve this?

The new MEWS score has been implemented and is successfully reducing the number of patient harms with regard to deteriorating patient. . It aims to identify deteriorating observations earlier with the aim to implement medical therapies sooner to try to avoid further deterioration if possible. It is used on all patients within the acute setting when observations are recorded. There have been fewer patient safety incidents with regard to the deteriorating patient. The continued use of the tool and the support from colleagues within the trust to maintain the improvement.

How will progress be monitored?

- Regular audit on incidents (6 monthly basis)
- Regular review of "code red" information (6 monthly basis
- Regular review of incidents surrounding deteriorating patients (6 monthly audit on unplanned admission to critical care)

This data will be reported to and reviewed at:
Patient Safety Group
Sign up to Safety campaign
Medical Division
Chief Nurse's performance group

3. Increasing the rate of Harm Free Care

Executive Lead: Chief Nurse
Operational Lead: Assistant Director of Patient Safety
CQC Domain: Safe

The NHS Safety Thermometer is a tool for assessing the safety of services based on data relating to avoidable harm. 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 Children's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that use children and young people's services. The Safety Thermometer collects data on Deterioration, Extravasation, Pain and Skin Integrity.

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

The Trust began participating in data collection for the Children's and Maternity Safety Thermometer during July 2015. The Maternity Safety Thermometer data collection commenced in 2015 and the process is now well embedded within the community and acute maternity areas. This effort will help the Trust continue to improve on its high benchmarked position – the Trust position is currently 80% against the national position of 71.08%. The Paediatric Safety Thermometer data collection programme commenced in July 2016.

The Trust aims to ensure achievement and sustainability of 95% Harm Free Care for the classic safety thermometer 85% for the Maternity Safety Thermometer and 100% for the Paediatric Safety Thermometer.

This priority continues from 2016/17.

Our objectives for 2017/18 are:

To understand performance variation within the organisation, to set improvement goals and measure progress.

What will we do to achieve this?

We will continue to monitor the implementation of key improvement work streams such as Stop the Pressure, falls reduction work, omissions in medication to ensure the levels of harm are reduced to patients.

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.

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.

How will progress be monitored and reported?

The data is shared monthly with the Divisions and reported through their governance meetings. The information is also provided to the Clinical Governance Committee and Quality Assurance Committee as part of the monthly Quality Report.

A monthly validation process is in place and continues to be evaluated for accuracy. In addition, the Trust will continue to undertake monthly spot audits and data validation to ensure that the data collected on the safety thermometer data collection days is accurately input by the ward 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

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 a DNACPR. The CQC Trust inspection in 2015 and more recently, the CQC Trust re-inspection in 2016, identified this is an area that should be subject to a 'must do' action.

Although a significant amount of work (to improve compliance of both these areas of concern) has been undertaken to improve the position, there continues to be poor compliance overall.

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

This is a new priority for 2017/18.

Our objectives for 2017/18 are:

- 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

Our measures

- To undertake a benchmark review to assess current position
- To undertake spot audits
- To undertake a formal audit
- To evaluate the effectiveness of training

What will we do to achieve this?

Build on the Trust Showcase consultation event held in March 2017 by:

- Sharing policy changes with all providers including the independent sector
- Engaging with professions to clarify accountabilities
- Seeking and learning from patient feedback
- Sharing information to ensure that all departments and clinical areas are aware of DNACPR status for each patient
- Removing from use old versions of documentation
- Clarifying how community staff can record DNACPR appropriately

How will progress be monitored and reported?

Progress will be monitored by a Task and Finish Group and through the relevant Governance Groups. Reporting will be to the Clinical Governance Committee via the Safeguarding and Resuscitation Committee.

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

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 a 'Must Do' action. This CQC requirement underlines the significance for the Trust of continued poor compliance with the Mental Capacity Act. Although a significant amount of work to improve has been undertaken, failure to deliver improvement will put the Trust's reputation at risk.

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 is a new priority for 2017/18.

During 2017/18, the Trust will:

- 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 will we do to achieve this?

We will establish a new MCA Task and Finish Group, which has been in place as from 23 March 2017 and will run until 15 June 2017. The group that will:

- Launch a new 'Assessment of Capacity' form and process across the Trust with 'Stop the Shift' training to support changes in practice.
- Share best practice with all with partners including the Independent Sector.
- Engage with professions to clarify accountabilities.
- Seek out and learn from patient feedback.
- Share information to ensure that all departments and clinical areas are aware of MCA status for each patient.
- Remove from use old versions of documentation.

How will progress be monitored and reported?

Progress will be monitored via the Task and Finish Groups and through the relevant Governance Groups within Safeguarding and Resuscitation Committee in addition via the Clinical Governance Committee.

One of the regulation breaches highlighted by the CQC report from our 2016 inspection, related to the MCA, and a detailed action plan has been developed. The action plan and priority for 2017/18 are aligned to meet the same aim, which is to ensure that all patients are treated in line with the MCA.

3. National quality requirements and clinical audit

Executive Lead: Medical Director
Operational Lead: Associate Medical Director
CQC Domain: Well led

Currently, the CQC 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 is a new priority for 2017/18. The aim is that the Trust has an Annual Audit plan which is produced and managed by individual departments led by the departmental Clinical Effectiveness Lead and facilitated by the Clinical Effectiveness department. The aim is 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 are to complete the annual audit plan within the year time frame and ensure that recommendations from the audits are implemented within the specific department.
Our measures are - Annual Audit Plan – managed within the Clinical Audit database from which the Clinical Audit Performance Report provides an overview of progress of the plan.

What will we do to achieve this?

- The annual audit plan for 17/18 was approved at the Clinical Effectiveness and Research Group meeting on 22nd March 2017
- Progress with the Annual Audit Plan is monitored via updates to the Clinical Audit Database from which the Clinical Audit Performance Report and Departmental reports are drawn
- Progress is reviewed at Clinical Effectiveness and Research Group meetings and Departmental Clinical Effectiveness meetings.
- Clinical Audit Specialists meet regularly with Departmental Clinical Effectiveness Leads to monitor progress

How will progress be monitored and reported?

Progress is reviewed at Clinical Effectiveness and Research Group meetings and Departmental Clinical Effectiveness meetings. Concerns are then reported to the Clinical Governance 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.

“After having emergency c-section, very scary, felt hugely supported, each member of staff has been so friendly, helpful, supportive and reassuring. This is all staff and doctors. Huge thank you.”

Friends and Family patient feedback
Wharncliffe

Part 2.2: Statements of Assurance from the Board of Directors

Subcontracted services

During 2016/17 The Rotherham NHS Foundation Trust provided and/or subcontracted 65 services, both community and acute services. The Rotherham NHS Trust has reviewed all the data available to them on the quality of care in all 65 of those relevant health services. The income generated by the relevant health services reviewed in 2016/17 represents 83% of the total income generated from the provision of the relevant health services by The Rotherham NHS Foundation Trust for 2016/17.

Clinical Audit and Research

During 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.

The national clinical audits and national confidential enquiries that The Rotherham NHS Foundation Trust participated in, and for which data collection was completed during 2016-17, 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
1. Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes		100%
2. Adult Asthma	Yes		100%
3. BAUS Urology Audits - Female Stress Urinary Incontinence Audit	Yes		100%
4. BAUS Urology Audits - Nephrectomy audit	Yes		Audit in progress at time of writing.
5. BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes		100%
6. Bowel Cancer (NBOCAP)	Yes		100%
7. Cardiac Rhythm Management (CRM)	Yes		100%
8. Case Mix Programme (CMP)	Yes		100%
9. Diabetes (Paediatric) (NPDA)	Yes		100%
10. Elective Surgery (National PROMs Programme)	Yes		88% (April-September 2016)
11. Endocrine and Thyroid National Audit	No	Local audit to be undertaken in November 2017 to compare The Rotherham NHS Foundation Trust with national results	
12. Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database	Yes		100%
13. Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient Falls	No	Audit to take place in May 2017	
14. Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Yes		100%
15. Learning Disability Mortality Review Programme (LeDeR)	Yes		17-21%
16. Head and Neck Cancer Audit	Yes		100%
17. Inflammatory Bowel Disease (IBD) programme / IBD Registry	Yes		100%
18. Major Trauma Audit	Yes		17-21%
19. Maternal, Newborn and Infant (MNI) Clinical Outcome Review Programme Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	Yes		100%
20. MNI Clinical Outcome Review Programme- National surveillance of perinatal deaths	Yes		100%
21. National Joint Registry (NJR) - Confidential enquiry into serious maternal morbidity	Yes		100%
22. MNI Clinical Outcome Review Programme National surveillance and confidential enquiries into maternal deaths	Yes		100%
23. MNI Clinical Outcome Review Programme Perinatal Mortality Surveillance	Yes		100%
24. MNI Clinical Outcome Review Programme Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes		100%
25. Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes		100%

National Audit	Participation yes/no?	Reason for non-participation	% Cases submitted
26. MNI Clinical Outcome Review Programme Maternal mortality surveillance	Yes		100%
27. Moderate & Acute Severe Asthma - adult and paediatric (care in emergency departments)	Yes		100%
28. National Audit of Dementia	Yes		100%
29. National Cardiac Arrest Audit (NCAA)	Yes		Data collection ongoing (Q4 (January-March 2017) data is not due to be validated until 2 June 2017.)
30. National Chronic Obstructive Pulmonary Disease (COPD) Audit programme Pulmonary rehabilitation	Yes		Data collection commenced in January 2017. This is continuous data collection – there is no deadline.
31. National COPD Audit programme Secondary Care	Yes		Data collection commenced in January 2017. This is continuous data collection – there is no deadline.
32. National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA) - Clinician/Patient Follow-up	No	Audit did not collect data during 2016-17	
33. National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA) - Clinician/Patient Baseline	No	Audit did not collect data during 2016-17	
34. National Comparative Audit of Blood Transfusion programme - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes		100%
35. National Comparative Audit of Blood Transfusion programme - 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	No	Audit to be undertaken during 2017/18	
36. National Comparative Audit of Blood Transfusion programme - Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016	Yes		60%
37. National Comparative Audit of Blood Transfusion programme - Audit of the use of blood in Lower GI bleeding	No	Audit did not collect data during 2016-17	
38. National Diabetes Audit – Adults - National Diabetes Foot Care Audit	Yes		100%
39. National Diabetes Audit – Adults - National Diabetes Inpatient Audit (NaDia) -reporting data on services in England and Wales	Yes		100%
40. National Diabetes Audit – Adults - National Pregnancy in Diabetes Audit	Yes		100%
41. National Diabetes Audit – Adults - National Core Diabetes Audit	No	Data regarding patients on insulin pumps was submitted but this could not be used in isolation, details of all diabetic patients was required but the data set could not be established due to absence of electronic data system	

National Audit	Participation yes/no?	Reason for non-participation	% Cases submitted
42. National Emergency Laparotomy Audit (NELA	Yes		74%
43. National Heart Failure Audit	Yes		100%
44. National Joint Registry (NJR) - Knee replacement	Yes		100%
45. National Joint Registry (NJR) - Hip replacement	Yes		100%
46. National Lung Cancer Audit (NLCA)	Yes		100%
47. National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes		100%
48. National Ophthalmology Audit	Yes		Data collection ongoing and will be complete 31 /08/17
49. National Prostate Cancer Audit	Yes		100%
50. Oesophago-gastric Cancer (NAOGC)	Yes		100%
51. Paediatric Pneumonia	Yes		94%
52. Sentinel Stroke National Audit programme (SSNAP)	Yes		Band A 90%
53. Severe Sepsis and Septic Shock (care in emergency departments)	Yes		100%
National Confidential Enquiries			
1. Child Health Clinical Outcome Review Programme - Chronic neurodisability	Yes		Data collection ongoing (to complete 31/05/2017)
2. Child Health Clinical Outcome Review Programme Young People's Mental Health	Yes		100%
3. Medical and Surgical Clinical Outcome Review Programme - Perioperative diabetes	Yes		Data not yet requested by NCEPOD. Period for data collection to be confirmed by NCEPO
4. Medical and Surgical Clinical Outcome Review Programme - Cancer in Children, Teens and Young Adults	Yes		Data collection ongoing (to complete 31/05/2017
5. Medical and Surgical Clinical Outcome Review Programme - Heart Failure	No	Due to start June 2018	
6. Medical and Surgical Clinical Outcome Review Programme - Acute Pancreatitis	Yes		100%
7. Medical and Surgical Clinical Outcome Review Programme - Physical and mental health care of mental health patients in acute hospitals	Yes		100%
8. Medical and Surgical Clinical Outcome Review Programme - Non-invasive ventilation	Yes		100%

The reports of 26 national audits were reviewed by the provider in 2016-17 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (where appropriate):

Title	Report published 2016 (calendar year)	Report Reviewed	Action(s) to improve quality of care
1. BAUS Urology Audits - Female Stress Urinary Incontinence Audit	Yes	Yes	None required.
2. BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	An additional service review was carried out in response to the draft report and an action plan developed and agreed by the responsible consultants which included: to print off copies of the BAUS nephrectomy information sheets and have these available in clinic to give to patients with the Macmillan booklet and Clinical Nurse Specialist details; to ensure thorough documentation of the provision of information to patients; Consultants to document the SORT mortality risk and the agreed consent information for each procedure in the notes/on the consent form (standardised stickers to be developed to assist with this); to take consent in clinic in advance of the procedure and not on the day of diagnosis/surgery and provide a copy of the consent information to the patient; to write legible operation notes with information on operation time, blood loss and to document any deviations from the norm/difficulties experienced (electronic operation notes to be developed); complex/high risk cases to be performed as a joint case, with a HDU bed booked and involvement from regular Anaesthetists, including at the pre-assessment stage; to consider the use of cardiopulmonary exercise testing; and to review weekend cover arrangements to ensure patients are reviewed by a Consultant on a Saturday and Sunday.
3. Bowel Cancer (NBOCAP)	Yes	Yes	Ensure the management of lower rectal cancer patients is in line with national guidance and standards by carrying out a review of current practice, including monitoring of neoadjuvant therapy, positive circumferential resection margins and APER rate.
4. Cardiac Rhythm Management (CRM)	Yes	Yes	None required.
5. Case Mix Programme (CMP)	Yes	Yes	None required.
6. Diabetes (paediatric) (NPDA)	Yes	Yes	Ensure Diabetes services continue with two diabetes consultants, and recruit replacement for recent retirement of PDSN. Change practice for Albuminuria screening (send requests to patients before appointment 6 monthly and follow up to check that test is done). Discuss in operational meeting and with clinical effectiveness team how we can improve our submission process, system 1 entries' for structured education. Ensure updated clinical guidelines on Trust website. Deliver departmental teaching sessions for each batch of Tier 1 & Registrar doctors on rolling education programme. Prepare business plan for purchase of 'safe use of insulin' e-learning package. Discuss in operational meeting re formalising structured education on each patient contact. Provide Blood ketone meter to all Diabetes patients and obtain Blood ketone meters for children's wards. Discuss in operational meeting re: aim to increase number of patients on insulin pump therapy. Encourage team to introduce new treatment interventions as recommendations as used by neighbouring trust with better HbA1c results. Consider ways of improving access to Psychological services. Request further outpatient Health Care Assistant (HCA) support for Diabetes clinics. Need electronic tablets to improve online patient feedback in outpatient settings.
7. Elective Surgery (national PROMs Programme)	Yes	Yes	The key findings will be disseminated to the Divisional Performance Meeting via the Clinical Director for Information.

Title	Report published 2016 (calendar year)	Report Reviewed	Action(s) to improve quality of care
8. Falls and Fragility Fractures Audit programme (FFFAP) - *National Hip Fracture Database*	Yes	Yes	Look into 9am-5pm trauma lists to determine whether this would improve the percentage of patients mobilised the day after surgery if medically fit and carry out an audit project of patient mobilisation. Implement an electronic spreadsheet to monitor best practice tariff checklist completion. Discuss results with anaesthetic colleagues to determine if a "standard" anaesthetic would improve care and to suggest the use of blocks with each case. Push the use of cemented ETS as the standard procedure. Ensure the correct implant for fracture type is recorded on the database by reviewing historic data with Lead Consultant and printing out the fracture classification for recording at the Trauma Meeting. Review the feasibility of expanding the Ortho-geriatric service for Hip Fracture patients and look at other models of care. Carry out individual case reviews of all deaths within 30 days of admission to ensure mortality rates are within the expected ranges.
9. Inflammatory Bowel Disease (IBD) programme / IBD Registry	Yes	Yes	Discussions to take place regarding the national recommendation that all new starters should commence treatment on infliximab biosimilars. Consideration should be given whether to switch those patients currently established on Remicade to infliximab biosimilar
10. Major Trauma Audit	Yes	Yes	Review of cases with GCS<9 and not intubated in April 2016 report. Review of cases with GCS<9 and not intubated in July 2016 report. Raise completion of trauma sheet at Divisional Governance meeting. Education to junior staff on the requirement for senior review. Discussion of themed reports with relevant lead.
11. Maternal, Newborn and Infant Clinical Outcome Review Programme *Perinatal Mortality*	Yes	Yes	Perinatal Mortality Surveillance Report – 2014: Learning points CO2 levels to be completed at booking, 2nd trimester and 36 weeks on all women and documented in both handheld notes and on SystmOne. We will achieve this via reminding staff on learning points and also ¼ monthly audits of 5 sets notes to check compliance. Need to check all areas have access to CO2 monitors. (Sept 16: only Community have monitors at present). Ensure GROW charts are generated on first visit to antenatal clinic, and any findings acted on for extra scans. Age at leaving full time education should be completed in handheld notes. Improvement in obtaining service user feedback especially in other languages
12. *Maternal mortality surveillance*	Yes	Yes	Maternal mortality surveillance report 2012-14 Requested a joint review of all deaths with RCOG in September 2016. VTE Risk Assessment chart revised; full day leaving event held in January 2017, and updates held in ward areas. To present a synopsis of the report to A&E and medics to raise general awareness of management of postnatal cardiac symptoms, which require a low threshold for investigations
13. Medical and Surgical Clinical Outcome Review Programme - Acute Pancreatitis	Yes	Yes	Pancreatitis management proforma to be circulated. Discuss the compliance at General Surgery CSU in respect of the recommendation that pancreatitis should be managed by a multidisciplinary team, comprising all specialties needed to treat the condition. The 2012 IAP/APA guidelines concerning key aspects of medical and surgical management of acute pancreatitis to be circulated to all general surgical consultants.
14. National Cardiac Arrest Audit (NCAA)	Yes	Yes	Introduce DNACPR e-learning package for staff. Feed back to DNACPR task and finish group regarding the need for improved DNACPR form completion rate. Collaborate further with palliative care colleagues by inclusion in the task and finish group.

Title	Report published 2016 (calendar year)	Report Reviewed	Action(s) to improve quality of care
15. National Diabetes Audit – Adults National Diabetes Foot Care Audit 16. National Diabetes Inpatient Audit (NaDia) - *reporting data on services in England and Wales*	Yes Yes	Yes	To roll out the foot risk assessments to all ward areas. Diabetes sub group terms of reference to be compiled formally. Insulin Drug Kardex to be devised. Education programme for all members of staff - already involved in Nurse Essential Training/HCA induction.
17. National Comparative Audit of Blood Transfusion programme *-Audit of the use of blood in Lower GI bleeding*	Yes	Yes	Provide education to all team members to improve compliance with: clinical examination/bedside investigations and tests; Warfarin/ INR reversal; national blood transfusion guidelines; national FFP transfusion guidelines; and with guidelines on appropriate investigation within 24 hours for patient. Highlight recommendations relating to input from elderly care consultants to Surgical Clinical Director (discussions for input into Emergency Laparotomy patients already underway).
18. National Emergency Laparotomy Audit (NELA)	Yes	Yes	Discuss potential arrangements to improve care of the elderly input into Emergency Laparotomy patients. Increase the number of eligible patients being submitted to the audit by retrospectively recording cases for year 3 and implementing a bi-weekly check of new cases against the theatre log and informing Consultants of missing data. Implement the Multidisciplinary Emergency Laparotomy Pathway (MELP) to ensure appropriate time of arrival in theatre and Consultant Anaesthetist input into appropriate cases.
19. National Heart Failure Audit	Yes	Yes	Education required regarding referral of all heart failure patients to Cardiologist/heart failure specialist nurses. Appropriate bed allocation and patient movement in order for heart failure patients to be admitted to a cardiology ward. Patient notes to be stamped when reviewed by the cardiology team. Echocardiogram to be performed if not done within one year. Disease modifying drugs for all left ventricular systolic dysfunction (LVSD). All heart failure deaths to be reviewed by cardiologists for clinical coding verification and audit. Improve coding accuracy by meeting with the clinical information leads, providing written guidance to the coding department and by educating physicians.
20. National Joint Registry (NJR) *- Knee replacement* *21. Hip replacement*	Yes	Yes	None required. Individual surgeon-level results will be reviewed at appraisals.
22. National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Request list of SCBU samples from Laboratory and retrospectively review all blood cultures and CSFs to improve recording of blood cultures and complete sepsis documentation on Badger. Redesign daily ward round sheet to prompt for completion of admission summary and discharge checklist. Local re-audit of Parental communication sheets. Disseminate audit findings on teaching programme
23. National Ophthalmology Audit	Yes	Yes	Findings presented to the Ophthalmology Clinical Effectiveness meeting. No actions required (The Rotherham NHS Foundation Trust did not participate in year 1)
24. National Prostate Cancer Audit	Yes	Yes	None required.
25. Oesophago-gastric Cancer (NAOGC)	Yes	Yes	Review of data collection processes/ recording on InfoFlex to ensure all therapeutic stents are recorded.
26. Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Improve access to speech and language therapists by recruiting to the vacancies. Facilitate early transfer of stroke patients to the unit by ring fencing 2 beds. Expedite CT scan time by streamlining the referral process for ordering CT scans

Review of Local Clinical Audits

The reports of 121 local clinical audits were reviewed by the provider in 2016-17 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table at Appendix 2).

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by The Rotherham NHS Foundation Trust in 2016/17 that were recruited during 2016/17 to participate in research approved by a research ethics committee was 540 compared to 262 in 2015/16. To be consistent with previous submissions, this data includes all participants (patients and staff) recruited to research studies actively recruited at The Rotherham NHS Foundation Trust i.e. included all studies that received Trust permission which includes studies that require research ethics approval and those that have no legal requirement to do so as per GAfREC.

The below table shows the number of active studies during this period.

Study Type	Number of studies
Commercial Portfolio	6
Non-commercial Portfolio (including Participant Identification Centres)	37
Non-portfolio The Rotherham NHSFT Sponsored	2
Other Non-portfolio (academic)	6
Studies not requiring local "capacity & capability" review	5

The table below shows numbers of participants recruited to studies where the Trust is hosting a study.

Study Type	Patient Recruits	All recruits
Portfolio study (ODP data cut 28 April 2017)	410	540

The table below shows the number of studies currently undergoing local capacity and capability review to receive approval for studies to commence at the Trust.

Study Type	Number of studies
Commercial	0
Non- commercial Portfolio (including Participant Identification Centres)	9
Non-portfolio The Rotherham NHSFT Sponsored	0

> *"Every single member of staff has been fantastic. Been looked after extremely well. A credit to the NHS."*

Friends and Family patient feedback
Wharncliffe

There have been difficulties with recruitment of volunteers for a number of reasons. However, achievement of the recruitment target for the Yorkshire and Humber Clinical Research Network is testament to the changes implemented in the Research and Development Department during 2016/17, including the appointment of a Lead Research Nurse in May 2016.

A RM&G Facilitator, appointed in April 2016, led a complete review of processes and SOPs to ensure that they were compliant with HRA requirements while providing appropriate assurance for the Trust's governance controls; the Trust was praised for the responsiveness in study set-up.

Progress has been made in building the foundation for a centrally located cohort of R&D research nurses by appointing to generic research nurse posts and taking steps to bring the historically "embedded" research nurses into the central team.

"I have nothing but praise for all the staff during my operation and post operation and the service was exemplary."

Friends and Family patient feedback
Urology Outpatients

CQUINs

A proportion of The Rotherham NHS Foundation Trust income in 2016/17 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 2016/17, £3,598,809 of Trust income was conditional upon achieving the CQUIN goals compared with circa £4million in 2015/16.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically from the Trust Website http://www.therotherhamft.nhs.uk/

CQUIN goals continue to form part of the National NHS Standard contract for 2017-2019. All schemes agreed are national indicators. A high level summary of the indicators applicable in 2017-19 is provided below:

CQUIN goals continue to form part of the National NHS Standard contract for 2017-2019. All schemes agreed are national indicators. A high level summary of the indicators applicable in 2017-19 is provided below:

National (N) Local (L)	Goal Name	Contract Year for delivery
N	NHS Staff Health and Wellbeing	2017/18
N	Proactive and Safe Discharge	2017/18
N	Reducing the Impact of Serious Infections (Sepsis)	2017/18
N	Improving Services for People with Mental Health needs who present to A&E	2017/18
N	Electronic Referrals	2017/18
N	Advice and Guidance	2017/18
N	Preventing Ill Heath by Risky Behaviours – alcohol and tobacco	2018/19

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 2016/17.

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 this time.

The tables below show the detailed ratings by key question and by core service, both for the original inspection in 2015 and the re-inspection conducted in September 2016.

CQC ratings for Trust Hospital Services 2015 CQC 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	Inadequate	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Good
Critical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Maternity and gynaecology	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Children and young people	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate
End of life care	Good	Requires Improvement	Good	Good	Good
Outpatients and diagnostic imaging	Requires Improvement	(Inspected but not rated)	Good	Good	Good

"My child has additional needs in which his usual dentist cannot meet, however the community dentist is very patient explains everything thoroughly at his level."

Friends and Family patient feedback
Community Dental Services

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	●	●	●	●

● not rated during this inspection visit

"Staff are polite, courteous and helpful, how hospital staff should be. A good example of good staff and an efficient ward for the NHS. Thank you."

Friends and Family patient feedback
Coronary Care Unit

CQC ratings for Trust Community services after 2015 inspection

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

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

	Safe	Effective	Caring	Responsive	Well led
Adults	Good	Requires Improvement	●	●	Requires Improvement
Children's & 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

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

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

A comprehensive action plan was created as a result of the inspection findings for the regulation breaches which was approved 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, make up the Trust's Quality Improvement Plan. The newly developed Quality Improvement Board will review and monitor achievement against the Quality Priorities.
Every CQC inspection concludes with a Quality Summit. This brings together CQC Inspectors, Trust managers and clinicians, representatives from partner agencies and the CCG, Governors and Patients. It is an opportunity for the Trust to present their response to the Inspection report and gain understanding of and approval for proposed actions.

The report noted that there has been considerable improvement across many services since the last inspection:

- All 'Inadequate' ratings were removed and replaced with 'Good' or 'Requires Improvement'
- All clinical areas were rated as at least 'Good' for caring with one being 'Outstanding'
- Examples of outstanding practice were identified, with notable progress in others

However the report also commented that the Trust had made insufficient progress to improve practice regarding the use of DNACPR and compliance with the Mental Capacity Act. These remain rated as 'Requires Improvement' for which a Requirement Notice was issued. In

total the report listed 65 actions, a combination of 29 'Must-Dos' and 36 'Should-Dos'.

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.

Amendments were made to the Trust's CQC registration during 2016/17 which included removing Barnsley Hospital NHS Foundation Trust from the Trust's Statement of Purpose as the Trust no longer provides Ophthalmology services at that location. In addition, the Medical Director Conrad Wareham, replaced Tracey McErlain-Burns as the Trust's Nominated Individual with the CQC.

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 a sequence of service-level and Trust-level self-assessments and quarterly presentation to the Medical Director and Chief Nurse reporting ultimately to the Clinical Governance Committee.

The standard most often self-assessed as at risk during 2016/17 was 'Are services Safe?' The Clinical Governance Committee reviews the reasons for these self-assessments in order to assure itself that the appropriate actions to improve this position were being taken.

The Care Quality Commission did not take any enforcement action against The Rotherham NHS Foundation Trust during 2016/17.

The Trust is also required to report any breaches of the **Ionising Radiation Regulations** to the CQC. In year 8 such breaches were reported (three in the previous year) with a further error occurring in February 2016 but reported in this year.

"She is a very thorough Nurse and has an extremely friendly approach towards her clients at all times."

Friends and Family patient feedback
District Nursing

Each of the incidents have been investigated and all have been escalated through to the Diagnostics and Support Divisional governance meeting and onto the Trust's Quality Assurance 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.

Month	Details
February 2016	Repeat image of breast taken in error (but reported in current reporting period)
June 2016	Incorrect body part examined(scaphoid instead of scapula)
June 2016	Incorrect patient examined for CT (incorrect patient referral on Meditech)
July 2016	Incorrect laterality of a hip (incorrect lateral view taken)
July 2016	Incorrect laterality of hip (incorrect lateral view taken)
August 2016	Incorrect laterality of shoulder (one view of the incorrect shoulder)
August 2016	Incorrect patient examined (incorrect patient referral on Meditech)
February 2017	Incorrect patient examined for CT (incorrect patient referral on Meditech)
March 2017	Patient had an unnecessary CT examination due to clinician not contacting Clinical Radiology following deletion of examination from Meditech, as per instruction/procedure.

Special Reviews and Investigations

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

Data Quality

The Rotherham NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data April 2016 – January 2017.

The percentage of records in the published data which included the patient's valid NHS number was:
99.9% (2015/16 99.8%) for admitted patient care
99.9% (2015/16 99.9%) for outpatient care and
88.0% (2015/16 86.6%) for accident and emergency care.

The percentage of records which included the patient's valid General Medical Practice Code was:
99.9% (2015/16 99.7%) for admitted patient care
99.8% (2015/16 99.9%) for outpatient care and
98.9% (2015/16 99.2%) for accident and emergency care.

Please note: 2015-16 data in this section is based on a refreshed data position from NHS Digital submissions.

Information Governance

The Rotherham NHS Foundation Trust's Information Governance Assessment Report overall score for 2016/17 was 72% and was graded Green (Satisfactory). (See details in the Performance Report on page 16)

Payment by Results

The Rotherham NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission[2].

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

The Trust is engaged in implementing the NHS Spine to our clinical information system Meditech within the next financial year and will be first of type on this system to implement. It is therefore anticipated that additional improvements will be seen, in particular in our Emergency Care data which has recently migrated from our legacy system Symphony onto Meditech.

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 2016 to January 2017 is available. There has been a marginal increase from the previous year; the Trust continues to outperform peer averages with an index of 96.0 compared to a peer average of 95.0.

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

The Trust has improved on its position for unaccepted diagnosis codes in the period up to January 2017, achieving 0.30% against a previous measurement of 0.46% for 2015/16. Our depth of coding (average number of diagnoses per coded episode) continues to increase from 4.8 in April to January of 2015/16 to 5.1 in April to January 2016/17.

Clinical Coding

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

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
Overall	94.5	96.5	96.9	95.4

These scores help us to achieve assurance Level 2 of the Information Governance Toolkit for coding accuracy, and are just short of achieving the highest level, Level 3.

> *"Delays but doctor was so apologetic that any frustration disappeared."*

Friends and Family patient feedback
Gynaecology Outpatients

> *"Put my mind at rest. Nice to know people are keeping an eye on you"*

Friends and Family patient feedback
Integrated Falls and Fracture Service

[2]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' with errors rates as envisaged by this line in the regulations. It is therefore likely that providers will be stating that they were not subject to "the Payment by Results clinical coding audit" during 2016/17.

In 2015/16 the Trust took the following actions to improve clinical coding data quality and we continued to do so throughout 2016/17:

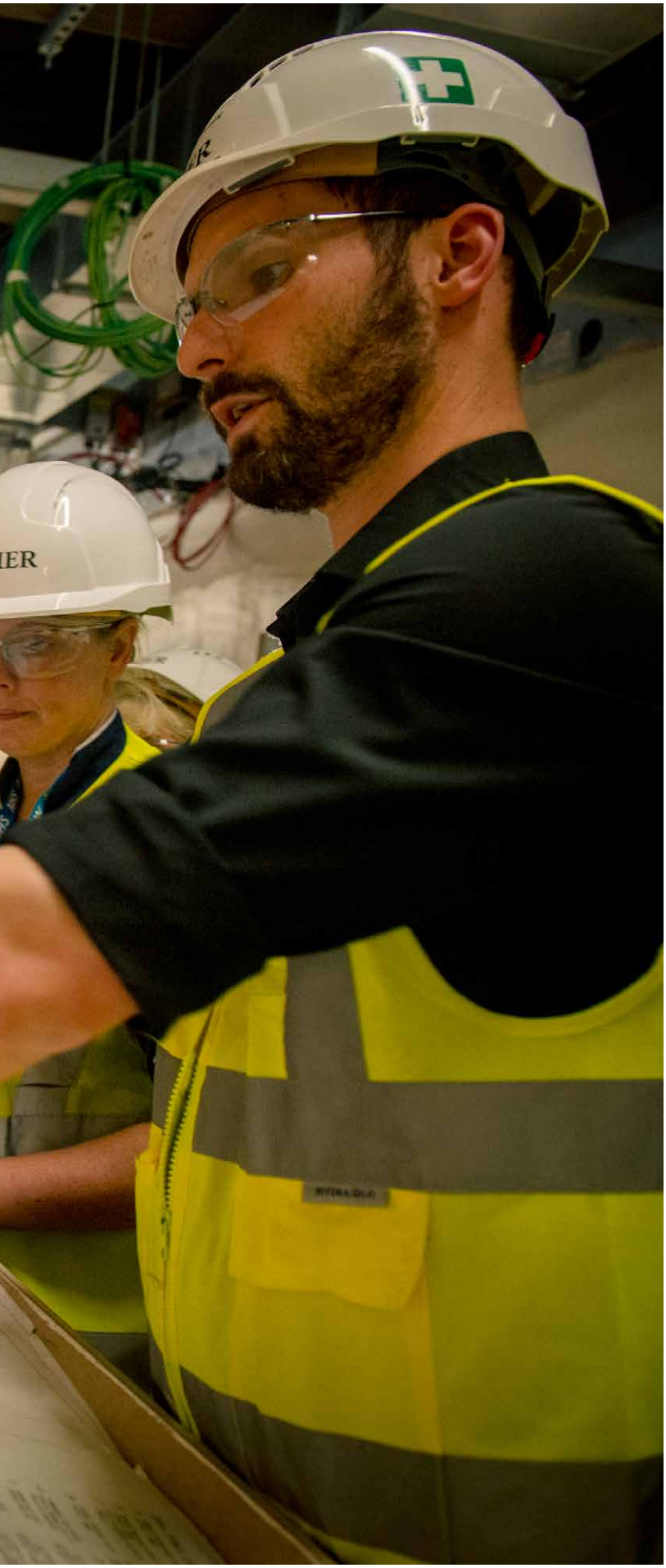
- Using data analysis to flag up potential coding and data quality errors and generate regular reports to monitor coding and data quality, using the ever expanding locally designed clinical coding indicators
- Engaged clinicians across specialties, creating coder/clinician two way communications through coding/documentation review sessions
- Provided in-house coding training sessions organised with the consultants, now there is an annual coding training sessions included on the F1 junior doctors 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 2016/17 included:

- Coding to within 2 weeks of month end ("flex" dates), over 95% of all coding is completed within this window. Coding staff are coding direct from wards in some instances to maintain accessibility of notes for clinical staff when required.
- Implement a programme of more coders working towards and achieving ACC professional qualification. The first of our trainee coders is due to qualify in September 2017, and we have two others in their first year of the programme.
- 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 operational manager has been appointed to lead the team and two supervisors appointed within the team to handle day to day support of the team.

	Areas selected for focussed improvement activity	Baseline period FY	Baseline Value	Target	Qtr 1 2016-17	Qtr 2 2016-17	Qtr 3 2016-17	Qtr 4 2016-17	YTD Apr 16 to Jan 17	Progress
IMPROVING DATA QUALITY	IDQ-1 Data Quality Index (CHKS Live)	2015 -16	96	Increase	96	96	97		96	↓
	IDQ-2 Blank, invalid or unacceptable primary diagnosis (CHKS Live)	2015 -16	0.46%	Decrease	0.15%	0.13%	0.24%		0.30%	↓
	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%		10.80%	↓
	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%		14.50%	↓
	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%		99.90%	↓
	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%	↓
	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%	↓
	IDQ-8 SUS Data Quality - Outpatients: Postcode validity (NHS Digital Dashboard)	2015 -16	99.90%	Increase	100.00%	100.00%	100.00%		100.00%	↓
	IDQ-9 SUS Data Quality - Accident & Emergency: NHS number validity (NHS Digital Dashboard)	2015 -16	86.60%	Increase	83.70%	83.70%	86.90%		88.00%	↓
	IDQ-10 SUS Data Quality - Accident & Emergency: Postcode validity (NHS Digital Dashboard)	2015 -16	99.10%	Increase	98.10%	98.30%	98.70%		98.80%	↓


KIER



Part 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.

Where data has not been available from NHS Digital, this is stated in the table on page 64.

However, as reported in the Performance Report on page 10, during the month of April 2017, HSMR was rebased and stood at 107 by the time of the April 2017 Board of Directors' meeting where the increase was highlighted.

"Treated with kindness, consideration throughout, many thanks to staff on a really busy night."

Friends and Family patient feedback
Urgent & Emergency Care Centre

	Indicator name	Latest & previous reporting periods	The Rotherham NHS Foundation Trust value July 15 - June 16	The Rotherham NHS Foundation Trust previous value April 14 - March 15	All Acute Trust average 15/16	All Acute Trust average 14/15
Domain 1 - Preventing people from dying prematurely	Summary Hospital Mortality Indicator – Value	April 14 - March 15 July 15 - June 16	102.26	109.4	100.3	100.2
	Summary Hospital Mortality Indicator – Banding	April 14 - March 15 July 15 - June 16	2	2	2	2
	SHMI: Percentage of patient deaths with palliative care coding at diagnosis level	April 14 - March 15 July 15 - June 16	32.40%	34.50%	29.40%	25.70%

Department of Health Core Indicators (source: NHS Digital)

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 2015 - 31st March 2016	156	0.268	0.763	0.496	142 (91%)	7 (4.5%)	7 (4.5%)
	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 2015 - 31st March 2016	75	0.735	0.86	0.126	40 (53.3%)	18 (24%)	17 (22.7%)
	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 2015 - 31st March 2016	183	0.413	0.711	0.298	140 (76.5%)	22 (12%)	21 (11.5%)
	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 2015 - 31st March 2016	No Data	No Data	No Data	No Data	No Data	No Data	No Data

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. (See Appendix 5)

	NHSD ref	Indicator name	Trust value [2015]	Trust value [2016]	Acute Trust highest	Acute Trust lowest	Acute Trust average
Domain 4: ensuring that people have a positive experience of care	PO1533	CQUIN: Responsiveness to patients personal needs	68.1		86.1	59.1	68.9
				77.2	88.0	70.6	77.3
	PO1533	Staff who would recommend their Trust to family or friends (Acute Trusts for comparison)	53.00%		85.00%	46.00%	72.00%
				57.00%	65%	41%	52.00%

	NHS DIGITAL Indicator	Indicator name	Previous reporting periods	Latest reporting periods	Trust previous value	Trust latest value	Acute Trust highest	Acute Trust lowest	Acute Trust average
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	PO1556	Percentage of patients admitted to hospital and risk assessed for VTE	Oct 15 - Dec 15	Oct 16- Dec 16	95.90%	96.89%	99.49%	81.49%	95.64%
	PO1557	Rate per 100,000 bed days of cases of C.diff amongst patients aged 2 or over	Apr 14 – Mar 15	Apr 15- Mar 16	18.3	12.2	66	0	14.9
	PO1394	Patient safety incidents: rate per 1000 bed days(acute non-specialist for comparison)	Apr 15 -Sept 15	Oct 15 - Mar 16	40.5	42.3	75.9	14.6	19.9
	PO1395	Patient safety Incidents: % resulting in severe harm or death (medium acute Trusts for comparison)	Apr 14 - Sept 14	Apr 15- Sep 15	0.05%	0.23%	1.12	0.03	0.17

Source of all data, NHS Digital.

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

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

"Everyone was brilliant, clean, caring, professional, mindful, miracle workers, made me feel special and that means a lot when you are ill."

Friends and Family patient feedback
Ward B4

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 Trust is banded as 2 ('As expected')	Score: banding 2 Score: 32.40% The Trust holds regular meetings of the Mortality Review Group which reports to the Clinical Effectiveness and Research Group. 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 quality reports. The Medical Division conduct an early review of all deaths (within one week). Time for earlier in depth mortality reviews will be incorporated into the 2017/18 Job Planning process for senior medical staff
12b. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*. (*The palliative care indicator is a contextual indicator)	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.	
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 Trust performs too few Varicose Vein procedures to reach the threshold for data analysis	Post Op Score (i) 0.875 (ii) / (iii) 0.824 (iv) 0.734 PROMS are measures recorded pre- and post-operatively by patients. They measure changes in quality of life and health outcomes.
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 non-elective patients is drawn from internal sources (CHKS).	The Indicator continues to be monitored through the Quality Report for the Quality Assurance Committee based on the Trust's own data. The TOCT works to reduce readmission rates through better planning of discharge. The Care Home Team identifies factors leading to admission and readmission and works with the sector to improve effectiveness.
20. The Trust's responsiveness to the personal needs of its patients during the reporting period.	The Trust's position is drawn from 5 key questions asked in the national in-patient survey (administered by the CQC). The most recent data is from the survey conducted between September 2015 and January 2016. Full results are available later in this report.	CQC will publish 2016 patient survey results in June 2017
21. Friends and Family Test (Q12d): If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.	Department of Health conduct an annual independent survey of staff opinion	Score: 57% For staff survey data see Part 3.6 Trust's Together We Can programme will continue in 2017/18 (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:
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 QAC
24. Rate per 100,000 bed days of cases of C-difficile infection	Data is validated and published by NHS Digital. Trust data quality is also subject to external audit	The Trust will continue to monitor VTE rates, and report through local clinical governance structures to the QAC; for further actions to reduce rate of c-diff see Part 3
25. Number and rate of patient safety incidents. Number and percentage of patient safety incidents that resulted in severe harm or death.	Data validated and published by NHS Digital (NRLS); latest data is for the period April – September 2016	The Trust will continue to investigate all serious incidents with learning shared through the divisional clinical governance structures.

Her Majesty's Coroner's Inquests 2016/17

The Trust continues to support HM Coroner and ensure inquests are investigated in a timely manner. The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances.

These are known as 'Reports to Prevent Future Deaths '; the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013. The Trust has received one such report during 2016/17 relating to the failure to recognise the need to adjust the dosage of paracetamol to reflect a patient's low body weight. The actions from this report are being led by the Chief Pharmacist and monitored by the Trusts Patient Safety Group and the Medication Safety Group.

3 Other Information

1. Overview of quality of care based on performance in 2016/17

A summary of the Trust's quality priorities for 2016/17 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: The management of discharge from hospital	Compliance with the SAFER care bundle will be audited and reported to the QAC each month	
	90% of patients will have an EDD recorded in their notes.	Average 67% for Quarter 4
	Case note audit will clearly show changes to EDD are discussed with patient	Not recorded
	40% of TTOs will be ordered by 3pm on the day before discharge	Not recorded
	Reduce complaints about discharge, first establishing a baseline and then reducing over following six months by 30%	2014/15 = 37 2015/16 = 28 2016/17 = 21
	Reduce readmission rates by at least 10% in year.	See appendix 5 for details
Patient Experience 2: Complaints Management	All complaints will be acknowledged within 3 working days.	100%
	At least 95% of complainants will be offered a face-to-face meeting.	95% recording of this data commenced in June 2016
	Every clinical area will have at least two members of staff trained in complaints investigation and management by year end.	100%
	95% of complaints responded to within the timescale agreed with complainant	41%
	Achieve an 'about the same' rating for access to complaints information in the 2016 in-patient survey	

Reference	Metric	Outcome
Patient Safety 1: Medication safety and efficiency	Reduce the rate and range of medication omission errors by 10% by year end	Audit dates Medication omissions Dec 15-Jan 16: 11.14% Aug–Sept 16: 11.16% Dec 16; 14.5% March 17- Apr 17 – Data being analysed
	In medicine administration charts 100% of entries will be signed and completed with rationale for non-administration where appropriate	Audi Dates Entries not signed: Dec 15- Jan 16: 36% Aug – Sept 16 :21.5% Dec 16 : 18.5% March 17- Apr 17 – Data being analysed
	By September 2016 at least 90% of admissions will have medication reconciliation before leaving ED	AMU Medicines reconciliation rate achieved in Sept 16: Including weekends: 73.9% Excluding weekends: 82.6%
	Undertake re-audit of medicine administration systems in by 31 December 2016	Re-audited three times: Dec 15- Jan 16 Aug 16-Sept 16 Dec 16 March 17- Apr 17 – Data being analysed Plan to audit quarterly
	Identify a process for benchmarking Trust performance against that of other Trusts	Identified: HPTP planning project: assessment and action planning. Completed 28.10.2016
Patient Safety 2: Avoiding missed or delayed diagnosis (Sign up to Safety Campaign)	95% of diagnostic tests and imaging will be requested via an electronic system	Electronic systems not in place in all services.
	90% of diagnostic tests used by the Trust will have a standardised procedure including agreed timescales for result reporting.	Electronic systems not in place in all services.
Patient Safety 3: Preventing the deteriorating patient. (Sign up to Safety Campaign)	Documentation audit will demonstrate that 100% of deteriorating patients are medically escalated as per policy.	Occasional patient still being escalated outside of policy.
	At least one Registered Nurse per shift on in-patient wards to have completed training relating to the deteriorating patient by 31 December 2016.	Successful stop the shift campaign trained the majority of nurses in 2016.
Patient safety 4: Harm Free Care	Take-up of relevant mandatory training will exceed 90% in 2016/17.	Training is available, however it is core training and monitored at local level.
	All incidents relating to falls and tissue viability will have an RCA completed within 3 weeks of event.	All falls are reviewed at the weekly SI Panel meeting. Tissue Viability performance has been variable in the year however RCAs have all been completed.
	Overall, the patient thermometer score for harm free care will be improved to and sustained at 96% and above.	92.6% at year end

Reference	Metric	Outcome
Patient Safety 5: Extending the scope of the NHS Safety Thermometer	Establish a process for collecting and submitting data by July 2016	
	Establish a performance baseline from data by August 2016	
	Identify improvement priorities from benchmarking by end-September 2016	
Clinical Effectiveness 1: Learning from Mortality	100% of unpredicted deaths of patients in hospital will be reviewed in line with the Mortality Review Process.	
	HSMR score will be at or below 100 by year end; SHMI score will be at or below 100 by year end	107

Domain	ID	Indicator Name	Rationale for Monitoring	Continued focus 2016/17?
Patient safety	PS_1	Achieve zero 'Never events'	Important measure of patient safety; zero target not achieved in 2015/16	Yes
	PS_2	Rate of patient safety incidents per 1000 bed days	Reflects an effective 'no blame, low threshold', reporting culture	Yes
	PS_3	Percentage of patient safety incidents resulting in severe harm or death	Reflects an effective 'no blame, low threshold', reporting culture and harm free care (Sign up to Safety; NHS Safety Thermometer)	Yes
	PS_4a	Number of patients with c-difficile	Continuing infection Control surveillance	Yes
	PS_4b	Number of patients with MRSA bacteraemia	Continuing infection Control surveillance	Yes
Patient Experience	PE_1	Increasing our responsiveness to patient's needs using a composite indicator of care (from April 2011 baseline)	Links to 'caring' objectives/continuing Trust requirement	No, superseded by Friends and Family Test
	PE_2	Increase in the number of patients assessed using the MUST nutritional tool	Important safety metric	Yes
	PE_3	Complaints response times	Supports improved patient experience and Trust learning	Yes
Clinical Effectiveness	CE_1	Reducing emergency re-admissions to hospital within 28 days of discharge	A measure of clinical effectiveness and the quality of care for patients	Yes
	CE_2	Reducing weekend mortality rates (death of patient admitted at weekend)	Integral part of the mortality review process to support Trust learning	Yes
	CE_3	Improve Dementia care using F.A.I.R. (Find, Assess, Investigate, Refer)	Measures progress against Dementia Care Improvement Programme	Yes
Culture	C_1	All applicable colleagues to have in-year PDR	Supports Caring and Learning Objectives	Yes
	C_2	Increase in Incident Reporting via 'Datix'	Supports 'no blame', low-threshold reporting culture	Yes
	C_3	Colleagues compliance with MaST training	Supports colleagues learning objectives and patient safety	Yes
	C_4	Employee sickness rates	Proxy marker reflecting morale and wellbeing of colleagues	Yes
Data Quality	DQ_1	Data quality Index	Trust requirement – supports DQ improvement programme	Yes
	DQ_2	Blank, Invalid or unacceptable primary diagnosis rates	Trust requirement – supports DQ improvement programme	Yes
	DQ_3	Depth of coding average diagnosis per coded episode	Trust requirement – supports DQ improvement programme	Yes
	DQ_4	Data quality composite indicator	Summary indicator to support progress against Improvement Programme	Yes

Monitoring continuing quality indicators in 2016/17

Patient Experience 1: The management of discharge from hospital

Lead: Director of Operations
Operational Lead: Head of Nursing – Operations
CQC domain: Responsive

Rationale:

Good discharge planning is an essential component of effective care and providing the best possible experience for patients. It requires early anticipation of potential issues, effective multi-disciplinary team work and good collaboration with patients, families and carers. Getting this right can be a complex task. The Trust has set itself the objective of getting this right every time. Timely, safe, discharge improves clinical outcomes for patients and helps make best use of resources.

In 2016/17 the Trust focused on:

- The management of 'medically fit for discharge' patients
- Patients with a longer length of stay in hospital
- Opening a new Transfer of Care Ward (opened in December 2016)
- Investing in a new Transfer of Care Team (TOCT) 'alignment and co-ordinator' role to facilitate planning of the best discharge pathways for patients

In addition, the Governors asked the Trust to reduce the rate of delayed discharges, 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.

> *"Both my wife and I were treated with the utmost courtesy, care and efficiency. The staff were very busy but nothing was too much trouble for any of them. The department was sparkling clean and it was a pleasure to be there."*
>
> **Friends and Family patient feedback**
> **Ward B6 - Ophthalmology**

Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
<= 3.5%	1.65%	2.42%	2.63%	3.21%	2.88%	2.51%	3.5%	3.75%	2.99%	2.81%	2.44%	2.69%	2.99%

Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
<= 3.5%	3.6%	2.3%	3.1%	3.6%	3.1%	2.5%	2.2%	2.9%	4.5%	4.1%	5.7%	2.8%	3.4%

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	YTD
<= 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

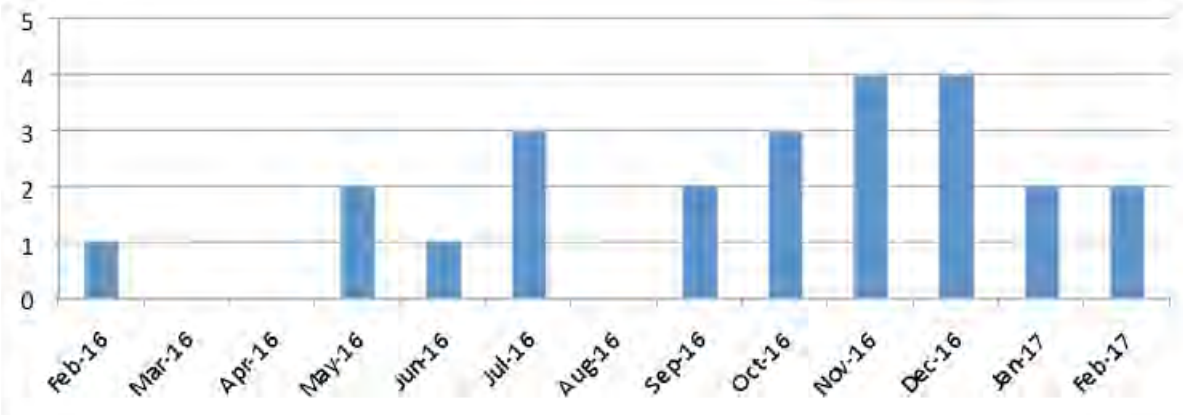
The criteria for this indicator are defined in NHS guidance and details are on the NHS Digital indictor portal. These are used by TRFT and for ease of reference these are:

'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 multi-disciplinary 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)

What did we do?

Produce better data: The Head of Nursing (Operations) now maintains a robust reporting dashboard with details of complaints, incident alert forms (IAFs) and Datix reports. The Trust now keeps this data that will provide a useful benchmark for future years. This helps the Trust improve information for patients and families whilst demonstrating higher levels of satisfaction with discharge arrangements.

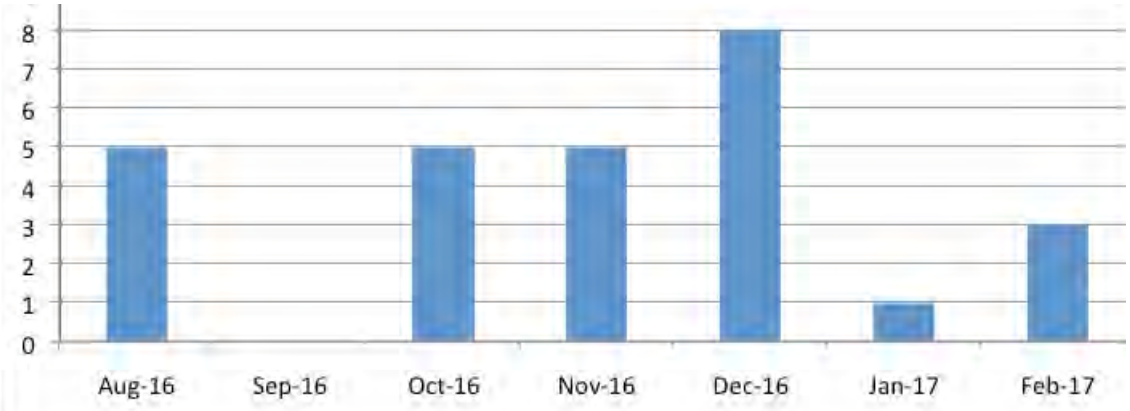


Incident alert forms (IAF) are used to log concerns from partner agencies about discharge. Previously the Trust has not systematically recorded concerns expressed by health professionals in the community, or social care partners. The Patient Experience Group receives reports of changes made across wards and departments as a result of feedback.

Encourage shared learning: Feedback helps teams to share learning and minimise reoccurrence. The most frequent concerns raised are

- Lack of relevant information in discharge letters
- Poor availability of mobility aids (such as rollators or walking frames) in intermediate care (IMC) facilities.

The Trust is now negotiating to allow the storage of appropriate mobility aids in IMC facilities.



IAFs related to discharge 2016/17 (Note – data for previous years is not available)

Improved response to concerns and complaints: In this period there were a total of 9 formal and 59 informal complaints, most of which were resolved prior to discharge. Formal complaints are managed as part of the Trust complaint process. Both categories reflect concerns that include differences of view within families regarding discharge arrangements.

Improved Discharge-related Education: initiatives completed or planned include:

- A Discharge Planning Conference: Managing the difficult messages (July 2017)
- Improving Discharge Planning: Pride in Our Discharge Plans Enhancing Patient Experience (April 2017)
- Posters and ward resource files across all base wards
- 'Stop the shift' completed November 2016
- Preceptorship for newly qualified colleagues in 2017

What next?

A roll-out of the SAFER care bundle across the whole of the Division of Medicine is being planned for 2017. This includes a review of the Multi-disciplinary board round and patients' hospital management plan
The Trust will continue to use the SAFER Care Bundle to reduce the length of hospital stays whilst improving quality of care and patient safety. SAFER means

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

Patient Experience 2: Complaints Management: Improving compliance with the Trust's Complaints Policy

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

Rationale:

People who complain about any aspect of the Trust deserve a prompt, honest and clear response that explains what happened and what the Trust intends to do to minimise the possibility of reoccurrence. The CQC re-inspection report remarks on improvements in responsiveness since the previous inspection, but that there remains room for further improvement.

In 2016/17 the Trust wanted to make progress towards:

- Acknowledging all complaints within 3 working days.
- Encouraging individual contact with complainants with at least 95% of complainants offered a face to face resolution meeting.
- Ensuring all complaints had an action plan.
- Data from complaints triangulated with claims and incident data.
- Improving the awareness of the complaints process within the Trust.
- Every clinical area having at least two colleagues trained in the management of complaints.
- Achieving an "about the same" rating for access to complaints information in the 2016 in-patient survey.
- 95% of complaint responses being issued within the timeframe agreed with those making the complaint without reducing the quality or sensitivity of the response.

Did we achieve this?

Throughout 2016/17 the Trust made some improvements to the management of complaints. However the Trust acknowledges that it has not yet achieved its target of responding to or resolving complaints within the agreed timeframes and this therefore remains an objective for 2017/18.

The Trust's complaints policy was reviewed to ensure it was consistent with NHS England best practice guidance and then benchmarked against Trusts rated as 'Outstanding' by the CQC. The policy now clearly describes the roles and responsibilities of colleagues in ensuring that all concerns are responded to consistently. The policy applies to all services, sites, departments and areas within the organisation, buildings or the environment and to all permanent and temporary staff working within the Trust. Governance and Quality Leads in each Division have responsibility for delivering the improvements required to sustain compliance with the new policy.

The Trust also strives to improve complaints management by offering face to face meetings at the start of the complaint in line with the Patient Association's Person Friendly Charter.

To support the handling of complaints the Trust's "How to raise a concern or make a complaint" leaflets and posters are available on wards/departments and reception areas across Trust sites. Regular audits are now undertaken to ensure there is a supply in all areas. The Trust is committed to ensuring that all those involved should be treated with respect, tact, compassion and concern and that the investigation is undertaken in a fair, objective and timely manner. The Trust has achieved its aim as being 'about the same' as other Trusts in patient awareness of complaints procedures.

Complaints and Concerns received over a three year period

	2014/15	2015/16	2016/17
Formal complaints	396	349	290
Concerns	634	697	968
Total	1,030	1,046	1,258

Formal Complaints numbers measured against Trust activity over a three year period

	2014/15	2015/16	2016/17
Inpatient Episodes			
Number of inpatient complaints	196	190	153
Inpatient Episodes	70,194	68,791	73,631
Complaints per 1000 inpatient episodes	2.79	2.76	2.07
Outpatient Attendances			
Number of outpatient complaints	104	93	67
Outpatient Attendances	266,939	258,443	255,244
Complaints per 1000 attendances	0.39	0.36	0.26
ED Patient Attendances			
Number of ED complaints	61	44	43
ED Attendances	772,21	771,61	760,98
Complaints per 1000 attendances	0.79	0.57	0.57

How was progress monitored and reported?

Data is recorded on the 'Complaints' module within Datix which allows for analysis against a defined set of categories. As part of the Trusts reporting mechanisms a quarterly complaints report is provided to the Clinical Governance Committee, Quality Assurance Committee and Rotherham Clinical Commissioning Group (CCG). Complaints performance is a standing agenda item on the Trust Board, Divisional Performance dashboard, Chief Nurse Performance meeting, Patient Experience Group (PEG) and the Complaints, Claims and Incidents Sub Group.

Weekly meetings are also held by the Patient Experience and Complaints Manager and divisional governance leads to ensure complaints remain high on the patient experience agenda.

What further actions need to be undertaken?

During 2017/18 the emphasis will be on supporting Clinical Divisions to improve compliance with the complaints policy and procedure. This will require the development and monitoring of action plans that enhance learning and improvement, and produce evidence to support improved performance and identify challenges. Key areas for improvement are in meeting timescales, capturing actions arising from complaints and demonstrating that learning takes place across the Trust.

Patient Safety 1: Medication Safety and Efficiency

Executive Lead: Medical Director
Operational Lead: Chief Pharmacist
CQC domains: safe, effective

Rationale:

A fundamental requirement is to have a safe and effective system for managing medicines that ensures all patients receive the medicines that they need, when they need them and irrespective of location within the Trust. The Trust wants to make it easy for staff to do the right thing, each and every time. An effective system means patients get the best out of their treatment, ensuring they receive the information, help and support that they need and have meaningful input into the decisions made about the medicines they receive and the services used to provide them.

In 2016/17 the Trust wanted to:

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

What did we achieve?

Having established a baseline position, the Trust

- Identified key areas of concern
- Engaged and educated prescribers, nurses and pharmacy staff on issues identified
- Shared learning from errors
- Reviewed and updated all medicines procedures
- Reviewed the tools used to manage medication errors
- Benchmarked Trust performance against national standards.
- Agreed that this would remain a Quality Report priority for 2017/18

Medicines Optimisation is a complex strategic issue fundamental to the way that hospitals work and to the quality of patient care provided. Further improvement in governance arrangements and performance are required before the Trust can be confident that objectives are met consistently and sustainably. There have been positive developments in the last year and these will provide a foundation for further improvement in 2017/18.

How was progress monitored and reported?

Progress has been monitored using NRLS medical data on the percentage of medication reconciliation within 24 hours of admission and the percentage of administrations signed, or reasons for non-administration clearly recorded in records. Data has been reviewed at the Rotherham Medication Optimisation Group, the Trust Quality Assurance Committee and the Medication Safety Group.

What further actions need to be undertaken?

In 2017/18 the Trust plans to undertake major audits in medication reconciliation and medication omission, whilst continuing to review NRLS data on administrations signed. Key themes in improvement will be shared through a regular Pharmacy communication bulletin and by providing benchmarking data and feedback at Trust and divisional level.

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

Executive Lead: Medical Director
Operational Lead: Associate Medical Director
CQC domains: Safe, Effective

Rationale:

There are currently three systems for requesting and reporting diagnoses and results. This is inefficient and poses a risk to both the patient and the organisation. There are two streams of work which are essential: a process for results acknowledgement and a process for actioning results. The duplication inherent in using both an electronic and paper-based system means that results can be missed. There is no method at present of identifying the risks arising from this situation, or of quantifying the cost to the Trust.

In 2016/17 the Trust wanted to:

- Approve standardised procedures for all diagnostic tests including agreed timescales for result reporting.
- Move to electronic requesting and reporting of diagnostic tests and imaging (with 95% of diagnostic tests and imaging requested via an electronic system and 90% of diagnostic tests used by the Trust have a standardised procedure including agreed timescales for result reporting).

What did we achieve?

During 2016/17 the Trust made progress in eradicating the use of fax machines and mandating the electronic requesting of all diagnostic investigations. New clinical pathways between community and hospital services also contributed to the early requesting of diagnostic tests. The initial phase has been completed by ensuring that Meditech was integrated within the ED.
Continued training and development of colleagues improved identification and monitoring of patients at risk.

Delayed or missed diagnosis incidents reported.

> *"Always on hand for anything or any concerns I have had. Very polite and friendly, easily approachable, always make you feel at ease."*

Friends and Family patient feedback
Antenatal Care

	Delay in diagnosis for no specified reason	Diagnosis - other	Diagnosis - wrong	Diagnostic images or Lab tests not available when required	Failure to act on adverse symptoms	Failure to act on adverse test results or images	Failure/ delay to order correct tests, image etc	History insufficient or symptoms unaccounted for	Total
14/15 Q1	1	0	0	0	0	0	0	0	1
14/15 Q2	2	0	1	0	0	0	0	0	3
14/15 Q3	0	0	0	0	0	0	0	0	0
14/15 Q4	3	0	0	0	0	1	0	0	4
15/16 Q1	4	0	0	0	0	0	0	0	4
15/16 Q2	2	2	0	0	0	1	0	0	5
15/16 Q3	1	0	0	1	0	0	1	0	3
15/16 Q4	2	0	0	0	0	0	0	0	2
16/17 Q1	0	0	0	0	0	0	0	1	1
16/17 Q2	2	1	0	0	1	0	0	0	4
16/17 Q3	0	0	0	0	1	0	0	0	1
16/17 Q4	0	0	1	1	0	0	0	0	2
Total	17	3	2	2	2	2	1	1	30

How was progress monitored and reported?
Progress has been monitored and reviewed by the Child Health Information Department and the Integrated Medical Directorate.

What further actions need to be undertaken?
The aim is to ensure patient safety by using one system across the Trust and be able to integrate this with the community setting to ensure that results are recognised and acted upon in a timely and efficient manner.
To achieve this the Trust will
- Switch off paper systems for requesting investigations
- Design and implement a system to enable and monitor results acknowledgement
- Complete regular audit on results reporting
- Undertake regular review of incidents surrounding results acknowledgement and results reporting

Patient Safety 3: Preventing the deteriorating patient. (Sign up to Safety Campaign)
Executive Lead: Medical Director
Operational Lead: Associate Medical Director
CQC domains: Safe, Effective

Rationale:
Avoidable deaths and poor clinical outcomes are strongly correlated with failures to identify and act upon deterioration in patients.
To ensure that deteriorating patients are identified and managed appropriately in a timely manner to avoid harm, the Trust uses the MEWS assessment tool. There is evidence that the tool is not yet used consistently across all clinical areas.

What did we achieve?
The new system of Modified Early Warning Scores (MEWS) was introduced last year. There has been extensive work undertaken to review the process, leading to the implementation of a modified "code red" system of review. Consequently patients are reviewed and managed in a timely manner to minimise patient harm. The new MEWS score has also been implemented and is successfully reducing the number of patient harms.

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

How was progress monitored and reported?
In the last year the Trust has
- Conducted regular audit of incidents
- reviewed "code red" information
- Reviewed all incidents involving the deteriorating patient

Progress and challenges have been reported through the Patient Safety Group and at the Medical Directorate. Incident reporting forms part of the safety dashboard for the Quality Assurance Committee.

What further actions need to be undertaken?
Performance data and information from incident reviews will continue to be shared at Divisional Clinical Governance Meetings. Progress will be monitored by the Clinical Governance Committee and reported quarterly to the Quality Assurance Committee.
The Trust will continue to develop the Hospital at Night Team, supporting the aim of having at least one Registered Nurse per shift on in-patient wards having completed 'deteriorating patient' training.
The use of the MEWS tool will continue to be monitored with reviews of incidents used to support learning.

'Harmfree'care
Executive Lead: Chief Nurse
Operational Lead: Assistant Director of Patient Safety and Risk
CQC domain: safe

Rationale:
Harm free care is defined by the absence of pressure ulcers, harm from a fall, urinary infection (in patients with a catheter) and new VTE. It is one way of measuring how safe services are and enables comparisons over time and with similar Trusts. A harm-free care score is derived by reporting events where patients have incurred harm. An improving score reflects safer care and a better experience for patients. The Trust's aspiration remains to achieve and maintain a patient thermometer score of 96% which is above the 95% level expected by NHS England.

What did we achieve?
In 2016/17 the Trust did not achieve its overall target of 96%. Although the incidence of falls with harm was at its lowest for three years, there was an increase in pressure ulcers, particularly in community areas. There has been a further reduction in the incidence of catheter related infection and compliance with VTE assessment remains above the national average. Meanwhile work continues to improve performance including:
- Reviewing all current assessments and documentation to ensure compliance with national and local guidelines
- Participating in the National Audit of Inpatient Falls and Fragility Audit Programme (FFFAP) from the Royal College of Physicians and undertaking appropriate actions and monitoring as identified in the final report
- Improved awareness and training for all clinical staff on falls assessment and prevention for patients.
- Continuing the STOP Pressure campaign and the React to Red campaign designed to raise awareness of early signs of tissue viability concerns.
- Improved support for patients identified as being at high risk of falls by continuing to provide 1:1 observation or grouping patients
- Improving the knowledge of staff by undertaking RCAs following incidents to ensure that learning is embedded locally.
- Continue to review the range and location equipment available to reduce the risk of falls

The Rotherham NHS Foundation Trust performance against Harm Free Care

2012/13

Month	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
HFC - TRFT	86.99%	84.47%	87.16%	88.51%	86.29%	89.78%	91.01%	88.46%	89.03%	90.90%	93.19%	90.94%

2013/14

Month	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
HFC - TRFT	89.05%	90.70%	91.72%	92.49%	92.35%	89.32%	91.93%	93.92%	90.92%	90.46%	91.73%	92.56%

2014/15

Month	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
HFC - TRFT	93.30%	93.07%	92.60%	92.62%	92.73%	93.52%	95.11%	93.79%	93.93%	93.48%	93.36%	94.35%

2015/16

Month	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
HFC - TRFT	94.32%	93.03%	94.07%	94.10%	94.80%	94.57%	94.67%	94.85%	94.05%	94.99%	93.21%	94.87%

2016/17

Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
HFC - TRFT	92.30%	92.32%	90.21%	93.92%	92.33%	91.69%	92.80%	92.52%	92.55%	93.22%	91.66%	92.16%

How was progress monitored and reported?

Monthly reporting of local and national data is received by the Trust and monitored through the Quality Assurance Committee, Clinical Governance Committee, Patient Safety Group and Chief Nurse Performance meetings.

Additional monitoring is undertaken by the Patient Safety team who validate the data prior to external submission and work with the clinical teams as appropriate.
Falls which occur in patients living with dementia are recorded by the dementia specialist nurse who identifies and addresses any themes and trends to minimise future risk. Currently an average of 7% of all falls recorded on Datix are dementia related.

What further actions need to be undertaken?

During 2017/18 the Trust aims to

- Continue detailed reviews of the community data. It might be helpful to identify a methodology that enables a direct comparison within community locations due to differences in population sizes and provision, with some areas having more care homes within their locations.
- Provide additional support and training for clinical teams from the Tissue Viability team.
- Review current equipment stocks and locations due to the increase demand for therapy mattresses and other aids.
- Consider, with partner agencies, a review of 24/7 care provided in community settings for frail elderly patients.
- Ensure all incidents relating to falls and tissue viability have an RCA completed within 3 weeks of event.
- Achieve at least a 90% take-up of relevant mandatory training.

Patient Safety 5: Extending the scope of the NHS Safety Thermometer

Executive Lead: Chief Nurse
Operational Lead: Assistant Director of Patient Safety and Risk
CQC domains: Safe, Effective

Rationale: The NHS Safety Thermometer is a tool for assessing the safety of services based on data relating to avoidable harm. 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.

What did we achieve?

The maternity and paediatric safety thermometer data collections have been implemented. The Trust has also used the opportunity provided by collecting this data each month to review other safety metrics, specifically in relation to high risk children.

How was progress monitored and reported?

Monthly reporting of local and national data is received by the Trust and monitored through the Quality Assurance Committee, Clinical Governance Committee, Patient Safety Group and locally through the Family Health Governance meetings. Data is shared nationally with NHS Improvement.

What further actions need to be undertaken?

The Trust currently undertakes a series of medication audits based on safety reports and the recent CQC assessment visit.

At this time The Trust feels these cover the main risk issues for medications safety and therefore we will not be participating in the medication safety thermometer. It is an optional requirement to participate in this data collection and many Trusts do not currently undertake this.

Clinical Excellence 1: Learning from Mortality

Executive Lead: Medical Director
Operational Lead: Associate Medical Director
CQC domains: Safe

Rationale: Learning from mortality has been a priority for the Trust over several years; all unpredicted deaths in hospital are subject to review. The outcomes of these reviews are shared through the clinical governance system, with appropriate support and training provided to improve mortality rates. The Trust uses data from HSMR and SHMI to monitor mortality rates, enabling comparisons on performance to be made over time and with other Trusts.

What did we achieve?

New procedures now ensure that every unexpected death is reviewed within a week with learning points identified and shared across clinical areas. The Trust continues to roll out the SAFER Care Bundle that requires regular senior review for all patients and has used MEWS to improve consistency of escalation to senior clinicians where a patient is seen to be deteriorating. Investment in the Practice Development Team has provided training and learning resources focussed on management of the acutely unwell and the potentially deteriorating patient. The Trust continues to work towards its target of an HSMR score of less than 100 and a SHMI score at or below 100.

How was progress monitored and reported?

The Mortality and Quality Alerts Group has enabled the Trust to analyse and understand trust-wide hospital standardised mortality ratios (HSMR) and summary hospital-level mortality indices (SHMI). Performance is compared with other providers, and the reasons for variations are explored. The Trust undertakes specific pieces of work such as a review of deaths at the weekend, deaths by source of admission and a review of all unexpected deaths.
The performance against HSMR and SHMI is detailed in part 2.3.

What further actions need to be undertaken?

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

The roll-out of the SAFER bundle will continue across the new Integrated Medical Division.

Additional information about how we provide care

Friends and Family Test

The Trust continues to use the Friends and Family Test as one method of gaining feedback from patients and their families. The data is anonymised and reported to NHS England who publish the data each month. The latest data is for February 2017 and shows the Trust has approval ratings comparable to acute trusts across England. The rate of return remains very low and the Trust will continue to explore ways for increasing the completion rate.

> *"Caring staff who are willing to 'go the extra mile'. Courtesy and respect shown to patients by staff."*
>
> **Friends and Family patient feedback**
> **Ward A5**


NHS
Tell us what you think...
1 How likely are you to recommend our labour ward/ homebirth service to friends and family if they needed similar care or treatment?
2 Please can you tell us the main reason for the score given?
The Rotherham NHS
NHS

Service	Rate of return	% recommending	% not recommending
A&E (Trust)	4.4%	90%	4%
A&E (All England)	12.7%	87%	7%
Inpatients (Trust)	49.1%	97%	1%
In Patients (all England)	24.3%	96%	2%
Outpatients (Trust)	3.82%	98%	1%
Outpatients (All England)	6.3%	93%	3%

Data is reviewed and acted on by the Patient Experience Group

In recent months the service has experienced significant staffing challenges, which are currently being addressed.

Mixed-sex accommodation

The trust has a zero tolerance to using mixed-sex accommodation and, since CQC inspection in 2015 there have been zero occurrences within in patient wards. The Trust also monitors patients who are stepping down from 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 has been one instance of an external report in 12 months.

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.

Noise at Night

The Trust scored well on the last patient survey for noise at night caused by staff. The Chief Nurse conducts night visits from time to time and there is an audit tool to measure performance.

Improving pain control across all clinical areas

Pain relief is a key aspect of patient care. Ineffective pain management has negative effects on a patient's physical and psychological recovery; effective pain management is also central to enhanced recovery and early discharge.

In the 2016 National In-patient Survey 80% of patients felt that the Trust did everything possible to help control their pain. This result was an improvement on previous years although national average data is not yet available

So what has been done to address this?

1. 'Intentional rounding' continues to be a standard element of nursing care and includes assessing patients' pain hourly or two hourly, according to need.

2. 213 nurses completed nurse essential training in 2016 which includes pain management. As well as being offered separately to meet the needs of both medical and surgical areas, a third alternative is now available for Community teams. In 2016 medical ward training included the use of Patient Controlled Analgesia to increase their use within this speciality. This provides a more effective level of pain control than oral analgesia alone and is a safer option than sub cutaneous morphine. Although this is only currently being used for small numbers of medical patients (approximately 15 per year) it is hoped that this will increase following the recent training and with the ongoing clinical support from the Acute Pain Team as this provides an improved patient experience.

3. The epidural and local anaesthetic service for patients having Orthopaedic and Gynaecology surgery is now well established. This is in addition to the long established service provided for General Surgery and Urology patients. The Acute Pain Team are actively involved in the weekly Hip and Knee School for Orthopaedic patients to provide information, education and choices for pain control in advance of surgery. Work is currently being undertaken to audit the impact of this intervention and to update accompanying patient information booklets to further enhance the service.

4. The Accupin service to help prevent nausea and vomiting is an area of significant achievement for the service. All adult elective surgical patients are now offered a pin to control post-operative pain and work has commenced to roll this service out to Medical, Paediatric and Community patients. Data is being collected to show the number of patients benefitting from this intervention.

In 2016, this initiative was presented as a poster at the National Acute Pain Symposium (NAPS) entitled 'Using Acupuncture in the Prevention and Treatment of Post-Operative Nausea and Vomiting'. This was well received and has generated interest from a number of hospitals around the UK that are keen to follow our policies.

The Lead Specialist Nurse for the In-Patient Pain Team is one of five nominees shortlisted nationally for an RCNi award in the 'Innovations in Your Specialty' category. This is for the project 'Accupin for Post-operative Nausea and Vomiting, Hyperemesis, Chemotherapy and Palliative Care Nausea and Vomiting'. The award ceremony takes place in May 2017.

5. Patients with fractured ribs have significant pain. Patients admitted with fractured ribs to this hospital are mostly elderly patients who have had a fall. Inadequate pain management in these patients can have devastating consequences including chest infection, pneumonia and death. The Shared Care model for patients with fractured ribs continues to be followed enabling patients to receive epidural pain relief based on surgical wards, whilst receiving medical care from respiratory physicians. The service continue to aim for daily involvement from all members of the care delivery team to support the pathway back to medical wards once the acute phase is complete.

6. There have been further improvements made to the Dementia Friendly Pain Assessment Tool through partnership working between the Acute Pain Team and the Dementia Nurse Specialist. The use of this tool has significantly increased and is being promoted within all areas to further improve pain management in this vulnerable group of patients. Pain assessment tools have been extended to ensure that non-verbal pain can be assessed in patients living with dementia where communication has become difficult. An evidence based non-verbal pain assessment tool is available in each clinical area and training has been provide to ensure that colleagues are empowered to use the most appropriate assessment tool.

7. The external reputation of the service provided continues to grow and in March 2017 the Lead Specialist Nurse for the In-Patient Pain Team was invited to present on Pain Management at the British Limb Reconstruction Society Annual Meeting. Over the coming year the team plan to continue to build on their accomplishments to enhance the care that patients in both the hospital and the community receive to manage their acute pain.

Patient-led assessments of the care environment (PLACE) 2016

The 2016 PLACE assessment was conducted in April 2016. Visits were made to 18 clinical areas at Rotherham Hospital and 2 at Breathing Space. The 2016 visits again involved governors, Healthwatch and Trust colleagues. This year's results demonstrate some significant improvements, even over previously good scores.

"I have had to come to hospital for various treatments and therapy and had the best nurses and doctors. I could not wish for more."

Friends and Family patient feedback
Transient Ischaemic Attack (TIA)

Trust results 2015 and 2016	Cleanliness		Rate of return		% recommending		% not recommending	
	2015	2016	2015	2016	2015	2016	2015	2016
Breathing Space	95.77%	98.56%	86.48%	90.11%	85.76%	88.52%	87.29%	91.45%
Hospital	96.66%	97.70%	79.95%	91.06%	86.84%	86.73%	78.73%	92.21%

Trust results 2015 and 2016	Privacy Dignity and Wellbeing		Condition Appearance and Maintenance		Dementia		Disability	
	2015	2016	2015	2016	2015	2016	2015	2016
Breathing Space	79.73%	83.78%	93.16%	94.19%	69.56%	77.23%	n/a	82.46%
Hospital	75.86%	73.13%	84.78%	87.94%	59.33%	69.24%	n/a	72.83%

Healthcare Associated Infections

The Director of Infection Prevention and Control (DIPC) published the annual infection prevention and control report in July 2016. The 2016/17 annual report will be completed in April 2017 with the aim to have final approval in June 2017.

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 is the Executive lead for Infection Prevention and Control and meets regularly with the DIPC.

In year there has been one case of hospital acquired MRSA bacteraemia which was above the zero trajectory. This is the first clinical case of MRSA bacteraemia for over 6 years. The patient responded well to treatment and the case has been fully investigated using the SI process.

There were two community acquired cases of MRSA bacteraemia which were investigated jointly with the Lead Nurse for Infection Prevention and Control at Rotherham Clinical Commissioning Group (CCG) using the national toolkit and were subsequently submitted to the MRSA arbitration panel where it was agreed that neither case was attributable to any Trust care provision.

Throughout the year the Infection Prevention and Control and Decontamination Committee has maintained a focus on blood culture contamination rates. The national average is 3%, i.e. 3% of samples taken are contaminated, usually with flora or bacteria on the skin. There has been a reduction of contamination from 2015/16 however the Trust has continued to exceed the 3% target with the exception of October 2016 which was 2.87%. Action plans to reduce contamination risk have continued in the Emergency Department (ED) where the highest percentage of blood culture sampling is undertaken. The whole of the ED team are working to in a multi-professional and multi-disciplinary manner reduce contaminated samples.

MRSA and C-difficile are both alert organisms subject to annual improvement targets. The MRSA target for 2016/17 was 'zero preventable cases' which was not achieved due to the one case in January 2107. The C-difficile trajectory was 26 cases to year-end and the Trust achieved better than trajectory, recording 18 cases.

A single case that was allocated as community acquired by the National Public Health England reporting system based on dates was investigated as a hospital acquired case and was reported internally as 18+1.

Details from the Infection Prevention KPI report March 2017.	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 % 2015/16	4.27%	4.03%	4.47%	4.51%	5.07%	4.46%
Blood culture contamination actual % 2016/17	3.35%	5.8%	4.39%	4.58%	4.66%	3.89%

Details from the Infection Prevention KPI report March 2017.	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 % 2015/16	4.42%	5.78%	5.08%	4.02%	3.79%	5.41%
Blood culture contamination actual % 2016/17	2.87%	3.80%	4.03%	3.90%	3.79%	3.58%

Rates of contaminated blood samples for 2015/16 & 2016/17(data source: Trust Winpath System)

The Rotherham NHS Foundation Trust incident of C difficile		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16 Target = 26	Monthly Actual	0	4	1	4	0	4	0	1	1	2	1	1
	Monthly Plan	2	2	1	2	2	3	2	3	2	2	2	3
	YTD Actual	0	4	5	9	9	13	13	14	15	17	18	19
	YTD Plan	2	4	5	7	9	12	14	17	19	21	23	26

The Rotherham NHS Foundation Trust incident of C difficile		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Target = 26	Monthly Actual	0	0	2	2	1	2+1	1	3	1	5	1	0
	Monthly Plan	1	4	2	2	1	4	2	2	2	2	2	2
	YTD Actual	0	0	2	4	5	7+1	8+1	11+1	12+1	17+1	18+1	18+1
	YTD Plan	1	5	7	9	10	14	16	18	20	22	24	26

C-difficile trajectory 2016/17 (data source: Trust Winpath system)

All cases of hospital acquired C-difficile are reviewed in depth by the 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 and prolonged length of stay, the antimicrobial subgroup regarding antimicrobial prescribing. Multi-disciplinary Team (MDT) meetings with the relevant Division take place in the following week where a full review of the RCA is undertaken.

A post-infection review (PIR) is carried out each month with the Lead Nurse for Infection Prevention and Control for Rotherham CCG, The Antimicrobial Pharmacist for the CCG. The PIR scrutinises not only the Infection Prevention practices but also examines if there is any other lapse of quality of patient care identified during the whole patient care pathway.
In 2016/17 twelve cases have been classed as unavoidable with no lapse in quality of care identified whilst 6 cases did have an identified lapse in quality of care. 1 case has not yet been closed. The lapses were:

- One delay in sample acquisition and use of the Bristol stool chart,
- One linked to antibiotic blood level monitoring
- One linked to the drug Kardex not being able to be reviewed.
- Two classed as cross infection.
- One case linked to antibiotic prescribing.

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 34 samples Ribotyped during 2016/17, 18 (+1) of which were hospital acquired cases. Community acquired cases may be tested and reported via the Trust on admission or may be direct GP samples which are tested and reported via Barnsley Laboratory.

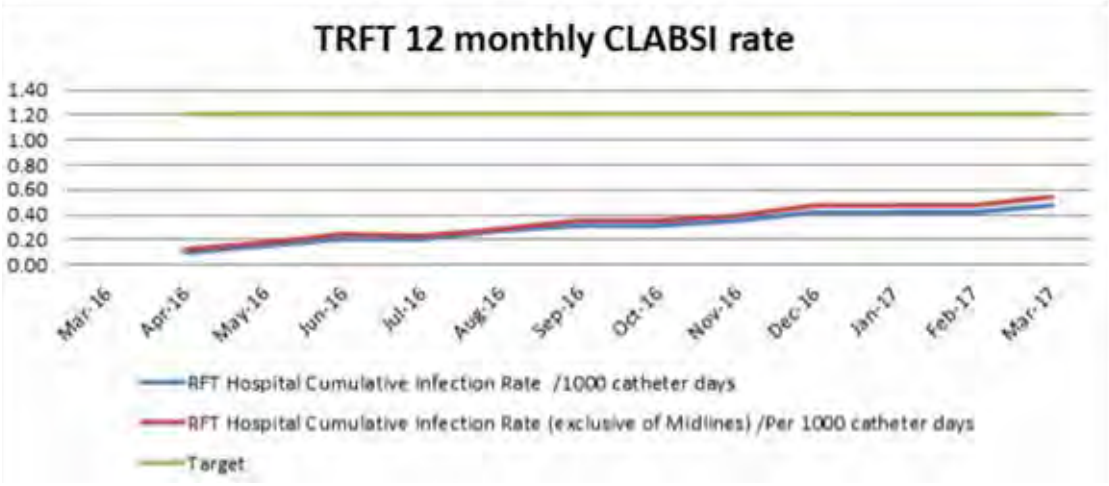
There were 27 different Ribotypes identified from the 34 samples tested. Whenever there is more than one sample of the same Ribotype they are further analysed to determine if there is any correlation between the cases.

The Trust continues to have an outstanding, 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 2016/17 (data 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 2016/17 has seen an increase in numbers of cases of Norovirus, Rotavirus and Influenza which have been well managed to reduce further cases and to avoid outbreak situations. A number of beds were closed where indicated but no wards have been closed.

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

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 16/17 to include continual surveillance of all lower limb arthroplasty. The results of the surveillance will be provided to the Orthopaedic governance group during 2017/18

The Consultant for Podiatric Surgery completes continual SSI surveillance via the speciality national data base and has had zero post-operative infection.

Whilst the Trust was very disappointed that a case of MRSA bacteraemia occurred, the Trust is very pleased with infection prevention in other areas such as central line associated blood stream infections, rates of C diff against trajectory and the low SSI rates for Caesarean sections and Podiatric Surgery. Norovirus, Rotavirus and Influenza infections have been well managed; there has been no need to close wards. More patients are being treated in the community with I/V antimicrobials which means that patients are prevented from hospital admissions or discharged earlier. The IPC team has been instrumental in education and training at regional level.

Reducing the incidence of Falls with Harm

During 2016/17 the Trust has seen an on-going reduction in the number of falls with harm. The reduction has been mainly due to an improved compliance with the Trusts falls assessment documents and improved use of equipment to help reduce the risk of patients falling, use of the Safe and Supportive Framework which helps staff identify patients who need more intensive observation and the introduction of Falls Champions in the clinical areas.

All falls are reviewed on a daily basis and intensive support has been provided by the Patient Safety team to clinical areas to help them identify specific issues in their areas which may have contributed to individual patient's falls.

An example of this would be following a fall with harm at the Community Elm unit it was identified there was an issue with the type of 'Falls Alarms' used within the Trust. Due to the layout of the Community Unit, with its long corridors and the position of the nurse station, the alarms could not be heard very well. A trial of adaptations to the current Tabs alarms has commenced: this includes using a type of pager that is carried by the nurse which bleeps to inform her when a falls alarm has been activated. The pager also informs the nurse which room she needs to attend immediately.

Individualised training has been provided to the clinical areas on the falls prevention equipment and a new e-learning package is available for staff to access which will initially be offered to the Falls' champions and areas at high risk of falls.

Duty of Candour

During 2016/17 the Trust has taken the following steps to comply with Duty of Candour (DoC) regulations:

- Trust Policy has been reviewed, updated and approved and is available on the Trust intranet
- Establishment of the SI panel which identifies who is leading on these investigations and ensure compliance with the DoC letters
- Governance leads are actively involved with the compliance with DoC
- Leaflets sent to all colleagues with payslips explaining their responsibilities for DoC
- Posters and training for ward colleagues
- Information added to Datix to ensure colleagues are reporting when the DoC has been applied

An Internal audit was undertaken in February 2017 with results due in April 2017

For 2017/18 there will be

- Additional training for medical and nursing colleagues.
- Exploring easier ways of identifying in the notes when the DoC discussions have taken place.
- Improve the letters sent to patients/relatives being more explicit about the apology
- Review the policy to add any changes as implemented
- Extend the fields on Datix to provide the information needed for monitoring of compliance

The Trust receives information each month on the compliance with Duty of Candour for Serious Incidents and the internal auditors have just undertaken an audit on our compliance and we will produce an action plan to address any areas that are indicated.

Sign up to Safety – Patient Safety Improvement Plan

The Trust is committed to delivering consistently safe care and taking action to reduce harm. TRFT will work with partners to protect the most vulnerable. TRFT is supporting the NHS England's 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 drivers 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.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Trust has continued to provide training and support to enable colleagues to deliver care consistent with the requirements of the Mental Capacity Act (MCA) 2005. This has been provided in a variety of formats including workshops, e-learning, brief support sessions and face-to-face taught sessions. The Trust has also commissioned some training from Rotherham, Doncaster & South Humber NHS Foundation Trust.
- All colleagues have been provided with prompt cards describing the five MCA principles and the questions to consider in assessing capacity.
- Audit was completed which demonstrated that colleagues felt they had knowledge of the MCA. An action plan was developed from this and is being progressed and monitored to completion.
- In the year 2016/17 requests submitted for Deprivation of Liberty (DoLS) authorisation have risen to 250. This represents a substantial increase on 2015/16 (201 requests made) which demonstrates increased staff awareness of the MCA within the Trust. A database collates all DoLS requests. This is serviced by the MCA Support Worker, employed through additional funding.
- A quarterly report is provided to the Contact Quality Group (Rotherham Clinical Commissioning Group) to provide assurance that the Trust continues to work towards improved implementation of the MCA and DoLS agenda.
- A Task and Finish Group has been set up to further progress and embed the actions that have been identified and also monitor and audit to ensure the actions are fully embedded into practice
- A new MCA Assessment of Capacity form was launched in the Trust on 5 April in order to support the documentation and evidence of assessment in the patients' records.

"Very informative in a warm relaxed atmosphere, which makes it feel easy to feel you can ask questions."

Friends and Family patient feedback
Osteoporosis - Bone Health

Safeguarding Vulnerable Service Users

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

The Trust is committed to ensuring Safeguarding is an absolute priority. The Chief Nurse is the Trust's Executive Lead for safeguarding. The Chief Nurse is supported by the Assistant Chief Nurse (Vulnerabilities) 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 Dementia Care and a Lead Nurse for Learning Disabilities. These posts enhance support for vulnerable patients and together this part of the team leads on all safeguarding adult matters including the Mental Health Act and Deprivation of Liberty Safeguards.

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

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

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

The CQC Inspection in September 2016 revisited safeguarding with the inspection involving external assessors speaking with staff and service users, reviewing Trust policies and procedures. The outcome was positive with areas identified as showing notable practice being increased compliance with Safeguarding training, the paediatric liaison service in the Emergency Department and the CAMHS Liaison Nurse role within TRFT.

Throughout the last 12 months there has been significant progress and developments in order to ensure TRFT fulfils its statutory requirements in relation to safeguarding.
The Safeguarding Training Strategy has been fully reviewed in line with National Intercollegiate Guidance. Training is mandatory for all Trust colleagues and is provided by a number of approaches including face to face, Safeguarding Information booklets and E-Learning.

The Trust's Safeguarding Vulnerable Service Users Strategy is embedded in the organisation and key performance indicators against which safeguarding performance is monitored are in place and reported to the Clinical Governance Committee quarterly. In addition a number of safeguarding standards are in place and monitored externally via the Rotherham Clinical Commissioning Group and throughout this year all feedback on safeguarding performance has been really positive.

An annual work plan is in place and monitored by the Trust Safeguarding Operational Group to ensure all plans progress. The Trust will continue to strive to develop and further improve safeguarding systems and processes in order to protect vulnerable children, young people and adults.

Macmillan Cancer Information Support Service

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

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

The MCISS in 2016 supported 1503 enquires of which 53% were level 3, complex, cases. In the last 8 months of 2016 the service prevented the need for:

- 3 A&E visits
- 170 GP appointments
- 48 Consultant contacts
- 286 Nurse Specialist contacts
- 272 other contacts, such as District Nursing and Social Care.

The MCISS works with primary care, the Borough Council (RMBC), 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.

> *"The staff are efficient, kind and very friendly and welcoming and my daughter recieved a high standard of care. Thankyou."*
>
> **Friends and Family patient feedback**
> **Children's Ward**

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

- Future development of primary care/General Practitioner champions
- Future development of an extensive training programme
- Further development and roll out of Information Prescriptions
- Future development of outreach services in residential care homes in order to try to address the needs of the older population in Rotherham
- Current expansion and consolidation work to foster closer links and collaborative working practices with:

o RDASH (Rotherham Doncaster and South Humber NHS Foundation Trust) for people with mental health needs
o 'Speak Up' self-advocacy organisation to look at ways to address needs of people with learning disabilities
o Rotherham Health Watch
o Voluntary Action Rotherham (VAR) through their social prescribing programme
o Providing Outreach through Urology Services breaking bad news clinics for support to patients and carers in distress.
o 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 one of their Volunteers was awarded 'The Rotherham NHS Foundation Hospital Trust Proud Volunteer of the year award'. In addition, the whole MCISS Volunteers as a team were placed as 3rd runners up.

Wound Management Service

This innovative Rotherham-wide service is led by Trust staff from the Tissue Viability Team. It has built a deserved reputation for clinical excellence and effective use of resources having improved the service to patients.

An initial audit was undertaken in 2011 within the central locality community nursing service as part of the initial pilot so in comparison data can be taken from central locality community nursing service in the January 2017 audit. This audit also contains the rest of the TRFT community nursing service.

2011

- 62.5% of wounds are progressing (granulation and epithelialisation indicate wound healing)
- 63% of wounds had no clinical signs of infection
- There was 81% adherence to formulary

2017

- 87% of wounds were progressing (granulating and epithelializing)
- 90% of wounds had no clinical signs of infection
- There was 97% adherence to formulary

Dementia Care

The Trust continues to develop its approach to improving care for those living with dementia evidenced through the dementia strategy. The specialist dementia lead nurse has improved access to Dementia Awareness Training (provided to ALL colleagues) and led to the identification of Dementia link nurses with a higher level of training in all clinical areas, Level 2 dementia awareness is now easily accessible via e-learning. The number of colleagues who now have undertaken dementia awareness training has increased to 86%

Dementia champions have completed gold level dementia awareness training provided by the Alzheimer's Society and lead on dementia workshops in their own clinical areas. Bespoke training sessions are provided to clinical areas on purposeful walking and nutritional dementia. Although the CQUIN for Dementia care associated with FAIR (Find, Assess, Investigate, Refer) has now been discontinued; the process continues to be embedded in the Trust as gold standard practice to facilitate early diagnosis.

The 'This is me' booklet is proving to be a valuable resource with colleagues understanding the value of being able to provide person centred care.

The Trust has also invested in a range of games and activities for people with dementia (and for people with learning disabilities) supported by increased volunteer input to help provide focussed cognitive stimulation for inpatients living with dementia and awaiting complex discharge arrangements to be completed.

The Trust continues to

- Measure the quality of dementia care through the digital dementia survey.
- Work in partnership with the Police and the Fire service to achieve a response should a person with dementia go missing.
- Participate in the regional development of a delirium assessment tool for acute hospitals which should be available for implementation late in 2017.

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 now 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 ED. Since commencing in post the Lead Nurse has focused on

- Setting up an electronic alert when a person with a learning disability/and or Autism is admitted.
- 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.
- Fostering links with established organisations to support learning. Royal Mencap are using the hospital as a pilot for their new core skills education and training framework, delivering free training to our staff in April.
- Submitting a successful bid for funds to develop a bespoke e-learning package for the Trust. The project work will be delivered in conjunction with Speak Up, a Rotherham Advocacy organisation for people with learning disabilities and Autism.
- A mentoring programme for learning disability nurse/social worker students from Hallam University in conjunction with the Transfer of Care Team, who mentor the social work aspect of their placement.

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
- 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'

Hospital at Night Team

In November 2016, the Trust introduced a new way of working to help transform out-of-hours care. The first phase of the new service, known as Hospital at Night, has seen the team working across Medicine, Surgery and Orthopaedics from 9pm until 9.30am.
The objectives of the service are:

- To match tasks to the most appropriate member of the team according to their skills and to have an oversight of the workload out of hours.
- Improve handovers and communications by allowing dedicated time for multi-disciplinary handover at the start of each shift and to foster close team working throughout the night.

Some key achievements since the introduction of the Hospital at Night service include:

- Improved coordination to provide the most appropriate clinical intervention, first time
- Increase in uptake of clinical activity across the hospital. On initiation, the Hospital at Night service averaged 409 'jobs' a week with a completion rate of 91%. This has increased to an average of 604 'jobs' a week with a completion rate of 96.7%.
- Training with the Physiotherapy Team with the intention of greater team working and a reduction in physio call-outs
- Three trainee Advanced Nurse Practitioners (ANPs) have commenced their Masters courses
- Liaising with the Vascular Access Team to ensure that there is access to the vein viewer scanner and a skilled operator at night
- A survey of colleagues since the implementation showed that Hospital at Night promotes effective team work, improves morale and reduces the isolation of colleagues working at night.

Practice Development Team: supporting learning and Innovation
The Practice Development Team (PDT) was established in February 2016. Since then the team has:

- Developed and introduced an electronic handover process using the established SBAR approach but incorporating
  - Patient identity data to reflect the patient as an individual
  - Clinical observations to aid identification of the deteriorating patient.
- Created the ISOBAR handover template, now rolled out across all acute adult in-patient wards. Assessment of ISOBAR provides clear evidence of handover improvement. Evidence from audit, supported by feedback from ward managers and colleagues shows most areas improving allowing the team to focus on supporting wards where further help is required to deliver and embed changes in practice.
- Developed and implemented harm free huddles that include the wider multi-disciplinary team across all acute adult in-patient wards following consultation with the Improvement Academy.
- An example folder was created to address the recurring issue of inadequate nursing documentation. The folder teaches nursing colleagues how to correctly complete each piece of nursing documentation.
- An example drug Kardex demonstrates the correct way of completing patient medication information and highlights some common errors. This has been rolled out to all acute adult in-patient ward areas following approval by the Chief Pharmacist.
- Since September 2016 the PDT participates in the Nursing Escalation Panel, convened by the Deputy Chief Nurse to provide a formal process of escalation and referral based on Nurse Sensitive Indicators and Datix data. Trigger levels are determined as a guide to informing future PDT intervention based on current available metrics.
- Provided intensive support on three wards and through the Nursing Escalation Panel meeting two of the wards have been de-escalated whilst one continues to receive intensive support.
- Provided 1 to 1 support for individuals identified as having a practice development need. This has largely been related to medicines management, ability to identify the deteriorating patient and/ or how to escalate.

In addition the team have also:

- Undertaken Observation audits
- Supported roll out of MEWS with 'stop the shift' and 'code red' prompts prepared for every ward
- Devised documentation to assess professional behaviours against the NMC code
- Provided teaching re fluid balance
- Used Learning Into Action process to embed changes in practice

The team has also led an innovation week, collecting improvement ideas from colleagues, patients and the public. The ideas, suggestions and comments were compiled and categorised into innovations which can be taken forward and suggestions which may require a wider change in culture.

Library and Knowledge Services

The LKS vision is to ensure patients are at the heart of what the department does: providing the evidence-base for excellent clinical outcomes and a safe and first class experience.

The Service achieved 100% in our 2016 NHS Library Quality Assurance Framework (LQAF) assessment. LQAF "enables a robust quality assessment of library/knowledge services so that an organisation can assess its level of compliance to national standards and demonstrate the fitness for purpose that our 21st century health system demands".

The underpinning aim of NHS library/knowledge services is to put knowledge to work, which in turn will transform patient care and public health. This aim is supported by implementing the NHS Library Quality Assurance Framework (LQAF) England.

In 2016/17, LKS has:

- Embedded evidence-based learning in the organisation by providing evidence at the point of care by attending clinical handovers, ward rounds, MDT meetings and teaching meetings. For example attending weekly clinical meetings in Paediatrics and Hand Surgery.
- Worked with Trust management to find, evaluate and synthesise the best available evidence to answer complex strategic and policy questions to inform decision making, service transformation, innovation, workforce development, risk management and governance.
- Supported the organisation to deliver safe, high quality care by improving the organisation and availability of up-to-date policies and guidelines. This includes responsibility for making local clinical guidelines available via the Ignaz Handbook App and membership of the policies and guidelines subgroup for the new SharePoint intranet.
- Developed over 30 specialty gateways to support evidence-based practice. Each gateway is dedicated to one clinical or professional group and connects you straight to the latest news items, eBooks, ejournals and guidelines for each specialty
- Supported the patient experience and health and well-being for colleagues through initiatives such as the Patients' Library, development of reminiscence resource boxes for colleagues to use with patients and membership of the Mindfulness Interest Group.
- Campaigned to support nurses preparing to revalidate to meet reflection & CPD requirements.
- The librarian is a core member of the Together We Can initiative.
- As well as providing services to all Trust colleagues and students, we have contracts to provide services to the wider health community including RCCG, GPs, Rotherham Hospice, HEE working across Yorkshire & the Humber, NHS England (based at Oak House), Rotherham Public Health and the NHS England Clinical Effectiveness Team.


Stroke
association

Engaging with Colleagues

The Trust is committed to harnessing the energy and skills of its workforce through encouraging a culture of openness and inclusivity. To reflect this, there are a number of strands that make up the engagement strategy. The Trust responded to feedback from colleagues during the Listening into Action sessions and as a result, reviewed its vision, mission and values this year, redefining the vision as 'to be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital.'

Our three new core Values; Ambitious, Caring and Together (ACT), were developed through direct engagement with colleagues, patients and carers during our values week in the summer. Following feedback from colleagues we have developed our Colleague Forum which is helping us shape our organisation and provide a channel enabling colleagues to identify and drive meaningful dialogue and action to improve our working environment and patient care.

We have revised our approach to appraisal to ensure that our organisational values are represented and that it is more meaningful for colleagues.

Further work has been undertaken to ensure our engagement platform and methodology is accessible and relevant to a wider audience. Development of our Together We Can (TWC) methodology has helped us integrate our approach to ensure colleagues are at the heart of change. The TWC programmes have replaced LiA and utilises the '5 Factors to Success' Toolkit.

Throughout the year teams will embrace TWC to help shape change putting colleagues at the heart of the change. Successes will be shared throughout the organisation and with our partners and stakeholders in our publications. We have also developed a bespoke colleague newsletter embracing the qualities and successes of our workforce.

Every quarter the Friends and Family Test model is used to survey colleagues to determine how likely they are to recommend us as a place to work and as a place to receive treatment. This is done through a variety of online and paper based surveys and the results are used to support improvements.

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.

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 2016 Trust National Staff Survey was facilitated through the Picker Institute Europe. The Picker Institute was commissioned by 20 Trusts classified as Acute Community Trusts. The Trust undertook a full census of eligible employees, achieving a 41% response rate (a reduction of 1% from last year); two thirds of returns were completed on line.

The overall colleagues' engagement score shows a slight improvement from last year. The Trust recognises that this trend needs to continue if we are to improve further compared to other similar Trusts, and this is an area of focus for us.

Where the Trust has focused on local change, areas such as the reporting of bullying harassment and abuse, there has been improvement. We have also seen a positive response in the number of colleagues experiencing harassment, bullying and abuse from patients. Colleagues have also reported an improvement in fairness and effectiveness in procedures of reporting errors, near misses and incidents, in addition to an increase in colleague's confidence and security in reporting unsafe clinical practice.

Evidence from last years' dedicated team engagement sessions with the Estates and Facilities teams has resulted in considerable improvements in overall engagement, particularly, themes such as management, team work and involvement, appraisal, motivation and job satisfaction.

Where improvement is seen in the top five ranking scores (see table below) we attribute this to the increased focus throughout the year on effective reporting, training, inception of mediation services and focus on Freedom to Speak up Guardians.

In the table below (the bottom five ranking scores for the Trust) all areas show an improving trend. It is encouraging to note that communication between senior management and colleagues has improved; this is in part due to an improved interactive team brief, development of our colleague forum, executive senior visibility through 'board to ward' visits across the organisation and the promotion and use of social media and other communication channels.

Some results are expressed as percentages, others as scores on a scale of 1 – 5

The Rotherham NHS Foundation Trust Response rate	2015/16 (previous year)	2016/17 (current year)	Benchmarking group (trust type) average	Change
Response rate	42%	41%	Picker Institute 42%	1% decrease

Trust Top 5 ranking scores	2015/16	2016/17	Benchmarking group (trust type) average	Change
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	24%	20%	26%	4% Improvement
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	24%	24%	29%	No change
Percentage of staff appraised in last 12 months	94%	93%	86%	1% decrease
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	12%	10%	13%	2% improvement
Percentage of staff working extra hours	68%	68%	71%	No change

The Trust has experienced most improvement in:

- Percentage of staff reporting most recent experience of harassment, bullying or abuse (positive increase from 31% to 45%)
- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (positive decrease from 63% to 57%)
- Effective use of patient and service user feedback (increase from 3.58 to 3.72)
- Percentage of staff satisfied with the opportunities for flexible working patterns (increase from 47% to 50%)

"Friendly and approachable staff - good bedside manner of all doctors throughout care given. All help fully appreciated and nurses are extremely helpful."

Friends and Family patient feedback
Acute Medical Unit

Bottom 5 ranking scores	2015/16	2016/17	Benchmarking group (trust type) average	Trust improvement / deterioration
Staff motivation at work	3.80	3.82	3.94	improvement
Staff satisfaction with level of responsibility and involvement	3.83	3.85	3.92	improvement
Percentage of staff reporting good communication between senior management and staff	24%	28%	32%	4% improvement
Percentage of staff able to contribute towards improvements at work	65%	66%	71%	1% improvement
Staff recommendation of the organisation as a place to work or receive treatment	3.52	3.54	3.71	improvement

Key areas of improvement

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (positive decrease from 23% to 20%)

Areas of deterioration

There are no statistically significant areas identified from the Staff Survey where the Trust's performance has deteriorated; however, we recognize that there is still room for improvement in our strategic objective, Colleagues: Engaged, Accountable Colleagues.

Statement of Key Priorities

The Trust will focus on leadership, culture, health and wellbeing of our colleagues, continuing to ensure colleagues have opportunity to participate in meaningful engagement events using the Together We Can methodology to support and deliver effective change supported by our executive team.

Our ambition to continue to build on effective engagement remains the focus for 2017/18. We are committed to undertake detailed work using the NHSI Culture Tool and continued adoption of our Together We Can engagement methodology.

Application of the NHSI culture tool kit, phase 1, will be implemented in quarter 1 of 2017/18 and will be aligned to the Trust's strategy. Our ambition is that the full deployment of the NHSI toolkit will be delivered over an operational time line of 2-3 years.

The first Together We Can (TWC) teams are already underway and will deliver against their key objectives by the end of June 2017. The next wave of TWC teams will commence in July 2017 with an expected completion date of January 2018.

Performance against priority areas

The Trusts performance against the staff survey priorities have been reported to the Operational Workforce Committee. Additionally, elements of the survey: staff health and wellbeing, flu vaccination uptake, health food, access to MSK support and workplace stress will be monitored via the Trusts CQUIN steering group.

The Trust is working to achieve its performance in respect of the wellbeing and flu vaccination uptake.

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 action of 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 the HR Business Partners. 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.

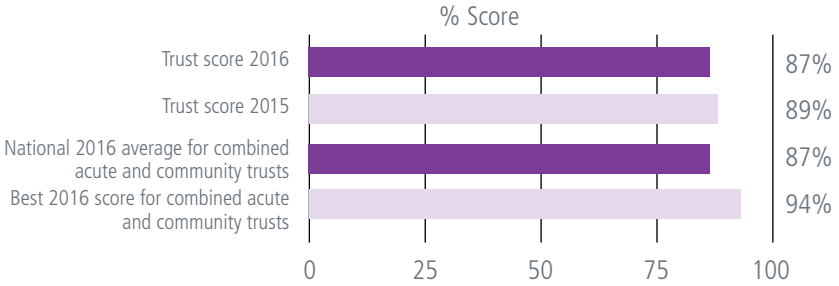
Staff Survey Questions

NHS England has asked that Trusts pay particular attention to performance against two areas: equal opportunities and harassment, bullying and abuse. In the latest staff survey the Trust performed in line with similar Trusts across England.

"I was very poorly when I came. I had 24 hour care,cannot fault anyone or anything. Excellent care!"

Friends and Family patient feedback
Breathing Space

Key finding 21. Precentage of staff believing that the organisation provides equal opportunities for career progression or promotion
(the higher the core the better)



The Trust utilises the NHS Jobs system for all its recruitment activity. The system ensures that candidate's personal data is kept separate when shortlisting. The Trust is currently working on improving the quality of data reporting as part of an on-going commitment to Equality and Diversity within the Trust. As of 30/03/2016, 79% of colleagues had completed the Equality and Diversity mandatory training module compared with 72.62% in 2014/15.

The Trust has a robust policy supported by training for managers in how to respond effectively with bullying. There are Freedom to Speak Up guardians in place who act as an advocate for any employee with concerns and a confidential hotline where colleagues can obtain support and advice. Trained mediators are available to support colleagues and resolve bullying and harassment issues. During 2016/17 the Trust has completed a review of policy and procedures, moving towards an approach based on mediation and de-escalation.

Freedom to Speak up 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 had been recruited to ensure that all Divisions have representation, there are currently 12 Guardians, the majority of whom undertake this role on a voluntary basis in addition to their substantive post. At the current time the FTUG lead role is 0.1WTE.

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

Since October 2016 when reporting officially commenced the FTSU guardians have received 8 concerns. The majority of these concerns have been received either through the FTSU email (2) address or directly to the FTSU guardians (5). Of these concerns, 5 relate to attitudes and behaviour, with colleagues being directed to HR or union support for further advice. Two concerns related to staffing levels and the other to quality and safety of patient care.

Colleagues are able to contact the FTSU Guardians through an answer machine, 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 lead guardian.

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 venue convenient to the complainant.

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. To date the concern raisers contacted have not reported any detriment following raising a concern.

Since the appointment of the National Guardian, Dr Henrietta Hughes, there has been increased direction from the National Office regarding the role to FTSU guardians. As a result there is now a regional network that meets every 3 months and national events; FTSU guardians from the Trust have been supported to attend. Guidance has been issued regarding the means of reporting concerns and two guardians have attended the training. There is an expectation that the FTSU guardians support regional and national education on the role.

During 2017/18 there are plans to increase the awareness of colleagues across the organisation of the FTSU role and their role in raising concerns. E-learning that has been developed nationally will be included as part of induction training and there will be a two year period whereby all colleagues will be expected to complete the 'Reporting concerns' E-learning programme. There will an additional expectation for colleagues involved with the management of teams to complete the responding to concerns E-learning in addition.

Whilst the Trust is keen for concerns to be raised openly it is acknowledged that some colleagues may wish to raise concerns anonymously. Work is underway to look at the potential of Datix as a means of reporting both anonymously and confidentially and to hold any documentation associated with concerns raised.

In order to gain feedback on the service provided by the FTSU guardians a questionnaire has been developed which will be sent to colleagues raising a concern following the wellness check. This feedback will enable the development of the FTSU role as required by colleagues and understand the roles effectiveness.

An increased number of concerns have been raised to the FTSU guardians over the past 6 months, compared to the previous 12 month period. Robust systems have been implemented to respond to concerns and record meetings held with those raising a concern. There is also a process for logging concerns which enables more effective reporting of the issues raised.

Further developments are planned over the next 12 months to increase colleague knowledge of their responsibilities in raising a concern and to support managers in supporting those raising a concern.

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?

However, the table below shows the responses collected during the year

	Quarter 1 2016/17		Quarter 2 2016/17	
	Response %	Response Count	Response %	Response Count
Extremely likely	20.1	63	20.2	69
Likely	38.3	120	43.7	149
Neither likely or unlikely	16.3	51	17.0	58
Unlikely	13.1	41	9.7	33
Extremely Unlikely	10.9	34	9.1	31
I don't know	1.3	4	0.3	1
	Quarter 3 2016/17 *		Quarter 4 2016/17	
	Response %	Response Count	Response %	Response Count
Extremely likely	11.4	179	17.5	7
Likely	41.2	648	47.5	19
Neither likely or unlikely	28.4	447	22.5	9
Unlikely	12.5	196	7.5	3
Extremely Unlikely	6.6	104	5	2
I don't know	0	0	0	0

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

	Quarter 1 2016/17		Quarter 2 2016/17	
	Response %	Response Count	Response %	Response Count
Extremely likely	32.6	102	31.1	106
Likely	31	97	39	133
Neither likely or unlikely	18.5	58	15.5	53
Extremely unlikely	8.6	27	7.3	25
Unlikely	8	25	6.5	22
I don't know	1.3	4	0.6	2
	Quarter 3 2016/17 *		Quarter 4 2016/17	
	Response %	Response Count	Response %	Response Count
Extremely likely	12.8	202	32.5	13
Likely	44.2	696	47.5	19
Neither likely or unlikely	28.7	452	10	4
Extremely unlikely	9.9	155	7.5	3
Unlikely	4.3	68	0	0
I don't know	0	0	2.5	1

*Source: The Rotherham NHS Foundation Trust Staff survey questions 21c and 21d.

Remainder of data from source: Trust Information Systems

Responsibility for staff friends and family has transferred to the Head of Engagement. A review of approach has taken place and implemented for quarter 1 20117/18, including streamlining the friends and family questions into the Together We Can annual evaluation and increased viability for collection of data. This will ensure an increase in the number of responses received.

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

The Rotherham NHS Foundation Trust's PROUD Awards 2016 took place in November 2016. PROUD Awards celebrate dedicated and caring colleagues who ensure patients receive the best and most compassionate treatment they deserve. The event was held at a local hotel with more than 150 colleagues attending to support 62 amazing, shortlisted nominees.

This year's awards received 432 nominations, including 137 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 21 awards by the Mayor of Rotherham, the Trust's Directors and Chairman, Martin Havenhand, and reporter Joe Cawthorn from the Rotherham Advertiser.

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

PROUD AWARDS 2016 Winners!

Patients
Winner - Mark Smith, Consultant Anaesthetist
Runner Up - Steven How

Colleagues
Winner - Kate Phillips, Nutrition and Dietetics

Governance
Winner - Debbie Holmshaw, Human Resources

Finance
Winner - Clinical Coding Team

Partners
Winner - Matt Birkett, Wrights Electrical
Runner Up - Stuart Lakin, Rotherham CCG

Compassion
Winner - Beth Goss-Hill, Lead Nurse Dementia Care
Runner Up - Nicola Renzi

Respect
Winner - Ashleigh Mellor, Alcohol Liaison Service
Runner Up - Dawn White
Runner Up - Dawn Peters

Responsible
Winner - Diane Burkinshaw, Service Support
Runner Up - Heather Walling

Right First Time
Winner - Rebekah Delap, Senior Occupational Therapist
Runner Up - Data Quality Team

Safe
Winner - Karen Waldie, Rawmarsh District Nursing
Runner Up - Shirley Hatfield

Together
Winner - Stroke Pathway Support Workers
Runner Up - Maggie Boldan

Team of the Year (Clinical)
Winner - Transfer of Care Team
Runner Up - Oakwood Community Unit

Team of the Year - Non-Clinical
Winner - Domestics Team
Runner Up - A&E Reception

Our Top Leader
Winner - Jane Lawrence, Ward Manager, Children's Ward
Runner Up - Kate Martin

Unsung Hero
Winner - Sean Walker, Support Worker, Community Stroke Team
Runner Up - James Davidson

Most Accomplished Learner
Winner - Zoe Chew, Cardiology
Runner Up - Jonathan Ruston

Outstanding Volunteer Award
Winner - Alistair Hammond
Runner Up - Anita Langdon

Public Recognition Award
Winner - Joanne Rose, Parkinsons Disease Nurse Specialists
Runner Up - Sue Barrow

Chief Executive's Award
Winner - Chris Birks, Health Informatics, IT Services

Chairman's Award
Winner - Mario Shekar, Anaesthetics and Theatres
Runner Up - Richard Slater

Lifetime Achievement Award
Winner - John Cartwright
Winner - Kate Phillips, Nutrition and Dietetics

3 Other Information

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 2016/17 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 four 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

> *"Efficiency from phoning 999 right through to discharge."*
>
> **Friends and Family patient feedback**
> **Acute Medical Unit**

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

% of patients waiting less than 18 weeks	YTD	Apr	May	Jun	Jul	Aug	Sep
Target > = 92%							
2015/16	96%	96.8%	97.3%	97.2%	96.4%	95.2%	96.3%
2016/17	95%	95.00%	95.00%	95.02%	94.20%	93.80%	94.17%

% of patients waiting less than 18 weeks	YTD	Oct	Nov	Dec	Jan	Feb	Mar
Target > = 92%							
2015/16	96%	96.1%	96.0%	95.0%	97.0%	95.0%	94.0%
2016/17	95%	94.53%	94.90%	94.39%	93.70%	94.60%	94.8%

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.

There are slight differences in the figures detailed in this report for the 2015/16 monthly data and the previous quality report, this is due to rounding of the figures.

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

Cancer National Waiting Times

Performance against all cancer waiting time standards has been good throughout the year.

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

Metric	Target	2014/15	2015/16	2016/17
Cancer 2 week wait from referral to date first seen, all urgent referrals	93%	94.90%	95.12%	95.89%
Cancer 2 week wait from referral to date first seen, symptomatic breast patients	93%	94.70%	97.43%	94.98%
Cancer 31 day wait from decision to treat to first treatment	96%	99.40%	98.82%	99.21%
Cancer 31 day wait for 2nd or subsequent treatment - surgery	94%	100%	98.67%	96.85%
Cancer 31 day wait for second or subsequent treatment - chemotherapy	95%	100%	100.00%	100%
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	92.70%	88.46%	86.93%
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	100%	98.20%	96.28%
Consultant Upgrade	TBC	TBC	94.72%	91.95%

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
2015/16	91.85%	90.59%	93.72%	97.42%	96.97%	93.65%	88.63%
2016/17	88.63%	92.94%	90.10%	91.89%	89.1%	95.0%	92.76%

% of A&E attendances seen within maximum waiting time of 4 hours from arrival to admission/transfer/discharge							
Target >=95%	YTD	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	91.85%	92.47%	93.67%	85.53%	88.45%	85.83%	77.41%
2016/17	88.63%	85.18%	*	79.20%	79.81%	85.06%	90.11%

*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.

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.'

For A&E data EPAU figures are added to the Trust totals.

During January 2017, the Trust started to include Walk in centre figures within its dataset returns to bring it in line with other Trusts across the region who provide walk in centre type services.

Note – there is a difference in the YTD reporting figure from 2015/16 as reported in the Quality report last year and this report. This is due to the reconciling of year end data.

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

Incidence of C.Difficile

Number of reported cases of C.diff	Incidence of C.Difficile						
Target = <24	YTD	Apr	May	Jun	Jul	Aug	Sep
2015/16	19	0	4	1	4	0	4
2016/17	19	0	0	2	2	1	3

Number of reported cases of C.diff							
Target = <24	Oct	Nov	Dec	Jan	Feb	Mar	Sep
2015/16	0	1	1	2	1	1	4
2016/17	1	3	1	5	1	0	3

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	2014/15		2015/16		2016/17	
			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	31 cases	24 cases	19 cases	26 cases	19	>24
Number of cases - MRSA	x	x	0 cases	0 cases	0 cases	0 cases	1	0
Delayed transfers of care	x	x	3.12%	3.5%	3.41%	3.5%	3.41%	3.5%
Infant health & inequalities: breastfeeding initiation	x	x	59.71%	66%	60.52%	66%	57%	66%
Percentage of all adult inpatients who have had a VTE risk assessment on admission using the national tool	x	x	97.58%	95%	97.30%	95%	96.89%	95%
Maximum time of 18 weeks from point of referral to treatment in aggregate, ADMITTED PATIENTS, NON ADMITTED PATIENTS and INCOMPLETE PATHWAYS.								
Admitted	x	x	94.48%	90%	92.30%	90%	84%	90%
Non - Admitted	x	x	98.99%	95%	97.90%	95%	96%	95%
Incomplete	x	x	97.18%	92%	96.20%	92%	95%	92%
Diagnostic waiting times - nobody waits 6 weeks or over for a key diagnostic test	x	x	0.17%	less than 1%	0.4%	Less than 1%	2.4%	Less than 1%
Patients waiting less than 4 hours A&E	x	x	93.07%	95%	90.59%	95%	88.63%	95%
Cancelled operations for non-medical reasons	x		0.66%	0.8%	0.8%	0.8%	0.76%	0.8%
Women who have seen a midwife by 12 weeks and 6 days of pregnancy	x		91.07%	90%	89.6%	90%	92%	90%
Patients who spend at least 90% of their time on a stroke unit	x		78.82%	80%	86.1%	80%	85%	80%
Higher risk TIA cases who are scanned and treated within 24 hours	x		82.95%	60%	90%	60%	66%	60%
Elective Adult patients readmitted to hospital within 28 days of discharge from hospital	x		4.75%	6%	5%	6%	5%	6%
Non Elective Adult patients readmitted to hospital within 28 days of discharge from hospital	x		13.15%	11.50%	13.24%	11.5%	13.6%	12.5%
Elective patients 0-15 years readmitted to hospital within 28 days of discharge from hospital	x		2.40%	3%	0.5%	3%	0.6%	3%
Elective patients >16 readmitted to hospital within 28 days of discharge from hospital	x		1.40%	3%	2.6%	3%	5.38%	3%
Non-Elective 0-15 years patients readmitted to hospital within 28 days of discharge from hospital	x		8.50%	10.40%	8.7%	10.40%	6.5%	10.40%
Non-elective>16years patients readmitted to hospital within 28 days of discharge from hospital	x		10.00%	12.50%	9.8%	12.5%	14.5%	12.5%

Ensuring patients have a positive experience of care (Pt survey overall score)	x	x		10	7.9	10	8.0	10
Community care data completeness - activity information completeness		x	100%	100%	100%	100%	N/a	100%
Community care data completeness - patient identifier information completeness		x	100%	100%	100%	100%	N/a	100%
Community care data completeness - End of life patients deaths at home information completeness		x	100%	100%	100%	100%	N/a	100%
Patients waiting no more than 31 days for second or subsequent cancer treatment								
Anti-Cancer Drug Treatments - Chemotherapy	x	x	100%	98.0%	100%	98.0%	100%	98%*
Surgery	x	x	100%	94.0%	98.70%	94.0%	96%	94%*
Radiotherapy	x	x	n/a	94.0%	n/a	94.0%	n/a	94%
62-Day Wait For First Treatment (All cancers)								
From Screening Service Referral	x	x	96.4%	90.0%	98.20%	90%	95%	90%*
Urgent GP Referral	x	x	92.7%	85.0%	88.50%	85%	87%	85%*
31-Day Wait For First Treatment (Diagnosis To Treatment)								
All cancers	x	x	99.10%	96.0%	98.80%	96%	99%	96%*
Two week wait from referral to date first seen93%								
All cancers (%)		x	94.9%	93.0%	95.10%	93%	95%	93%*
For symptomatic breast patients (cancer not initially suspected)		x	94.7%	93.0%	97.40%	93%	98%	93%*
Health visitor numbers against plan	x		56	54 wte	65.48	54 wte	59.77	54wte

Annex 1: Statements from Commissioners, the local Healthwatch organisation and the Overview and Scrutiny Committee

Statement on behalf of the Council of Governors

The Quality Report details the delivery of quality improvements for the year 2016/17 against the quality improvement priorities proposed and commented on by colleagues, Governors of the Trust and members of the public. We as Governors appreciate and acknowledge the efforts and dedication shown by the Trust in striving to attain the highest quality of care for our patients whilst acknowledging the difficulties encountered in the delivery of our objectives. We also appreciate the opportunities we have had in the decisions on quality indicators for the coming year.

The accuracy of the report is acknowledged by Governors in its honesty and ambition. We also acknowledge the time and effort placed in quality Improvements and fully support the decisions made by the Trust in respect of the chosen priorities for the year ahead. We also note the Trusts determination to further address the areas where we have not achieved our desired objectives.

Throughout the year, the Trust has seen substantial progress in many areas but without the cooperation of our partners in the social, health and voluntary sectors many of our objectives could not have been achieved.

The "Village Pilot" in which a new model of care is being trialled would not have been possible without the full cooperation, dedication and support of our partner agencies. We have many areas in which we achieve excellent results. We have progressed in areas of patients experience by our improvements in good discharge planning and producing more detailed data to assist future discharge arrangements. Although our complaints management system has shown some improvement we have not yet achieved our targets. Governors hope to see further progress in the year ahead thus providing a robust process that can be maintained. We have seen progress and improvements in terms of medication errors and timely intervention regarding the deteriorating patient.

In the area of harm-free care the Trust did not achieve the overall target of 96%. The incidence of falls was at three year low however, Governors are disappointed that there was an increase in the incidence of pressure ulcers in the community. We particularly share the disappointment and concern in our continued inability to attain the 4 hour Accident and Emergency waiting target. We do however, acknowledge and commend the tremendous dedication and effort by both staff and management in striving to achieve the stretching target. We must also stress that any patient requiring urgent attention is always attended to in a timely, effective and caring manner.

The Governors wish to acknowledge the opportunity offered by the Board in being able to attend the various Board Committees. On a monthly basis, we participate in the monitoring of the actions and workings of the committees particularly in the areas of quality Improvement. We take part in the quality assurance visits in the acute area of the Trust by the senior nurses and continue to hold quarterly Governors Surgeries thus ensuring patients and visitors are able to voice their opinions about our care and services. Any concerns and opinions are reported on and subsequent actions taken.

Once again Governors wish to acknowledge the efforts of the staff and the openness and honesty shown by the Board in difficult times both in terms of finance and patient care targets. In the year ahead the Governors will continue to challenge, monitor progress and support the Trust in striving to be outstanding in terms of quality care for our patients.

Dennis Wray.
Public Governor and Lead Governor

NHS
Rotherham
Clinical Commissioning Group

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Date: 26th April 2017

Statement from NHS Rotherham Clinical Commissioning Group – 26th April 2017

The delivery of high quality care whilst achieving efficiencies has remained a priority and key challenge for both NHS Rotherham Clinical Commissioning Group (RCCG) and The Rotherham NHS Foundation Trust (TRFT) during the financial year of 2016/17. RCCG commends the Trust on the recent CQC re-inspection and the notable improvements that have been made since the CQC inspection in 2015 and are particularly keen to highlight the achievements of TRFT in relation to a number of areas which are detailed below.

Throughout the year TRFT have worked with RCCG to secure continuous improvements in the quality of services, with particular regard to clinical effectiveness and outcomes, safety, infection control, and patient experience. To support this, engagement from TRFT clinicians and executives has been key at Board-to-Board and contractual meetings between the two organisations. Engagement in committees such as the Clinical Referrals Management Committee and A&E Delivery Board has significantly improved for 2016/17 and commitment to work in partnership with the CCG and Primary Care clinicians and deliver joint initiatives such as clinical thresholds and the Urgent and Emergency Care Centre has been evident. For 2017/18, RCCG and TRFT are in discussions to ensure consistent and appropriate representations at all committees.

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 2016/17, these being Gastroenterology, Diagnostics, Community Nursing Services and Childrens and Maternity Services. Overall the four visits concluded with positive feedback from RCCG clinicians with a series of recommendations for improvement to be implemented and some urgent actions to be addressed in Gastroenterology. A programme of visits is in the process of being agreed for 2017/18 and RCCG representation on the unannounced senior nurse visits to clinical areas where patient/GP feedback has raised concerns will continue.

Rotherham's Multi-Agency Safeguarding Hub (MASH) goes from strength to strength. Having an effective MASH is critical to effective working relationships but can be a practical challenge for diverse health providers. TRFT have supported the function of the MASH throughout 2016/17. To support this, a number of safeguarding standards have been put in place by RCCG and compliance against these during 2016/17 has been extremely positive.

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TRFT achieved a better than trajectory position against the number of Clostridium Difficile cases during 2016/17 and both the CCG's Infection Prevention and Control Nurse and Antimicrobial Pharmacist are involved in all post-infection reviews. To date there have been 18 cases of hospital acquired C diff to date against a trajectory of 26 for the end of March. Of the total 18:

- 8 had no lapse in quality of care identified
- 6 had a lapse in quality of care and actions have been identified to address these
- 4 have further information required before the CCG next Post Infection Review (PIR).

There was one confirmed case of hospital acquired MRSA reported during 2016/17 and whilst this is above the zero trajectory it is recognised that this is the first case in over 6 years.

The achievement of the 'seen within 4-hours of attending A&E' target proved to be extremely challenging for all providers this year and TRFT ended the 2016/17 financial year with a performance against the quality standard of 88.40%. TRFT and RCCG worked closely together to develop and agree robust actions encompassing the whole health economy of Rotherham to address performance issues and the difficulties that were being faced both locally and nationally as a result of an increase in A&E attendances and a national shortage of clinicians in this field. RCCG continues to offer support to the Trust from CCG GPs for both A&E and the Acute Medical Unit.

RCCG wish to acknowledge the excellent joint work that has continued throughout the year in regard to the management of serious incidents and the continual improvement in cancer quality standards and 18 week wait referral to treatment standards which have remained compliant against the national quality standards throughout the year.

In regard to mortality rates, the Hospital Standardised Mortality Ratio (HSMR) has continued to rise throughout 2016/17 and became statistically significant at 109 at February 2017. These figures included some deviation for increases in April, May and June 2016. RCCG continues to seek assurance through the monthly Contract Quality Meeting that there will be a return to normal levels once the figures are rebased for the year, although this remains a concern until assurance can be confirmed at year-end.

RCCG and TRFT agreed a number of Incentives Schemes for 2016/17 to support the delivery of improvements in quality for patients. This included the continuation of the SAFER Care Bundle and national 7-Day Working Standards which support the work to improve the management of hospital discharge ensuring people leave hospital in a safe and timely way. RCCG will continue to incentive these ways of working throughout 2017/18.

RCCG acknowledges and is supportive of the Trust's intention to develop a new Quality Improvement Board to deliver focused improvement activity. It is hoped that this help to build on the successes that the Trust has seen during 2016/17 in continuing to deliver quality services.

Dr Phil Birks
GP Executive Lead – TRFT Contract
NHS Rotherham CCG

S. K. Cassin

Sue Cassin
Chief Nurse
NHS Rotherham CCG

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Statement from Rotherham Healthwatch

The Rotherham Foundation Trust Quality Accounts 2017
Statement from Healthwatch Rotherham

Healthwatch Rotherham continues to have an excellent co-operative working relationship with The Rotherham Foundation Trust.

Healthwatch Rotherham now attend the Clinical Governance Committee and act in an observer capacity on that committee.

Healthwatch Rotherham attends Patient Experience Group meetings chaired by the Deputy Chief Nurse to review complaints, comments, compliments and concerns we have received from the public.

Volunteers from Healthwatch Rotherham have taken part in PLACE (Patient-led assessments of the care environment) which was 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 supported the CQC inspection into The Rotherham Foundation Trust last year and has been fully involved in the action plan meetings following the report.

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.

Healthwatch Rotherham was invited to the public consultation event around the Quality Accounts and this was well organised. It is good to see patient experience at the top of the improvement priorities, with discharge and complaints. These are two areas regularly raised. 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 2016. This was then followed by a similar session in April 2017, after Members had 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 driving further quality improvements over time.

The Commission is pleased to see the improvements in the CQC ratings following the re-inspection, reflecting positive changes and new initiatives within the trust. The progress this year on improving discharges through investment in the Transfer of Care Team and on initiatives in the Sign Up to Safety Campaign was welcomed. Positive improvements to scores on the annual staff survey questions were noted and Members hope to see this trend continue as staff engagement through Together We Can rolls out.

Holding initial face to face meetings with people making a complaint seems to be working well, but Members would like to see the Trust meeting its target for timeliness on responses. Timeliness also needs to be improved in relation to responding to reported incidents and ensuring the learning from them is disseminated.

Although there has been further progress on reducing falls as part of Harm Free Care, Members were concerned to learn of an increase in avoidable pressure ulcers, particularly ones acquired in the community/ residential care. They would like to see this issue considered under the Care Home Liaison work stream of the Better Care Fund.

The Commission supports the seven improvement priorities for 2017-18 and ambitious longer term plans for the next 3-5 years, building on the progress made since 2015, but ensuring that the targets and milestones set are achievable.

The 4 hour target for A&E has again been challenging for hospitals. As Chair I look forward to the opening of the new Emergency Centre in the summer, bringing together modern facilities and skilled staff to triage patients and provide high quality urgent and emergency care.

The Health Select Commission appreciates the willingness of the Trust to engage regularly with Members, and anticipates that this will continue as work to embed the quality improvement plan progresses.

Cllr Stuart Sansome
Chair, Health Select Commission

27 April 2017

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 2016/17 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 2016 to 31 March 2017
  - papers relating to quality reported to the board over the period April 2016 to 31 March 2017
  - feedback from commissioners dated 26/04/2017
  - feedback from governors dated 25/04/2017
  - feedback from local Healthwatch organisations dated 03/05/2017
  - feedback from Overview and Scrutiny Committee dated 27/04/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23/05/17
  - the national patient survey 17/02/2017
  - the national staff survey 07/03/2017
  - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2017
  - 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.

As a result of the outcome of the external audit on the mandated indicators, the Board of Directors was informed of issues relating to the quality of this data, and the processes in place to collect such data. The Trust is investigating the issue raised, and is taking actions to address these.

By order of the board

Martin Havenhand
Chairman
26 May 2017

Louise Barnett
Chief Executive
26 May 2017

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 113 - 117, 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 Auditor's 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 2017 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 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 113 of the Quality Report within the Annual Report.
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 114 of the Quality Report within the Annual Report.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the 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 requirements for quality reports for foundation trusts 2016/17" 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 2016/17";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

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 2016/17"; 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 2016 to March 2017;
- Papers relating to Quality reported to the Board over the period April 2016 to March 2017;
- Feedback from Governors dated 25/04/2017;
- Feedback from the Commissioners (Rotherham CCG) dated 26/04/2017;

- Feedback from the local Healthwatch organisation (Rotherham Healthwatch) dated 03/05/2017;
- Feedback from the Overview and Scrutiny Committee (Rotherham Health Select Commission) dated 27/04/2017;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23/05/2017;
- The national patient survey dated 17/02/2017;
- The national staff survey dated 07/03/2017;
- Care Quality Commission inspection report dated 02/03/2017;
- The draft Head of Internal Audit's annual opinion over the Trust's control environment dated 19/05/2017.

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 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and 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 2016/17";
- 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 2016/17"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-mandated indicators in the Quality Report, which have been determined locally by the Rotherham NHS Foundation Trust.

As a result of our work, our limited assurance report in respect of the mandated performance indicators is qualified as follows:

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The system is subsequently updated by the Trust for any identified errors through a monthly validation process. However, the monthly snapshots are not updated or used to recalculate the Trust's performance for previous months or final year end performance.

Additionally, errors exist within the monthly snapshots where the incorrect snapshot date was used impacting on the performance reported for the year resulting in under and over reporting of breaches.

In our testing, we found a number of patients incorrectly included within the indicator, which did not meet the inclusion criteria and instances where the clock had not been started in the right period or stopped at the end of applicable month. We were also not able to obtain supporting documentation to validate appropriate clock start/stop for all cases selected as part of our work.

In addition, no supporting records were made available to verify the community data recorded, which accounts for 4% of the total population of this indicator (based upon information provided to us), as patient level detail is over written each month.

The Trust was not able to review and update the whole data as a consequence of the above issues. Therefore, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Basis for Disclaimer of Conclusion – Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

The Trust implemented a new system part way through the year. During the transition process, as agreed with NHSI, the reporting has been suspended between 2 November and 18 December 2016. The implementation of the new system meant that there were no supporting records made available at the time of audit to verify the Trust's performance prior to that.

No supporting documentation was made available for patients attending the Walk in Centres (WiC) and Early Pregnancy Assessment Units (EPAU). Therefore, we were unable to verify appropriate inclusion within the indicator. The WiC and EPAU accounts for 13.8% and 2% respectively of the total population of this indicator (based upon information provided to us).

In our sample testing performed, we found instances of non-compliance with NHS England's guidance:

- Although the Trust receives data from the Ambulance Trust on ambulance arrival times, due to issues with the completeness and accuracy of the data received, the Trust starts the clock from the time of patients' registration on the Trust's system. The Trust has not been able to demonstrate that for 2016/17, applying a start clock using Ambulance Trust data would not impact on overall reported performance; and
- Errors in the validation process that resulted in some patients being excluded from the indicator and removal of breaches. This was as a result of rolling back clock stops between 4 hour 0 minutes and 4 hours 5 minutes to just under 4 hours, and also rolling back any patients that do not wait who have been waiting longer than 4 hours to under 4 hours.

Additionally, based upon sample testing performed, a lack of evidence exists to corroborate the outcome of the validation process and we were not able to corroborate appropriate clock start/stop for all cases selected.

The detailed listings for this indicator at the time of audit included patients still waiting between 1-173 days. The Trust was not able to review and update the whole data. Therefore, we were unable to access accurate and complete data to check the waiting period from arrival in A&E to admission, transfer or discharge reported across the year.

Basis for Qualified Conclusion – Content of the Quality Report

NHS foundation trusts must specifically use part 3 of the Quality Report to present an overview of the quality of care offered by the Foundation Trust based on performance in 2016/17 against indicators selected by the Board in consultation with stakeholders, with explanation of the underlying reason(s) for selection. The indicators selected must include at least three indicators for each of patient safety, clinical effectiveness and patient experience.

However, the Trust has only included two indicators for each of clinical effectiveness and patient experience. The Trust informed that this selection was to focus on patient safety, where five indicators were selected. The Trust are unable to update the Quality Report and amend the indicators that are being reported.

Disclaimers of Conclusion/Qualified Conclusion

Because of lack of supporting documentation and data quality issues, as described in the Basis for Disclaimer of Conclusion paragraphs, we have not been able to form a conclusion on the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period and the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

In addition, except for the matter described in the Basis for Qualified Conclusion paragraph above relating to content of the Quality Report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 2016/17"; and
- The Quality Report is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP
Chartered Accountants
Central Square
29 Wellington Street
Leeds
LS1 4DL

30 May 2017

The maintenance and integrity of The Rotherham NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendices

Appendix 1:
CQC Re-Inspection Report published March 2017

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 this time.

The tables below show the detailed ratings by key question and by core service, both for the original inspection in 2015 and the re-inspection conducted in September 2016.

CQC ratings for Trust Hospital Services 2015 CQC Inspection:

> *"Extremely friendly team who put me at ease whilst having my procedure, explained all aftercare thoroughly."*
>
> **Friends and Family patient feedback**
> **Theatre Treatment Suite Inpatient**

CQC ratings for Trust Hospital Services 2015 CQC 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	Inadequate	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Good
Critical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Maternity and gynaecology	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Children and young people	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate
End of life care	Good	Requires Improvement	Good	Good	Good
Outpatients and diagnostic imaging	Requires Improvement	(Inspected but not rated)	Good	Good	Good

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	●	●	●	●

● not rated during this inspection visit

CQC ratings for Trust Community services after 2015 inspection

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

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

CQC inspectors identified good and outstanding areas of practice:

- The Multi-Disciplinary Team approach in the locality pilot
- The culture, care and philosophy at Breathing Space - the only entirely nurse-led model of care for respiratory in and outpatients in Europe
- The impact of the activities coordinator at Oakwood on the experience of patients during their stay
- SEPIA Portal – access for staff across our integrated Trust including primary care so we all have up-to-date information about our patients
- Safeguarding liaison within the Emergency Department
- Children with mental health needs - CAMHS Liaison team/nurse practice
- Successful offering of acupins for the relief of nausea, particularly in gynaecology services

In particular, Services for Children and Young people that were rated as inadequate for both Safe and Well-led in the 2015 review were rated as Good for Safe and Requires Improvement for Well Led in the 2016 inspection. Building on this success, the service is introducing a new Paediatric Early Warning tool, progressing the CAMHS training and will continue to look at how it can provide services that work best for the children and young people and their families.

Inspectors also identified areas of continuing concern

- Compliance with DNACPR policy
- Compliance with the Mental Capacity Act (2005)
- Staffing skill mix and unclear roles and responsibilities in some clinical areas
- Staffing levels in hot spot areas
- Unevenness in Incident reporting, review and learning
- A need to improve completion of mandatory training and development

- Insufficient staff with a current appraisal and concerns regarding the quality of some appraisals
- Lack of a consistent approach to risk assessment, monitoring and management, with some risks noted by inspectors that were not on the relevant risk registers.
- Too many policies and procedures, out of date and awaiting review date

Inspectors also noted concerns about
- Lone Working in the Community
- Access to safeguarding supervision and support
- Waiting times for Child Development Centre and Looked-After children
- Complete the RCOG maternity review and actions arising from the visit
- Environmental issues
- Some individual patient records not held sufficiently securely

There were areas of notable improvement since the previous inspection. These included:
- safeguarding training and awareness
- access to sexual health records
- improvements to training data
- nutritional screening

The report identified concerns which led to three requirement notices, in the following areas;
- Regulation 11 - DNACPR
- Regulation 17 – Governance
- Regulation 18 - Staffing

In addition to this there were 65 actions, a combination of 29 'Must-Dos' and 36 'Should-Dos'.

A comprehensive action plan was created as a result of the inspection findings for the three 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.

Together the Annual Quality Report priorities and the CQC requirements (from the concerns identified by the CQC that did not constitute requirement breaches) make up the Quality Improvement Plan. The newly developed Quality Improvement Board will review and monitor achievement against the Quality Improvement Plan.
Overall the Trust has made significant improvements since the full inspection in 2015. This was reflected in the positive and constructive discussion at the Quality Summit. The Trust's response to the CQC Report is fully reflected as a component of the Quality Improvement Plan, with key elements incorporated into the 2017/18 Quality Report priorities.

"This is a specialist service and knowledgeable, efficient caring service"

Friends and Family patient feedback
Audiology

Appendix 2: Review of Local Clinical Audits

The reports of 121 local clinical audits were reviewed by the provider in 2016-17 and The Rotherham NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see table below). Data up to end of Jan 2017

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
A&E	Transient loss of consciousness	Simple guidelines on transient loss of consciousness to be produced based on NICE, along with a proforma/checklist and included on sharepoint.	R569
A&E	Trauma Audit	Trauma and primary survey coding to be recorded on Symphony. A folder to be created with useful/accessible information on trauma e.g. NICE guidelines for head injury/quickly reversing warfarin/rivaroxaban in a bleeding patient, and having the latest ATLS booklet available with the folder. Criteria for activating a trauma call to be displayed on the wall of the nursing station, in resus and in the triage room. Educate all staff about trauma. Trauma proforma to be designed for use within the department.	R640
A&E	Sepsis	Include sepsis as part of education programme with emergency care. Posters to be produced and displayed regarding sepsis. New proforma to be developed. Proforma to be inbuilt into the new IT system.	R641
A&E	Pneumonia care bundle	Teaching sessions with the new trainees to be organised to highlight the importance of this.	R649
A&E	Consent Audit 2015	Establish a consistent approach to verbal, recorded and written consent for various procedures. Poster to be devised to remind all staff about consent. Consider some advice/consent proforma for certain regular procedures (wrist manipulation, shoulder dislocation, chest drain) to get consistent advice and a record of consent.	S1356
A&E, Medicine	Audit of the acute chest pain pathway	The Trust to explore the option of moving to a new troponin assay, by reviewing the cost and workload of such a change. A retrospective audit to be undertaken in 18 months' time.	S1214
AMU	Consent 2016	Document clearly on the consent form the type of anaesthesia used. Clinicians to always check that the patient has signed and dated the form.	S1536
Anaesthetics	Emergency Equipment Audit	Contact Matrons in areas with poor compliance to discuss actions required to ensure emergency equipment checks are completed in line with trust guidance. Circulate continuation sheets and offer new red files if required to ensure appropriate documentation and resources are readily available for use.	R540
Anaesthetics	Audit in to the medical management of patients with Acute Kidney Injury	Deliver teaching session as part of ongoing quality improvement work for Acute Kidney Injury in order to improve adherence to the Acute Kidney Injury bundle and coding.	S1502

"It has been a happy experience and great to feel better due to the wonderful staff."

Friends and Family patient feedback
Rehab Services

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Anaesthetics	Peri-operative management of the obese patient: audit of AAGBI/ SOBA guidelines	Liaise with pre-operative assessment team to ensure patients with a Body Mass Index of greater than 40 are identified on theatre lists. Email all members of staff to ensure the department and trainees are aware of the audit results and recommendations. Re-introduce Association of Anaesthetists of Great Britain and Ireland (AAGBI) sheet guidance to every anaesthetic room and remind staff. Re-audit after 6-12 months looking specifically at patients with a body mass index greater than 40.	S1505
Anaesthetics	Unplanned admissions from Day Surgery 2015	Undertake detailed case note review of patients admitted, in particular those who were unable to pass urine to determine if admissions were appropriate. Discuss findings with Urology team. Clarify guidance on the need to pass urine (after TVT surgery and Hernia report) with Gynaecology and General Surgery teams. Re-audit for 2016.	R552
Anaesthetics	Consent for Anaesthesia	Research consenting practices at other trusts and as part of the national agenda for consent for anaesthesia. Introduce consent for anaesthesia through the agreement and implementation of a new process.	R735
Anaesthetics	Unplanned admissions from Day Surgery Unit 2016	Undertake data collection exercise to review unplanned admissions July-Dec 2016. Carry out Laparoscopic Cholecystectomy Service evaluation and develop anaesthetic 'recipe' document for day case laparoscopic surgery. Optimise the management of pain and post-operative nausea and vomiting by considering developing post-operative nausea and vomiting and pain guidelines.	R708
Anaesthetics	Postoperative recovery care for Obstetric patients	Add the following to the learning points at the Labour Ward handover: documentation of vaginal blood loss must be recorded a minimum of once during the 30 minute period in recovery; blood loss from wound must be documented (where applicable) a minimum of once during the 30 minute period in recovery; and a 'Transfer from Recovery' sticker must be completed and filed in the notes. Discuss the findings at the Labour Ward Forum meeting.	S1504
Anaesthetics	Obstetric Patient at Risk (PAR) scoring	Add the following to the learning points at the Labour Ward handover: all patients must have 12 and 24 hour fluid balance documented on the Obstetric PAR chart; input and output must be documented with each set of observations; a full set of observations must be performed to enable a total PAR score to be calculated; once PAR scoring has been commenced the patient should remain on a 4 hourly PAR chart for a minimum of 24 hours; and observations should be performed at intervals as per the algorithm and guideline – 4 hourly minimum interval as dictated by clinical condition. Ensure current charts and scoring systems are fit for purpose through review of current PAR charts and algorithm and scoring system with plan to develop and implement a new MEOWS system.	S1506
Anaesthetics	Emergency Theatre audit	Improve recording of consultant supervision by reminding trainees to accurately record discussion with consultants on the anaesthetic chart and feed back at Anaesthetic Clinical Effectiveness meeting. Reinstate the theatre coordinator role (to be removed from theatre 'numbers' in emergency theatres to resume previous role as coordinator).	S1526
Community Adult Services	Quality of Radiographs in Rotherham Community Dental Service 2015	New column regarding the use of the rectangular collimator to be added to the radiograph quality sheets, which will allow a separate analysis of quality of the use of the rectangular collimator compared to the circular open ended collimator.	R792
Community Adult Services	Clinical audit of the Quality of Radiographs taken in Barnsely Community Dental Service 2015	Feedback audit results to all operators at a department and staff meeting in June 2016. Amend the x-ray log form for recording the quality of radiographs to document if the rectangular collimator has been used for the exposure and if not, documenting the reason why. Amend the x-ray log form to make clearer the IRMER prescriber (i.e. the dentist) and the operator if different. Radiation Protection Supervisor in Barnsley to ensure the quarterly checks are carried out. All dentists to ensure that all radiographs are justified and reported in the patient's clinical notes. To investigate the possibility of recording the quality and ability to extract results from Software of Excellence in Barnsley, as part of IT business case implementation. Consider interim audit of quality of radiographs in 6 months to review percentage of quality 1, 2 and 3 radiographs and use of rectangular collimation.	R804

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Community Adult Services	Re-audit of the inclusion of valid, signed consent and FP17-DC forms in patient's notes	Audit report and recommendations to be discussed/emailed to all staff reminding that it is the responsibility of the individual dentist to ensure the patient has a current valid consent and FP17DC for all Band 2/3 treatment courses. This should be checked before any Band 2/3 treatment is commenced. Remind dental nurses to get out a consent form and an FP17 DC when a dentist prescribes any treatment that will go into band 2/3. To ensure that all the forms (both consent and FP17DC) are stocked up in the surgery which will help to ensure that they are signed.	R657
Community Adult Services	Clinical audit of the quality of radiographs taken in Doncaster Community Dental Service 2015	Individual results to be made available to operators. Re-iterate to dentists that all radiographs taken must be graded for quality. Clarify with all operators that RPS checks must be done quarterly i.e. 4x per year or 3-monthly. Written report to be made available to staff electronically. Consider re-design of audit for 2015 radiographs to compare different processing/developing systems and look at rectangular collimation use.	R662
Community Adult Services	Hall technique audit and 5 year follow up	Information Leaflet to be developed	R98
Community Adult Services	Consent Audit 2015	Ensure that any frequent or significant risks are documented on the consent form. Recommendations presented at Doncaster community dental service staff meeting where dentists were asked to act upon. Give out patient information leaflets to aid consent process when appropriate e.g. inhalation sedation leaflet. Ensure the consent form is signed and dated by the clinician. Ensure the consent form is signed and dated by the patient/parent.	S1360
Community Adult Services	Documentation 2015-16	Discuss at team brief the need for every single sheet in the record to have patient's full name on it, this includes the second sheet of the new patient assessment, and the NHS number should also be on every sheet in the record. Results to be emailed to Rotherham Community Dental Service staff and documentation standards to be included in the student induction.	S1407
Community Adult Services	An audit to assess caries risk designation and compliance with national preventative guidance and recall interval guidance for adult special care patients in the Community Dental Service	Update the adult oral health assessment form to include caries risk, a prevention plan, risk factor control and recall interval to assist dentists comply with national guidance. Liaise with Special Care dentists to produce an updated workable assessment form that aids in compliance with national guidance.	R737
CYP Service	Re-audit of quality assurance of initial health assessment for looked after children between January 2016 and May 2016	To inform the doctors doing the assessment about this recommendation (Where child has got capacity to consent. A written consent should be sought) and make sure that they do it and document if the child does not wish to speak. For better engagement and getting child's view, liaise with social care to make sure Looked after children are brought earlier than their appointment timing to spend more time with play worker.	R787
CYP Service	Re-audit of investigation and management of Urinary Tract Infections (UTI)	Remind staff to only use the clean catch method for collecting urine & always to record method of urine collection on urinalysis printout. To include a box in the MDT admission booklet in the nursing section for the method of collection, as a way of reminding staff, plus consider a tick box in the MDT admission booklet for a nurse to confirm that medical staff are aware urine sample sent. Addition of a box in the MDT admission booklet to be logged for when admission booklet is next updated. To remind nursing staff to ensure that doctors are aware when a urine sample has been sent and to record this in the main body of the shared clinical record. To ask doctors to check whether urine has been sent on discharge and if so add to outstanding job To remind doctors and nursing staff to record/ensure urine sample sent & recorded in main clinical record. To display in all clinical areas a printout of the NICE imaging criteria for UTIs, and classification of typical versus typical UTIs. Present audit at ward meeting, and discuss recommendations. Ensure NICE imaging criteria displayed. Ensure discharged children have re-test parents 48 hours after finishing course of antibiotics if child treated for positive UTI. To discuss establish agreed process with microbiology lead, the system for ringing/faxing all positive urine cultures to the wards. Register re-audit in 2017.	S1318

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service	Audit of quality criteria for young people friendly health services	Create poster message on Teen board saying 'Did you know you can ask to be seen alone?' Create small prompt on every board in each clinic room for doctors to remember to ask young people if they wish to be seen alone. Add to list for re-audit in 2years. Re-audit to include free text box for comments.	R545
CYP Service	Audit of Health Assessments for Looked After Children (aged 5-9 years)	Record words of the child by the assessor. Take consent from all over 16s and any under 16s deemed Fraser competent. Establish Wakefield model: social workers are sent blank forms to complete in advance of assessment. Medical assessors to send referral to LAC team if required. Re-audit.	R642
CYP Service	Paediatric Early Warning Tool on CAU	Terminate pilot PEWT chart and revert to original.	R671
CYP Service	Staff (Health Visiting) Interview	Develop Curriculum for Infant Feeding Update and deliver Update October 2016-March 2017. Implement HV Breastfeeding Assessment Tool. Complete Practical Skills reviews for all staff	R808
CYP Service	Audit of mothers' experiences of Health Visiting services in Rotherham (Breastfeeding and bottle feeding mothers)	Deliver Infant Feeding Update October 2016-March 2017. Cascade conversation guides to HVs to promote the use of the Antenatal, Breastfeeding, Formula Feeding and Infant Feeding (6-8 weeks) Conversation Guides & HV Breastfeeding Assessment Tool. Promote the discussion and distribution of the Rotherham Breast Buddies Support Groups Information Sheet to all HVs. Provide feedback on Rotherham Safe Sleep policy to ensure compatible with Unicef UK Baby Friendly Initiative Standards. IFC to provide comments and encourage development of evidence based information provision for parents.	R809
CYP Service, Safeguarding	Audit of outcome of 'Did Not Attend' (DNA) for children on child in need or child protection plan (Safeguarding)	DNA audit key findings and action plan presented and DNA policy profile raised at CEG. Presented to ophthalmology and orthopaedic CE or governance meetings. Working group to be set up to look at modifications of EPR IT system to improve clinician view of; 1. Whether a scheduled appointment has been cancelled, changed or not attended, 2. DNA's by alert box in the EPR clinician view to all DNA appointments & 3. System for flagging safeguarding concerns to all 1 and 2 s. CYPHS admin team to be informed that all clinic letters regarding a child or young person should be copied to Universal services (HV/SN) 1-other clinical therapy and investigative services to be informed via CEG. CYPHS admin team to be informed that DNA Letters are required for all children with 2 or more DNAs, in line with guidance given in DNA policy. Include significance of DNA's and signpost to policy in safeguarding training & induction pack. Safeguarding nurses to work with clinical, administrative, and investigative and therapy teams seeing children to support and embed implementation of the DNA policy across the Trust after ratification. Re-audit regularly to improve performance with information sharing about non- attended appointments.	S1396
CYP Service, Safeguarding	Audit of SystmOne child electronic health record in Health Visiting and School Nursing	Discussion between safeguarding children team and CYPS senior managers to identify next steps to be taken. Re- circulate record keeping "prompt list" to CYPS team leaders for reference when accessing records in supervision sessions. Review prompt list against NMC guidance. Key area 1: Review of templates in children's universal services and safeguarding template to ensure there is opportunity and consistency in capturing the voice of child. Record keeping audit Task & Finish group. Key area 2: Review of templates in children's universal services and safeguarding template to ensure there is opportunity and consistency in recording summary and analysis. Key area 3: Review of templates in children's universal services and safeguarding template to ensure there is opportunity and consistency recording risk assessment. Key area 4: Review of templates in children's universal services and safeguarding template to ensure there is opportunity and consistency when recording professionals and extended family members. Key area 5: Compile list of accepted abbreviations for use in SystmOne. Add to next CYPS agendas for locality team meetings and for Safeguarding Operational Group meeting. Safeguarding team to add audit to appropriate agenda (LSCB sub group) following presentation as Clinical Effectiveness meeting. Register re-audit 6-12 months following change stop SystmOne and safeguarding templates. Timeframe dependent on actions re key areas 1-5.	S1294

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
CYP Service, Medicine, O&G	Review of pathway for Bacillus Calmette-Guerin vaccination in newborn babies to ensure vaccination is given in line with NICE guidelines 2011	Joint local Maternity and CYP guidelines will be developed and implemented	S1040
Dermatology	Consent 2016	Nursing team to be reminded to stamp in the case notes when a skin surgery information leaflet has been given to the patient via discussion at clinical governance meeting and by emailing results to dermatology team (medical and nursing). Medics to be reminded to detail on the consent form the anaesthetic used via discussion at clinical governance meeting and by emailing results to dermatology team (medical and nursing). Medics to be reminded to detail the tissue sampling box correctly on the consent form via discussion at clinical governance meeting and by emailing results to dermatology team (medical and nursing). Discuss at clinical governance meeting and via email the need to guide patients to the correct place to sign and date the consent form in skin surgery.	S1472
Endoscopy	Gastroscopy Audit: Oesophago-Gastric Duodenoscopy (January to June 2016)	Liaise with Theatre Systems Information Manager to revise InfoFlex to ensure the required data items are completed/made mandatory in order to improve documentation of reasons procedures incomplete and complications (or confirmation of no complications)	S1424
Endoscopy	Number of procedures performed by each operator (January to June 2016)	Ensure endoscopists are performing the minimum number of procedures required - Clinical Lead to hold meetings with staff and developing individual action plans to ensure compliance.	S1428
Endoscopy	Consent 2016	Introduce standardised consent process to ensure all required sections of the consent form are accurately and consistently completed. Provide education at the Endoscopy User Group meeting regarding the required standards for completion of the form.	S1523
Endoscopy	Gastroscopy Audit: Oesophago-Gastric Duodenoscopy July 2015-December 2015	Remind all staff not present at the meeting to record the required information on complications	S1260
Endoscopy	Colonoscopy Completion Rate (October 2014-March 2015)	Monitor the number of procedures for low volume endoscopists. Continue to improve documentation of polyp treatments by feeding back to all endoscopists. Circulate tattoo guidance to all and provide education on the requirement to tattoo polyps later than 2cm.	S1265
Endoscopy	Percutaneous Endoscopic Gastrostomy (PEG) Audit July 2015-December 2015	Improve documentation of 'photograph taken to confirm PEG position' and 'complications' by reminding all staff of these requirements and liaising with the Theatre Systems Information Manager to update the InfoFlex system.	S1258
Endoscopy	Gastroscopy Gastro Intestinal Bleeding January 2015-June 2015	Liaise with Endoscopy nursing staff to ensure 'Rockall Scores' are recorded on the InfoFlex system using information available in the case notes. Remind all Endoscopists regarding the requirement to record blood transfusion details. Implement a process where Endoscopy nursing staff send back requests on the incorrect paperwork for resubmission to avoid inappropriate use of the red form.	S1261
Endoscopy	Unplanned admissions, operations within 8 days, ventilation, perforation, bleeding and 30 day mortality (December 2015 - May 2016)	Monitor number of patients being readmitted with pain - review in next audit and consider reporting by Endoscopist if appropriate. Ensure all Endoscopists are meeting the required number of procedures and contact Endoscopist's not meeting this for review and action. Ensure all Endoscopist's are meeting the 90% completion rate target - Clinical Lead to meet with 2 Endoscopist's with completion rate less than 85% to discuss actions required. Ensure polyps greater than 2cm are tattooed - consider analysing data by Endoscopist for the next audit period. Improve documentation for polyp treatments and remind Endoscopist's of this requirement when the audit report is circulated. Ensure all required standards are being met and individuals have the opportunity to review their results, reflect and take appropriate action - circulate the report to individual Endoscopist's and provide their ID number.	S1430

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Endoscopy, Integrated Medicine	Upper gastrointestinal bleed management	Re-audit to be undertaken	S1058
ENT	Documentation 2016	Educate all staff at the ENT Clinical Effectiveness meeting of the requirement to record designation of author. Liaise with nursing staff to ensure entries are dated and timed and pages contain the unique identifier and name (patient sticker).	S1488
ENT	PTH levels following total or completion thyroidectomy as a predictor of post-operative hypocalcaemia	Ensure patients have a full set of blood tests carried out including Vitamin D levels, PTH and Calcium pre-operatively and a PTH and Calcium level done post-operatively by implementing a process for this to be checked in clinic and not pre-assessment. Re-audit with a greater number of patients, including Doncaster.	R248
ENT	Documentation 2015-16	Remind all staff at the Clinical Effectiveness meeting of the need to: use stamps to ensure all required information is documented for medical entries; apply patient ID labels to both sides of history sheets (the new history sheet template will encourage this); remember to note the time of appointment; and adhere to standards for deletions/alterations.	S1368
ENT, Trust wide	Audit of the Team Brief and WHO Surgical Checklist	Disseminate trust level results at Divisional and departmental level meetings and circulate theatre-level results to appropriate clinical leads. Work with the Improvement Academy to implement behaviour change techniques aimed at improving engagement and participation in the team brief and WHO surgical checklist. Circulate an explanatory note to appropriate colleagues outlining the importance of completing the team brief and WHO surgical checklist. Arrange for Band 7 staff to deliver 1:1 training sessions to Health Care Assistants to educate them on the use of the checklist and the rationale behind each of the elements. Submit a bid to obtain funding for Human Factors training for 20 staff (who will then be able to deliver training internally) to improve knowledge and understanding of the reasons for lack of engagement and compliance and determine appropriate methods to address these. Carry out 'safety surveys' for theatres in conjunction with the Improvement Academy as a rolling programme to identify any safety concerns. Re-audit over one quarter during 2016-17 to assess whether improvements have been made.	S1237
General Surgery	Documentation 2015-16	Suggest a designated space on the reverse side of each continuation sheet for recording of patient details. Education at Clinical Effectiveness meeting with regards to recording time of consultation, location of consultation and correct method of making alterations/deletions.	S1369
General Surgery	Are all Surgical Patients admitted to ITU or HDU Reviewed daily by a Surgical Consultant?	Emphasise the importance of consultant review of critical care patients in the surgical consultant meeting. Agreement of process where Surgical consultants review all patients admitted to ITU and HDU in the afternoon after registrar review in the morning. Re-audit to monitor impact of current audit and discussion regarding registrar review in morning and consultant review in afternoon.	S1453
General Surgery	Consultant Review of emergency admissions within 24 hours	Improvement documentation by educating all staff on the need to record the time the patient is seen by doctors at each stage in the pathway. Re-audit in 6 months.	S1515
General Surgery	Management of pancreatitis	Develop proforma for the management of pancreatitis to ensure adherence to BSG management guidelines and comprehensive documentation. Circulate BSG management guidances to all relevant staff. Ensure full utilisation of 'hot chole' list by raising awareness with all staff of the protocol and how to book. Ensure accurate coding of pancreatitis, send details of incorrectly coded patient to clinical lead for review.	S1388
General Surgery	Pre-operative IV iron	Liaise with pre-assessment nurses to fully establish the process where all elective patients with haemoglobin less than 10 have pre-operative intravenous iron infusion and a repeat haemoglobin check post-infusion (pre-operatively). Patients to be provided with form for repeat haemoglobin check at time of infusion.	R268
General Surgery	Laparoscopic Cholecystectomy	Implement checklist for hot Laparoscopic Cholecystectomy to ensure procedures are undertaken on the index admission where possible (and within 1 month where not possible). Provide education at the Clinical Effectiveness meeting to ensure appropriate cases are carried out as a day case and antibiotic prophylaxis given in accordance to local antibiotic formulary.	S1406

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
General Surgery	Consent 2016	Increase awareness of the need for every section of the consent form to be accurately and comprehensively completed by providing education at the Clinical Effectiveness meeting. Propose redesign of audit proforma by liaising with Clinical Effectiveness department before the next round of audits. Ensure leaflets already printed are available in appropriate rooms and consider the development of new leaflets if required (Lap Chole, Hernia).	S1475
General Surgery	Documentation of leak test, donuts and anastomotic patency following anterior resection	Remind all surgeons at Clinical Effectiveness meeting reversing ileostomy to record the patency of the distal anastomosis within 4 weeks of ileostomy closure.	S1384
GU Med	Documentation 2016	Use single lines and document and date entries for deletions and/or alterations. Verbal reminders to clinical staff in Clinical Effectiveness meeting. Ensure that time when patient is seen is documented. Verbal reminders to clinical staff in Clinical Effectiveness meeting. Record legible name and designation at end of clinical entry. Use name stamps for more legible and clear documentation.	S1490
GU Med	Re-audit of routine monitoring of adults with HIV	Continue improvements in CVD risk assessment to include the dates of the assessment and the timeframe in which the assessments should occur. Clinicians to continue document QRISK2 assessment for all patients attending clinic who are aged >40 and/or have CVD risk factors. Improvements in bone health monitoring required including the use of the FRAX calculator and DEXA scanning if clinically appropriate. Clinicians to carry out baseline assessment in all patients age > 50 yrs ; post-menopausal women or in the presence of other risk factors using FRAX tool. Hepatitis A vaccine uptake to be monitored & reviewed. Flu Vaccination dates should be documented and differentiation made between receiving the vaccine and being advised to receive the vaccination. Pneumococcal vaccination uptake and recording to be improved, including a reminder to the GP to offer pneumococcal vaccine.	R776
Haematology	Documentation 2015-16	Discuss the results at the haematology clinical governance meeting.	S1371
Integrated Medicine	Investigation of cancer for unprovoked Venous Thromboembolism	Detailed history and examination on admission and post take ward round needs to be undertaken In all patients aged over 40 years with a first unprovoked DVT or PE detailed history and relevant examination needs to be taken / revisited at least on the 2nd day of admission once the diagnosis of DVT/PE is confirmed. Serum calcium and urinalysis needs to be checked in all patients along with other suggested investigations. Further investigations for cancer with an abdominal-pelvic CT scan (and a mammogram for women) to be requested only where there is high index of suspicion from history and examination. Offer these investigations on individual basis after revisiting the detailed history, examination and required basic investigations.	S1324
Integrated Medicine	Prospective audit of admissions to stroke unit via A&E	Ensure stroke team meets new junior doctors during induction and inform them the need to clerk stroke patients quickly and efficiently. Reduce length of stay for stroke patients by improving through put through the unit by admitting patients within 4 hours of arrival to hospital.	S1332
Integrated Medicine	Consent Audit 2015	Consent' to be part of induction for in house teaching.	S1357
Integrated Medicine	NICE TA211 - Prucalopride for the treatment of chronic constipation in women	Any prescription of Prucalopride should include the date of the review in one month from the start of that medication before continuing long term with that medication. To discuss with pharmacy to ensure that hospital pharmacists adhere to the guideline on prescription of Prucalopride.	S860
Lab Med	National Breast Screening Programme	To monitor and review ER positivity within the department.	R442
Lab Med	National Bowel Screening Programme Audit Diagnostic testing of Polyps	To improve percentage of cases reported using polyp proforma. To ensure excision margins are recorded in reports.	R444
Lab Med	National Bowel Screening Programme Audit of reporting on resections	To ensure all cases reported include extramural vascular invasion information	R445

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Lab Med, O&G	National Cervical Screening Programme Audit	To monitor Turnaround times to ensure that department meets the Rcpath standards.	R443
Medicine	Paracentesis re audit	Patients should be appropriately managed immediately after and in long term following ascites drain insertion. SOP and flow diagram to be developed to guide all clinical staff.	S1053
Medicine	Documentation 2015-16	Increase the awareness of deletions in medical notes to be deleted with a single line before being signed and dated by education of trainee doctors and senior doctors. Increase the awareness of location and grade of author to be documented with each entry education of trainee doctors and senior doctors.	S1372
Medicine	Audit of Management of hypothyroidism with carbimazole therapy. Assessment of weight gain in patients with treated hypothyroidism	Discuss weight gain with all female patients being treated for Grave's disease	S302
Medicine	Retrospective audit of patients sent to Medical Admissions Unit due to Hyperkalaemia	Introduce guideline/ flow chart for responding to out of range serum potassium in Heart Failure Patients and make it available on intranet. A session on Potassium abnormalities in Friday Medicine teaching to educate trainee doctors.	S1311
Neuro-rehabilitation, Therapy Services & Dietetics	Audit of neuro-rehabilitation standards	Increase provision of medical cover to ensure patients are assessed within 4 working days of referral being received and to facilitate setting of anticipated length of rehab on day of assessment by recruitment to the consultant post. Stickers to be provided that will be inserted in the medical records to indicate that the patient has been assessed and accepted/not accepted by neurorehab team, to include key worker details. Where appropriate, in-reach/specialist advice will be provided to patients being cared for on the critical care units who have neurorehabilitation needs. They will be formally accepted by the service and standards commenced when they are transferred to a ward. The service should have a dedicated unit, with an appropriate rehabilitation environment and trained rehabilitation staff to enable an ethos of 24/7 rehabilitation and support patients to achieve 80% of their goals. To ensure patients have goals set within 7 days of acceptance to the service, the Team are to hold a weekly goals meeting to ensure that goals are set and reviewed with patients on a weekly basis.	R577
O&G	Re-audit of Midwife to Health Visitor handover	Audit results and recommendations for using the HV handover template in conjunction with the electronic referral at 15 weeks gestation communicated via email and at community midwifery meetings. Update the Midwife to Health Visitor SOP to reflect the changes in terminology & circulate to community midwives. Update the SystmOne template. To re-audit compliance once new SOP has been ratified and circulated (on 2017-18 audit plan)	R800
O&G	Audit of Obstetric High Dependency Unit (HDU) care	Ensure patients remain on PAR for 24 hours post step down from HDU care. Include reminder in learning points on labour ward.	S1460
O&G	Re-audit of Cardiotocography (CTG) and Foetal Blood sampling (FBS) in labour (Quarter 3)	Put on Labour Ward reminders for midwives to prompt medics and locums to document CTG and care plan in notes. Summarise audit standards and outcomes on Learning Points. Update FBS guidelines to incorporate NICE recommendations. Discuss in CTG meeting, and incorporate into guideline to always document 'left lateral' or indication if supine. Incorporate new guidelines into training and stickers. Register re-audit when the new local FBS guideline is ratified dependent on completion and ratification of the local Intrapartum Care guideline.	S1276
O&G	Post natal care planning	Redesign the postnatal care record to incorporate immediate and individualised plans of care. Design a sticker for use with care record to prompt actions required. Inform midwives about review of individualised care plans at each contact via learning points in hospital and any other suitable means in the community. 9 O'clock stop patient group discussions each day. Contraception training of midwives by Sue Mowatt. Condense the numerous patient information leaflets into one. Midwives to be informed via learning points to ensure all mothers receive advice on hygiene. Communicate this by learning points. To consider allocation of these women to a midwife or bay at each handover. Explore the possibility of community hubs to absorb some of the postnatal ward attenders. Meet with T Hutson to discuss the needed changes and finalise them. Laminate copies for the clinical areas and community.	S812

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
O&G	Survey of women's perception of postnatal thromboprophylaxis	Add the leaflet titled 'Blood clots Reducing your risk in hospital and at home' to the pack of leaflets given to all women to emphasize the life threatening nature of DVT, to promote prophylaxis compliance and identify symptoms to prompt treatment. Education should start in the antenatal period the (community, clinics and parent craft) to avoid overload in the postnatal period when women are busy with a baby. This should be discussed by SOMs at one of their meetings. Adopt Bradford practise of signing to say patients have received Tinzaparin training. Discuss amending blue sticker, recently designed by Sue Rutter, so that midwives can get women to sign the blue compliance sticker to indicate they have received training.	R796
O&G	Re-audit of Obstetric Anal Sphincter Injuries (OASIs) 2015	Manual Perineal Protection and angle of episiotomy training for new and existing cohorts of medical and midwifery staff. Add Manual Perineal Protection and angle of episiotomy to MAST.	R687
O&G	Re-audit of Obstetric Anal Sphincter Injuries (OASIs) 2015	Manual Perineal Protection and angle of episiotomy training for new and existing cohorts of medical and midwifery staff. Add Manual Perineal Protection and angle of episiotomy to MAST	R687
O&G	Management of patients seen in triage with early labour	Electronic documentation template in triage. To be built in Meditech by the team. S Poku to discuss with them. Dedicated HCA to help the midwife with the workflow. E.g. obs, notes location etc. To be decided on by the labour ward manager. Implement the traffic light system that was introduced after the first audit to reduce long stays. Explore possibilities of incorporating this into the 'universal handover' system for on-call team. To be built in Meditech by the team. S Poku to discuss with them. Review the triage guidance and incorporate recent changes in departmental guidance. Review guidance and send it out for comments.	S1067
O&G	Consent 2016 (Gynae)	To disseminate consent standards and audit recommendations at induction.	S1478
O&G	Documentation 2016	Remind everyone to put sticker on every page, both in booklets and on loose pages.	S1495
O&G, Safeguarding	Maternity risk assessments using GP records	A communication/ memorandum via email and disseminate the audit results and the recommendations at community midwifery meetings. Email audit to community midwifery. A communication of concern to be sent to community midwifery staff regarding the deterioration in repeat risk assessments and accessing GP records. Email audit to community midwifery after re-audit. Individual feedback will be offered for those consistently demonstrating poor compliance with expected standards. For re audits individuals will be informed they have been identified in the audit. The importance and relevance of this process to be included in safeguarding supervision sessions. Email to convey this process to named midwife for Safeguarding, for her to ensure this is communicated to the midwives via the supervisors. Re audited in December 2016.	R660
OMFS	Documentation 2015-16	Education at Clinical Effectiveness meeting regarding the standards to ensure time and location of patient reviews are recorded.	S1376
OMFS	Consent 2016	Inform and educate team members on the recording of benefits of treatment and provision of information leaflets.	S1474
OMFS	An audit of orthodontic outcomes measured by Peer Assessment Rating (PAR) score (2015)	Present findings at next Orthodontic department meeting and Clinical Service Unit meeting to enable consideration of all clinicians in the Orthodontic department consecutively Peer Assessment Rating (PAR) scoring their cases for the purposes of: appraisal, professional development, quality assurance, and commissioning. Consider whether PAR scores should form part of the departmental scorecard for quality.	R537
OMFS	Documentation 2016	Teaching of documentation requirements to all clinical staff. All junior staff to have stamps with their details.	S1496

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
OMFS	Temporal artery biopsies, are we maintaining the standard?	Implement a new referral form and pathway by presenting the audit results at the Rheumatology and Ophthalmology audit meetings and discuss the plan. Create a new referral form. Inform referrers and OMFS department of the new referral pathway once agreed. Train Staff Grades in OMFS to carry out Temporal Artery Biopsy procedures through clinical training and supervision.	R677
OMFS	Re-audit: Compliance with investigations for patients admitted with orofacial infections	Education to new Dental Core Trainees to ensure all required investigations are undertaken for patients with orofacial infections. Advise Dental Core Trainees to practice taking blood samples until they are competent and confident to do so and ask for support if required. Re-audit performance for current Dental Core Trainees - register audit for 2017-18 plan.	S1520
Ophthalmology	Documentation 2015-16	Obtain stamps to improve the recording of printed name, grade, date and time. Refresh clinician knowledge on how to correct mistakes in the proper manner (scored through with a single line, initialled and time/date stamped)	S1377
Ophthalmology	Adherence to NICE for examinations and investigations for the monitoring of COAG or Ocular Hypertension at follow up appointments	Develop and implement glaucoma monitoring proforma to ensure adherence to the standards. Re-audit performance to assess whether improvements have been made.	S1403
Ophthalmology	Consent 2016	Contact all staff within the department reminding them of the requirement to complete consent forms as fully as possible, highlighting those areas which were shown to be less well completed in this audit (leaflets provided and consent for pictures/videos).	S1479
Ophthalmology	Cataract Surgery Outcome audit	Education at the Ophthalmology Clinical Effectiveness meeting and email to all staff to ensure complete documentation of all cataract data in the surgical notes. Doctors to ensure complicated cataract patient details are passed on to nurse practitioners.	R781
Ophthalmology	To monitor WHO checklist compliance laser treatments	Ensure 100% compliance with completion of WHO Checklist for Laser Treatments by providing education at the Clinical Effectiveness meeting; designing and displaying a poster in the laser room; and emailing all staff reminding them of the importance of undertaking the WHO checklist and documentation of this. Assess improvement through re-audit of performance.	S1554
Orthopaedics	Evaluation of transfusion requirements following revision Arthroplasty	Obtain cell salvage machine for use within Orthopaedics to provide intraoperative cell salvage in revision hip and knee arthroplasty	S1299
Orthopaedics	Audit on management of flexor tendon injuries at Rotherham General Hospital	Education of the Emergency Department staff on the availability of the hand trauma service to ensure appropriate cases are referred to the TRFT hand trauma service (and not transferred to Sheffield) as per local guidance.	S1417
Orthopaedics	Consent 2016	Incorporate key findings into the consenting process at Induction - details to be passed to education department, specifically the recording of: blood transfusion where applicable; reconfirmation of consent; discussion regarding photography/tissue samples; and provision of information leaflets.	S1480
Orthopaedics	Documentation 2015-16	Liaise with Education Department to add trust policy and documentation standards to junior doctor induction. Liaise with Library staff to add to IGNAZ app for doctors.	S1378
Orthopaedics	DVT prophylaxis in hand surgery	Increase awareness through Clinical Effectiveness Meeting of the national guidelines for DVT prophylaxis in hand surgery and ensure these are being followed. Liaise with theatre staff to ensure complete documentation of VTE prophylaxis in theatre. Inform day surgery staff to complete the checklist accurately. Re-audit to assess if improvements have been made.	R797
Orthopaedics	Fascia/iliaca block for Fracture NOF	Educational meetings with A&E department doctors and Orthopaedic doctors to increase awareness of the use of fascia iliaca block for fractured neck of femur patients. Provide further education and training on fascia iliaca blocks to Trauma Nurses, A&E doctors and Orthopaedic junior doctors. Design and implement a checklist proforma for fascia iliaca blocks. Re-audit performance to assess if improvements have been made.	R803

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Palliative Care	Case note audit of documentation of care plan decisions/ actions and discussions following the publication of "One Chance to Get it Right"	Development of an Individualised Care Plan document to prompt good documentation of decisions, actions and discussions for use in patients in the last days of life. Local advanced communication skills training packages to be set up for health care professionals involved in last days of life care. Programme of end of life education at RFT to be organised.	S1281
Radiology	Request card details and patient check audit 2016	Results to be presented to the staff meeting in April 2016	R721
Radiology	A&E CT Head timings audit - annual re-audit	Remind reporters of the importance of reporting A&E CT heads in a timely manner and discuss at the radiology quality governance meeting. Remind and discuss with CT staff the need to inform the duty radiologist once a CT head has been performed.	R546
Rheumatology	Urinalysis in Connective Tissue Disease clinic	Liaise with Nursing Services Manager to ensure all patients attending Connective Tissue Disease (CTD) Clinic are checked for urinalysis on arrival in clinic. If unable to provide a sample on arrival, patients to be asked to provide one following the consultation with doctor. To ensure staff aware of requirement for all abnormal samples to be saved and sent to the lab appropriately. Monitor performance over first three months following changes to practice and carry out a full re-audit in 1 year.	S1513
Rheumatology	Documentation 2015-16	Obtain agreement for Consultants to ensure stickers are placed on both sides of history sheets. Remind all Consultants of the requirement to ensure accurate recording of: timing of entries; printed name; designation; and deletions/ amendments.	S1379
Safeguarding	Re-audit of Adult Safeguarding "raising a concern" forms (1&2)	To review and ensure forms are Care Act compliant and contain appropriate information. To develop a Trust wide implementation and distribution plan for the new forms. Upload agreed forms to InSite. Send a communication to alert all Trust staff to the changes and ensure all colleagues are aware of issues around information sharing. To disseminate the results of this audit via the Operational Safeguarding Group.	R719
Safeguarding	Completion of DNA CPR in patients with impaired capacity	To ensure that progress is monitored and practice improvements can be demonstrated, through the performance meeting and Mortality & Quality Alerts. To improve awareness of Trust and national requirements and support staff in recognising their responsibilities. To provide a DNAR poster to support clinical staff in completing the form and roll out DNACPR e-learning to appropriate staff. Patient leaflets to be provided to every patient admitted to TRFT to ensure patients are aware of the requirement for discussing potential DNACPR.	R720
Therapy Services & Dietetics	Consent Audit 2015	Consent forms completed by clinician to be checked by partnering clinician also carrying out the videofluorscopy and any errors highlighted and corrected with signature. This check should be done at the end of the VF session, prior to reviewing images, and before consent forms are scanned on to the patient record.	S1363
Therapy Services & Dietetics	Audit of Clinical Guidelines for the Physiotherapy Management of Adults with Lower Limb Prostheses	Develop protocols and standards around reviewing clients post discharge. Review feasibility of client self-referral back into service. Review information provided to patients on discharge. Establish formal links with Podiatry Service. Establish standards/protocols around what information is essential for documentation. Review documentation to ensure all aspect of amputee rehabilitation is covered, including the biopsychosocial & psychological aspects. Look at business continuity within the service, ensuring that it is robust and that the knowledge and skills are shared.	S932

Clinical Service Unit	Title	Action(s) to Improve Quality of Care	Project Number
Therapy Services & Dietetics	Consent 2016	Results to be feedback to the videofluoroscopy meeting on 6 September 2016. Consent forms completed by clinician to be checked by partnering clinician also carrying out the videofluorscopy. This check should be done at the end of the VF session, prior to reviewing images, and before consent forms are scanned on to the patient record. Errors on the consent form to be pointed out by partnering clinician and corrected, with signature.	S1483
Therapy Services & Dietetics	Audit of NG feeding on the Stroke Unit	Present results to the SLT stroke team & feedback at stoke networking day. Training for Nasal bridle on the stroke unit and with doctors to raise awareness of NGT feeding.	R701
Trust wide	Quality of VTE Risk Assessments - are they completed at 24 hours?	Present findings to Clinical Effectiveness & Research Group and VTE Steering Group. Disseminate results through departmental Clinical Effectiveness Meetings in conjunction with Clinical Effectiveness Leads to ensure VTE risk assessments are completed at 24 hours and 48 hours. Escalate concerns to Patient Safety Group. Undertake supplementary audit of assessment and treatment.	S1400
Trust wide	Re-Audit of Medical Records	Improve standards for information governance of medical records by feeding results into the trust wide CQC Improvement action plan.	R726
Urology	Consent 2016	Educate staff at Clinical Effectiveness & Governance meeting on the requirement to record: anaesthesia to be used; patient signature; and provision of information leaflets. Discuss the provision of information leaflets with Patient Information Lead to determine whether BAUS national leaflets can be utilised. Provide patients with the option of accessing further information directly from BAUS by including the website details on all letters.	S1482
Urology	Re-audit - The Forgotten Stent, A Never Event	Ensure all stents are recorded on the registry - all senior and junior clinicians to be reminded to use the stent registry and to be provided of details how to log in.	R656
Urology	Documentation 2015-16	Remind all colleagues at the Clinical Effectiveness meeting of the importance of clear and comprehensive record keeping, in particular the documentation of designation, printed name, location and time.	S1381
Urology	Documentation 2016	Produce crib sheet as a reminder of the documentation standards. Education at Clinical Effectiveness meeting to ensure documentation standards are adhered to, in particular recording of time and designation. Remind all staff to use stamps that have been provided.	S1501

Appendix 3: Staff Survey

Changes in the Key Findings for The Rotherham NHS Foundation Trust since 2015 survey

	2016 score	2015 score	Change	Change Statistically significant?
Response rate	40.8	41.8	-1	No
Appraisals & support for development				
KF11. % appraised in last 12 mths	93	94	-1	No
KF12. Quality of appraisals	2.98	2.92	0.07	No
KF13. Quality of non-mandatory training, learning or development	4.00	3.97	0.03	No
Equality & diversity				
* KF20. % experiencing discrimination at work in last 12 mths	9	7	2	No
KF21. % believing the organisation provides equal opportunities for career progression / promotion	87	89	-2	No
Errors & incidents				
* KF28. % witnessing potentially harmful errors, near misses or incidents in last mth	24	24	0	No
KF29. % reporting errors, near misses or incidents witnessed in last mth	92	88	4	No
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.68	3.60	0.08	Yes
KF31. Staff confidence and security in reporting unsafe clinical practice	3.65	3.56	0.09	Yes
Health and wellbeing				
* KF17. % feeling unwell due to work related stress in the last 12 months	38	37	1	No
* KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure	57	63	-6	Yes
KF19. Org and mgmt interest in and action on health and wellbeing	3.62	3.59	0.03	No
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	50	47	3	Yes
* KF16. % working extra hours	68	68	0	No

	2016 score	2015 score	Change	Change Statistically significant?
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.54	3.52	0.02	No
KF4. Staff motivation at work	3.82	3.80	0.02	No
KF7. % able to contribute towards improvements at work	66	65	1	No
KF8. Staff satisfaction with level of responsibility and involvement	3.85	3.82	0.02	No
KF9. Effective team working	3.76	3.70	0.06	No
KF14. Staff satisfaction with resourcing and support	3.27	3.27	0.00	No
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.39	3.33	0.06	No
KF6. % reporting good communication between senior management and staff	28	24	4	Yes
KF10. Support from immediate managers	3.72	3.67	0.05	No
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.88	3.85	0.03	No
KF3. % agreeing that their role makes a difference to patients / service users	89	88	1	No
KF32. Effective use of patient / service user feedback	3.72	3.58	0.14	Yes

"The Doctor was really friendly and we felt she didn't rush and listened to every word, would definitely recommend this clinic and Dr."

Friends and Family patient feedback
Rheumatology Outpatients

	2016 score	2015 score	Change	Change Statistically significant?
Violence, harassment & bullying				
* KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths	10	12	-2	No
* KF23. % experiencing physical violence from staff in last 12 mths	1	1	0	No
KF24. % reporting most recent experience of violence	67	66 **	1	No
* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12mths	20	23	-3	Yes
* KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths	23	22	1	No
KF27. % reporting most recent experience of harassment, bullying or abuse	45	31 **	14	Yes

** The methods used to calculate KF24 and KF27 have changed since last year and the 2015 Key Finding Score was recalculated for the 2016 reports (Picker Institute Europe). Therefore, adjusted reporting reflects the revised figures.

Note – there are other minor differences between the data reported for 2015 above and that in the previous quality report. This is due to the rounding of numbers.

Appendix 4: Working Together Programme / Acute Care Collaboration Vanguard

Guiding Principles

The Chairs and Chief Executives of the seven Trusts have agreed the following principles which guide the partnership:

- Through our partnership and collaboration with each other we aspire, for the benefit of our patients, to be one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems by 2020.
- We will remain as seven separate Trusts with our own accountabilities and responsibilities. We have no intention to pursue mergers or acquisitions.
- Our starting point for everything we do will be, can this be done better, safer, more economically for our patients if we work with our partners in a different way?
- We will move at pace in examining all our activities on a "bottom up" basis, across the partnership, engaging our clinical and non-clinical teams to adopt innovative approaches and best practice.
- We will challenge ourselves and embrace change where it benefits our patients or the health care system as a whole. Status quo is not an option if we are to do the right thing for our patients on a sustainable basis.
- We will establish a governance model which facilitates this approach. Structure will not be a barrier to innovative change while recognising the statutory responsibilities of all seven individual Trust Board of Directors.
- Models of cost/benefit equalisation will be a key ingredient of the partnership activity to ensure financial loss or gain for any individual Trust is not a barrier to beneficial system change/progress.
- We will seek support from Commissioners to ensure changes are achieved at pace in order to gain maximum benefits for patients and system stability.

What has Working Together achieved so far?

The Working Together Partnership has had success in a number of projects that have already delivered important benefits for patients, frontline clinicians and also enabled us to make better use of the resources we have. Read more about our success in latest news or in our newsletters, a few examples include:

- The introduction of a shared IT system called ICE OpenNet across the seven Trusts means test results are now able to be accessed securely by clinicians in any of the 7 Trusts regardless of which hospital undertook the original test. This has reduced the need for costly duplicate tests and speeded up treatment decisions for patients.

- Clinicians have come together to explore how best to provide out of hours cover for some specialist services where there are limited specialists available.

- Clinical and non-Clinical staff across any of the 7 Trusts can now

have access to each of the organisations Wi-Fi networks so that they can securely access relevant information even if they are not at their usual hospital base. This prevents delays and ensures clinicians have the information they need regardless of which Hospital location they are in.

- Almost £1M has been saved by combining the joint buying power of the 7 Trusts to get better prices on certain items like examination gloves and some syringes.

Appendix 5: 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 CHKS as an alternative means of validation.

The latest figures are:

Measure	2015/16		2016/17	
	End February Position	National Target	Year end Position	National Target
Elective patients 0-15 years readmitted to hospital within 28 days of discharge from hospital	0.5%	3%	0.6%	3%
Elective patients >16 readmitted to hospital within 28 days of discharge from hospital	2.6%	3%	5.38%	3%
Non-Elective 0-15 years patients readmitted to hospital within 28 days of discharge from hospital	8.7%	10.40%	6.5%	10.40%
Non-elective>16years patients readmitted to hospital within 28 days of discharge from hospital	9.8%	12.5%	14.5%	12.5%

Table 42: Trust readmissions data as at January 2016

'Unfortunately the publication for emergency readmissions to hospital within 28 days of discharge indicators has been delayed while HSCIC bring their production in-house from an external contractor. HSCIC are currently reviewing the methodology and specifications which will have an impact on when they will actually be published'.
(Source: HSCIC website)

In the meantime, the latest available readmissions indicators are available on the HSCIC Indicator Portal (https://indicators.ic.nhs.uk/webview/) at Compendium of Population Health Indicators > Hospital Care > Outcomes > Readmissions are the 2011-12 figures.

CHKS and HSCIC use different methodology for validating data so figures will vary.

"Whilst on Antenatal Clinic I was very well cared for, constantly asked for drinks etc, if I was ok, pain relief. The staff were very supportive and helpful. Really impressed. Thank you for your care towards me and my baby!"

Friends and Family patient feedback
Wharncliffe

Acronyms

A&E	Accident & Emergency Department
CEO	Chief Executive Officer
CEPOD	Confidential Enquiry into Perioperative Deaths
CLAS	Children Looked After and Safeguarding
CMACE	Centre for Maternal and Child Enquiries
CHKS	Comparative Health Knowledge System,
CCG	Clinical Commissioning Group
C-difficile	Clostridium Difficile
CGM	Continuous Glucose Monitoring
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSE	Child Sexual Exploitation
Datix	Computer software used by health services for risk management and reporting incidents
DNACPR	Do not attempt cardio-pulmonary resuscitation
DQI	Data Quality Index
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
EDD	Expected Date of Discharge
EPR	Electronic Patient Record System
FFFAP	Falls, Fragility and Fracture Audit Programme
GP	General Practitioner
HCAI	Healthcare acquired infection
HES	Hospital Episode Statistics
HFC	Harm Free Care
HRG	Healthcare Resource Groups
NHS DIGITAL	(Formerly Health and Social Care Information Centre)
HSMR	Hospital Standardised Mortality Ratio
IPC	Infection Prevention and Control
IOFM	Intra Operative Fluid Management
LiA	Listening into Action
KPI	Key Performance Indicator
LSAB	Local Safeguarding Adult Board
LSCB	Local Safeguarding Children Board
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act 2005
MCISS	Macmillan Cancer Information Support Base
MDT	Multi-Disciplinary Team
MRSA	Methicillin-resistant staphylococcus aureus
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide by people with mental illness
NHFD	National Hip Fracture Database
NHSD	NHS Development
NHSE	NHS England
NHSI	NHS Improvement
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OQSEG	Operational Quality, Safety and Experience Group
PALS	Patient Advice and Liaison Service
PAR	Patient at Risk chart
PHSO	Parliamentary and Health Service Ombudsman
PIR	Post Infection Review
PERC	Pulmonary Embolism Rule-out Criteria
PROMS	Patient Reported Outcome Measures
PDR	Personal Development Review
QAC	Quality Assurance Committee
RTP	Rotherham Together Partnership
RTT	Referral to Treatment
SHMI	Summary level Hospital Mortality Indicator
SI	Serious Incident
STP	Sustainability and Transformation Plan
SWC	Strategic Workforce Committee
TOCT	Transfer of Care Team
TRFT	The Rotherham NHS Foundation Trust
WHO	World Health Organisation
WNAS	Ward Nursing Accreditation System
WTP	Working Together Partnership
VTE	Venous Thromboembolism

Glossary of Terms

APGAR Score
Apgar is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score shows how well the baby is doing outside the mother's womb. The test measures breathing effort, heart rate muscle tone, reflexes and skin colour.

Clinical Coding
The translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised.

Comparative Health Knowledge System (CHKS)
A web based performance benchmarking system, utilised by many Trusts

Commissioning for Quality and Innovation (CQUIN)
A series of nationally and locally agreed improvement targets, linked to a proportion of Payment by Results funding as an incentive to achieve agreed outcomes.

Data Quality Index
A composite indicator reflecting data quality, provided by CHKS

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.

Dr Foster
A provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public

FFFAP
Falls and Fragility Fracture Audit Programme, led by the Royal College of Physicians, gathering and analysing data on serious harms across the NHS

FYFV
The Five Year Forward View is NHS England's plan for a sustainable health service. It will be delivered via 44 local Sustainability and Transformation Plans; the Trust is part of a plan covering the population of South Yorkshire and Bassetlaw.

Healthcare Resource Groups (HRGs)
HRGs are standard groupings of clinically similar treatments which use common levels of healthcare resource.
HRGs help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.
HRGs are currently used as a means of determining fair and equitable reimbursement for care services delivered by providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the service.
Presently, the Trust complies with HRG4 to code clinical activity

Healthwatch
The independent consumer champion that gathers and represents the public's views on health and social care services in England.

John's Campaign
A national campaign to win the right for relatives and carers to stay with people with dementia in hospital

Listening into Action
A method used by the Trust to support change

Monitor
Sector regulators for health services in England.

Mortality Rate
The rate at which patients die in a hospital. Data is collected nationally by HSCIC and enables Trusts to look at trends in Mortality Rates and make comparisons with other hospitals.

Mortality is generally measured in one of two ways: The HSMR measures the actual number of deaths occurring in a hospital compared to the number of deaths that might have been expected. The SHMI is a ratio of the actual number of patients who die against the number who would be expected to die on the basis of average England figures. The SHMI ratio includes those patients who die within 30 days of discharge from hospital.

Never Event
Defined by the DoH as a very serious, largely preventable, patient safety incident that should not occur if appropriate preventative measures have been put in place

NHS 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.

SAFER Care Bundle
A set of simple rules that if followed routinely will help improve patient flow, patient experience and reduce length of stay across adult inpatient wards (in acute hospitals).

Safeguarding
A process used to identify adults and children at risk and provide protection against further harm

Safety Thermometer
The expanded national patient safety improvement initiative, promoting 'Harm Free Care' and linked to National CQUINs

Sustainability and Transformation Plans
STPs have been published for every locality in England. They aim to make the best use of available health and social care resources often involving the re-design of services.

The Secondary Uses Service (SUS)
The single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services

UNIFY
A national database managed by NHS England that collates and monitors nurse staffing levels in hospitals

Vanguard Projects
NHS England has approved a series of local projects with the common aim of developing innovative solutions to improve health and social care. The Trust is a partner in the Working Together Partnership that brings together seven acute trusts across South and Mid Yorkshire and North Derbyshire.

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	From 18 April 2016
Heather Craven	Non-Executive Director	From 17 February 2017
Mark Edgell	Non-Executive Director	
Lynn Hagger	Non-Executive Director and Vice Chair	
Chris Holt	Chief Operating Officer then Director of Strategy & Transformation and Deputy Chief Executive	Became Director of Strategy & Transformation and Deputy Chief Executive on 16 February 2017
Barry Mellor	Non-Executive Director	
Ellie Monkhouse	Acting Chief Nurse	From 1 January 2017
Simon Sheppard	Director of Finance	
Paul Smith	Non-Executive Director	From 1 March 2017
Conrad Wareham	Medical Director	
Directors who served during the year, but who had left office before year end		
Alison Hope (formerly Legg)	Non-Executive Director	Until 28 February 2017
Tracey McErlain-Burns	Chief Nurse	Until 31 December 2016

Directors' biographies can be found within the Governance Report beginning on page 172, 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 2016/17 and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and
- Disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- Prepare the financial statements on a going concern basis.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Directors are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The 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.

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. During 2016/17 24.6% of the Trust's NHS and non-NHS invoices were paid within the target of 30 days.

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 2016/17.

Enhanced Quality Governance Reporting

The Trust continues to build upon its Quality Governance arrangements; the Trust established a new Clinical Governance Committee in early 2016 which was the major part of a restructure of operational committees considering quality and clinical governance matters.

However, whilst the Trust has regard to Monitor's Quality Governance Framework in arriving at its overall evaluation of its performance, internal control and Board Assurance Framework, the Trust recognises that there is still room for improvement in its quality governance arrangements.

This was reflected in the outcome of the CQC's re-inspection in September 2016 when the Trust was found to 'require improvement' in relation to the 'Well-led' domain. The Trust has therefore arranged for an external Quality Governance review to be undertaken in 2017/18.

In the meantime, work continues to be made to improve the following key areas:

- Engagement of colleagues;
- Incident reporting, investigation but particularly, sharing of learning;
- Maintenance of dynamic and 'live' risk registers;
- Embedding of the quality governance infrastructure within the clinical divisions.

It is worthy of note that, during their re- inspection, the CQC also found a number of areas of outstanding practice at the Trust, including:

- Multi-Disciplinary Team approach in the locality pilot;
- The culture, care and philosophy at Breathing Space - the only entirely nurse-led model of care for respiratory in and outpatients in Europe;
- SEPIA Portal which enables access for colleagues across our integrated Trust including primary care so they all have up-to-date information about patients;
- Safeguarding liaison within the Emergency Department;
- Children with mental health needs - CAMHS Liaison team/nurse practice;
- Successful offering of Accupin for the relief of nausea, particularly in gynaecology services.

Following due consideration the Trust has concluded that no material inconsistencies exist between Annual Governance Statement, annual and quarterly statements to the Board of Directors as required by NHS Improvement's Single Oversight Framework, Annual Corporate Governance Statement, Quality Report, Annual Report and CQC inspection reports.

Patient Care

The last year has seen extensive service developments which have had a positive effect on patient care.

Extensive work has gone into improving the recognition and response to the deteriorating patient, including the introduction of a new escalation tool (with supporting documentation and education). The use of the tool has resulted in a reduction in the late escalation of patients with deteriorating symptoms to the High Dependency Unit or Intensive Care Unit.

The Trust also implemented a 'Locality Pilot' during the financial year, to improve services delivered to patients outside of the hospital. Working with colleagues in primary care, social care, mental health, the voluntary sector and the hospice the locality pilot has been putting patients at the centre of their own healthcare and support throughout the year. Following the evaluation of the pilot, the intention is to roll out the locality approach across Rotherham to deliver integrated locality based health and care services for adults, children and families.

In November 2016, the Trust launched a 'Hospital at Night' programme designed to transform the way in which care is provided to hospital inpatients overnight.

Two new roles were introduced as part of this initiative, that of a Hospital at Night Practitioner/Co-ordinator and a Hospital at Night Clinical Support Worker. The Practitioner/Co-ordinator is the first point of contact for the wards overnight, distributing the clinical work load and ensuring that the appropriate person (doctor or Advanced Nurse Practitioner) undertakes the care for the patient.

In addition, the Clinical Support Worker role has increased the existing night services available by carrying out technical tasks such as obtaining ECG recordings, assisting with patient examinations and catheterisation.

Looking to the future the Trust will continue to strive to deliver excellence in the provision of healthcare and continually develop services and practice, learning from patients' and colleagues' experience.

The Trust's ambitions to deliver excellence in healthcare will be continuously developed; the actions to be taken to achieve excellence in the provision of healthcare are described in the Trust's Quality Improvement Plan which identifies 17 quality priorities (and more details can be found in the Quality Report on page 39.)

The arrangements for monitoring improvements in the quality of care, and monitoring progress towards meeting any national and local targets, 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 so that they can provide assurance to the Board that quality objectives are being met.

In this context, the highest level operational committee is the Clinical Governance Committee (CQC), chaired by the Medical Director and supported by the Chief Nurse. The committee's role is to oversee the operational delivery of high quality healthcare through the work of a number of sub-groups; medication safety; health and safety; infection prevention and control; patient experience; patient safety; safeguarding (adults and children) and screening programmes. During the year CGC has received quarterly reports on the progress of each of the 2016/17 quality improvement priorities contained in the 2015/16 Quality Report.

Service Improvements

Service improvements have been made throughout the year. Those identified by, or arising as areas for improvement out of the CQC's re-inspection, were described earlier in the Quality Report.

However, there have been further initiatives that we have introduced, or which have become embedded, during the year. Our e-rostering system was introduced during the year and has been rolled out across the majority of areas within the Trust. This has enabled a completely different way of rostering in our wards and clinical areas, and ensures that appropriate numbers of qualified and experienced colleagues are allocated accordingly.

The implementation of Meditech into our Emergency Department, whilst initially presenting some issues, is now being used alongside Sepia, our in-house developed software, which won an HSJ award during the year.

Following Nurse Innovation Week, the planned re-introduction of protected nurse medication rounds and clear identification of the Nurse or Midwife in charge of the ward was proposed and has been introduced to enable both patients, visitors and colleagues to know who to approach.

Following the last National Inpatient Survey, a significant amount of work has taken place in relation to the Trust's catering arrangements and standards of food in relation to the meals provided to inpatients. A regular inpatient audit is undertaken by one of the Trust's Governors which involves patients regularly being asked about the standard and quality of food they have eaten. Feedback from this audit has led to changes to menus, snack provision and the quality of meals provided, all of which has improved patients' experience of their meals.

"Prompt and sympathetic attention, good explanation of problem and prognosis"

Friends and Family patient feedback
Urology Outpatients

How health Informatics have supported service improvements

Our health informatics department were also busy during the year helping to improve patient care. In October 2016 the Trust went live with placing electronic referrals for inpatients to community teams via MEDITECH. This replaced an existing referrals system, STRATA. Placing referrals in MEDITECH has enabled data that is already present in the system, such as demographics, to pull through to the referral form saving time on data entry. All data pertaining to the patient's referral is now visible in MEDITECH and has removed the need for an additional system which, again saves time for the end user and has reduced costs.

"Extremely phenomenal service"

Friends and Family patient feedback
Osteoporosis - Bone Health

In order to comply with the eDischarge guidelines set by the 2016/17 NHS Standard Contract, a review was undertaken in autumn 2016 to identify every kind of "discharge" document in the Trust's 56 SystmOne Units to ensure that the data entered, complied with the guidelines. As a consequence almost 200 pieces of documentation were selected and amended by the end of October 2016. All these documents are now compliant with the new regulations.

The new Integrated Public Health Nursing 0-19's Service was created in March 2017 with the merge of the Rotherham Health Visiting Service and the Rotherham School Nursing Service. The two SystmOne units were successfully merged and reconfigured with the help of a small group of staff from the service and the Trust's health informatics department.

"Explained everything well, put me at ease. Friendly and professional"

Friends and Family patient feedback
Musculoskeletal Service

The Child Protection Information Service enables our clinicians in Unscheduled Care settings to view a national system of Child Protection Information. We supported our Children's Wards, SCBU, Maternity and ED to access this clinical tool to read any Safeguarding Flags. These staff were also supported in viewing Safeguarding information within a SystmOne record. Much of this training was done 1-1 in the clinical areas during 2016/17.

CQUIN

As reported in the Performance Analysis section on page 18, the Trust's performance against four key health care targets during 2016/17 was mixed.

The Commissioning for Quality and Innovation (CQUIN) scheme includes nationally mandated and locally agreed goals for improving quality of patient care. The schemes agreed with Rotherham Clinical Commissioning Group and our forecast year-end position is detailed below. It should be noted that the final reconciled position will not be confirmed until the end of May 2017.

Indicator Status National (N) Local (L)	Indicator Description	Forecast Year-end Position
N	Introduction of staff health & wellbeing initiatives	Achieved
N	Development of an implementation plan and implementation of a healthy food & drink offer	Achieved
N	Improving the up-take of flu vaccinations for frontline clinical staff	Achieved
N	Timely identification and treatment for sepsis in A&E and inpatient settings	Partial Achievement
N	Reduction in antibiotic consumption per 1,000 admissions	Partial Achievement
N	Empiric review of antibiotic prescriptions	Partial Achievement
L	Improving quality & timeliness of clinic letters from secondary care to primary care (outpatients)	Achieved
L	Improving quality & timeliness of discharge letters from secondary care to primary care including intermediate care and handover plans (inpatients)	Partial Achievement
L	Engagement in Clinical Referrals Management Committee/System Resilience Group including audits	Achieved
L	Clinical engagement in other CCG priorities	Achieved
L	Embed the SAFER Care Bundle and support 7 day working across inpatient wards	Partial Achievement

In addition to the above, the Trust monitors progress against delivery of an extended range of hospital services 7 days per week as well as a range of community schemes aimed at supporting admission avoidance and early discharge. The scheme headings and forecast year-end position are detailed in the two tables right:

Acute 7 Day Working Indicators	
Clinical Standard Description	Forecast Year-end Position
Time to Consultant First Review	Achieved
Diagnostics (Radiology)	Achieved
Intervention/key services	Achieved
Ongoing Review	Achieved

Community Scheme Indicators	
Indicator Description	Forecast Year-end Position
Alternative Levels of Care	Partially delivered
Rehabilitation and Enablement	Partially delivered
Community Nursing	Partially delivered
Specialised Services	Partially delivered
Governance	Partially delivered
Improving Management of Discharges	Partially delivered

Additionally in 2016/17 the Trust has demonstrated significant improvement in the following quality indicators:

- Significantly improved performance and compliance with National Stroke Indicators with the Trust achieving Level B standard in the Stroke Sentinel National Audit programme for the period August to November 2016. This represents the highest ever rating for the Trust.
- Cancer Two Week Waits – most patients being seen within seven days of referral (top quartile performance nationally)
- Percentage of patients with a fractured neck of femur meeting best practice targets has increased significantly from 61% to 93%

The Trust has provided a full range of Acute and Community services throughout 2016/17.

In June 2016 the Trust held the formal launch event for the Health Village 'locality pilot' at Rotherham Football Stadium. Over 120 healthcare professionals and other colleagues from across Rotherham came together and contributed ideas and suggestions designed to improve patient experience and care by working together more effectively. The event included colleagues from the Trust, NHS Rotherham CCG, the local authority, mental health and the voluntary sector as well as the fire and police emergency services.

The locality pilot was further progressed following this event in order to ensure patients' overall clinical needs are understood and managed efficiently with the ultimate aim of keeping patients safe and well in their own homes.

At the NHS Confederation Annual Conference in Manchester the Chief Executive, Clinical Director for Integrated Medicine and the then Chief Operating Officer gave a presentation alongside partners from the CCG and local authority to showcase the progress the Trust had made with locality working. This provided the opportunity to showcase the great work being undertaken in Rotherham and to gain feedback from colleagues across the country on what else could be done.

The Trust piloted a revised children's clinical pathway aimed at avoiding admission where possible. The revised way of working focuses on full clinical assessment to diagnose the presenting condition (within a maximum 24 hour period) allowing appropriate treatment to commence hence avoiding clinically unnecessary admissions. Whilst this has been in the pilot phase during 2016/17, the initial findings have shown positive outcomes.

Further to the loss of a formal tender process, from February 2017 the Trust ceased to provide ophthalmic services on the Barnsley hospital site for its resident population. The Trust's ophthalmology services currently provided at the Rotherham hospital site remain unaffected and the comprehensive range of services will continue to be delivered.

'Browsealoud' was made available on the Trust's internet site from August 2016. This commercially available software enables patients and members of the public to access our Trust website in various formats to support their communication needs. During the year, the Trust also received a request for patient information to be provided in a Braille format; this was undertaken in a timely manner to enable the patient to understand the relevant preoperative instructions.

Where there has been a request, or where there is a cultural need, patient information leaflets have been translated into appropriate languages. One such example is our 'medicines derived from animal products' leaflet, which has specific information that has cultural relevance for some members of our local community.

A positive patient and family experience is of the utmost importance to the Trust and colleagues strive to make their experience the best it possibly can be. The handling of complaints and concerns should also be of a high quality and robust so that any improvements are cascaded throughout the Trust in order to continually improve services and best practice and provide a tangible and measurable reflection of the organisation's commitment to an open and responsive safety culture.

Throughout 2016/17 the Trust continued on its journey of improvement in relation to the management of complaints, further details can be found in the Quality Report section of this Annual Report and Accounts.

Throughout the year the Trust has continued to improve the way in which it manages complaints by encouraging more individual contact through the offer of face to face meetings at the start of the complaint in line with the *Patients Association's Person Friendly Charter*.

To support the handling of complaints in the organisation, the Trust's *'How to raise a concern or make a complaint'* leaflets and posters are available on wards and departments and reception areas across Trust sites for members of the public and colleagues. Regular audits are now undertaken to ensure there is adequate supply in all areas.

When managing a complaint, all Trust colleagues seek to ensure that those who were involved (the complainant, their carers, colleagues, etc.) are treated with respect and compassion and with concern for their issues, and they ensure that the investigation is undertaken in a fair and objective manner.

Throughout the year the organisation reviewed how it enables children and young people to raise concerns. As a result the development of a dedicated complaints and communication leaflet is underway.

Information and complaint handling data including subject area, response times, actions and learning for the period 2016/17 will be included in the Complaints Annual Report. Targeted work has taken place to improve how actions and learning are captured and this work will be built on further in the coming year to ensure learning is shared across the Trust to promote and maintain a safe environment for all.

Partnerships and Alliances

Throughout 2016/17, the Trust has strengthened its partnership working both locally and regionally.

Rotherham's Integrated Health and Social Care Place Plan (the Place Plan) is a collaboration of the Trust together with Rotherham Doncaster and South Humber NHS Foundation Trust, Rotherham Metropolitan Borough Council, Rotherham CCG and Voluntary Action Rotherham. The Place Plan brings together the skills of primary care with those of emergency medicine, urgent mental health services and social care.

The Place Plan focuses on improving the health and well-being gap of the community of Rotherham, through prevention, self-management, education and early intervention. It will drive transformation to close the care and quality gap through:

- Rolling out our integrated locality model – The Village;
- Opening an integrated UECC;
- Further developing the Care Coordination Centre; and
- Building a specialist re-ablement centre.

It is envisaged that these initiatives will contribute to closing the finance and efficiency gap, and will help achieve the community's Health and Wellbeing Strategic Aims and meet the region's Sustainability and Transformation Plan objectives. A copy of the Place Plan can be found at http://www.rotherhamccg.nhs.uk/rotherhams-place-plan.htm

The Trust is also part of the Working Together Partnership Vanguard. The overall vision of the Working Together vanguard is to be one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems by 2020.

The Working Together Programme was established in March 2013 and became a Vanguard in 2015. It is a partnership between seven acute hospital trusts in South Yorkshire, Mid Yorkshire and North Derbyshire; Barnsley Hospital NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Mid Yorkshire Hospitals NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and The Rotherham NHS Foundation Trust.

Together the Trusts cover 15 hospital sites with approximately 45,000 staff, serving a population of approximately 2.3 million people. Working together on a number of common issues, the partnership aims to strengthen each organisation's ability to deliver safe, sustainable and efficient local services and improve the health and wellbeing of local people.

More details can be found about the Vanguard at http://workingtogethernhs.co.uk/

In October 2016, the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) was published. The Trust has worked closely with the other 24 health and social care partners involved in the partnership throughout 2016/17 to work towards achieving a common goal that everyone living in South Yorkshire and Bassetlaw have a great start in life, and are supported to stay health and to live longer.

A copy of the STP can be found at http://www.smybndccgs.nhs.uk/download_file/167/159

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. During the year the Trust has continued to work particularly closely with social care colleagues at Rotherham Metropolitan Borough Council (RMBC) on an initiative to facilitate multi-system and 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 both at RMBC and NHS England has also continued in year to support health awareness messaging as well as work with the voluntary sector to provide support where appropriate.

During 2016/17 the Family Heath Division has worked closely with RMBC after being awarded preferred bidder status to deliver care for 0 -19 year olds and Integrated Sexual Health services following a formal procurement exercise. Both parties have been jointly agreeing implementation and mobilisation plans in preparation for the 01 April 2017 commencement date. The revised service models will streamline systems and processes to improve patient experience and enhance service delivery.

In addition, the Trust and RMBC continue to work jointly 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 works in partnership with Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH) and has developed 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 our 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 mental health liaison team into the Emergency Department and improved assessment of adults in Emergency Department and ongoing assessment if admitted.

The Trust continues to work in well-established partnerships with Doncaster & Bassetlaw NHS Foundation Trust for the delivery of Ear Nose & Throat (ENT) and Oral Maxillofacial services. Management of these services across the sites is embedded and has been in place for a number of years. The Trust also worked with Doncaster & Bassetlaw NHS Foundation Trust in 2016/17 to develop joint pathways for the delivery of Gastroenterology service and supporting the gastrointestinal bleed rota out of hours.

Further collaboration and partnership working with Sheffield Teaching Hospitals has been progressed during 2016/17 with regard to the delivery of Community Dental Services.

Working in conjunction with other agencies plays an important part in enabling cross-organisation pathway reviews to shape seamless care pathways which are patient focussed and improve clinical outcomes and experience.

Consultation with local groups and organisations

The Rotherham NHS Foundation Trust has ensured that patients and members of the public were able to take part in activities across the Trust during 2016/17.

Rotherham patients living with Parkinson's disease raised awareness of the disease by taking part in the national Parkinson's Awareness Week from 18 to 24 April 2016. Patients affected by Parkinson's disease were joined by their families, friends and specialists at Rotherham Hospital, part of The Rotherham NHS Foundation Trust, to raise awareness of the disease and talk about their condition to visitors.

Specialist Haematology Nurses at the Trust joined forces with patients, their carers, families and Macmillan Cancer Support earlier this year to develop ideas for the group, which now meets monthly at Rotherham Hospital.

Monthly Macular Society meetings are held in Ophthalmology and an annual Age-related Macular Degeneration open day is always well attended.

Family and Child Health invited service users into the Trust during the year for learning events in MCADD[3] (Children) and Young Inspectors have visited the ward and conducted a review. Pool birthing has been discussed at a learning event by Maternity Services and feedback has been gained on leaflets prior to publication.

The Lead Nurse for Dementia Care at the Trust has frequent involvement with people and carers living with dementia in the Rotherham area, through regular attendance at the Alzheimer's Society Cafés and the Dementia Carers forum. This regular visibility and engagement with the dementia community in Rotherham enhances the Trust's dementia person centred care and supports people and carers living with dementia with any anxieties or challenges which may arise from being in an unfamiliar environment during a hospital admission.

Values Week, held in the summer of 2016, asked colleagues, patients and the public what the Trust's values should be moving forward. Over 2,000 comments were received which helped shape our new values – Ambitious – Caring – Together which were launched in November 2016.

Budding young artists from Rotherham's secondary schools were asked to shape the identity of a new 0-19 integrated public health nursing service. The new service, which will be run by the Trust, is being launched on 1 April 2017. It will provide young people and families in Rotherham with streamlined access to care.

The Trust's Community Corner ran 160 promotions during 2016/17. It joined forces with NHS Blood and Transplant to encourage people of all ages to sign up to the NHS Organ Donor Register. Twenty four activities were also arranged to support self-care week and encouraged people to have their blood pressure checked as part of the Stroke Awareness events.

Colleagues, patients and the public were encouraged to have their say about proposed changes to services through the Sustainability and Transformation Plans (STPs). Consultations on Hyper Acute Stroke Services and Children's surgery and anaesthesia services have been actively promoted across the region during January and February 2017.

In February 2017 the Trust ran a Nursing Innovation week asking colleagues, patients and visitors about how new ideas could be developed and practice on the wards and across nursing changed.

In March 2017 the Quality Priorities Showcase for staff, patients, public and stakeholders took place. This allowed the Quality Priorities for the Trust to be shared and those present to make suggestions for outcomes and what should be focused upon.

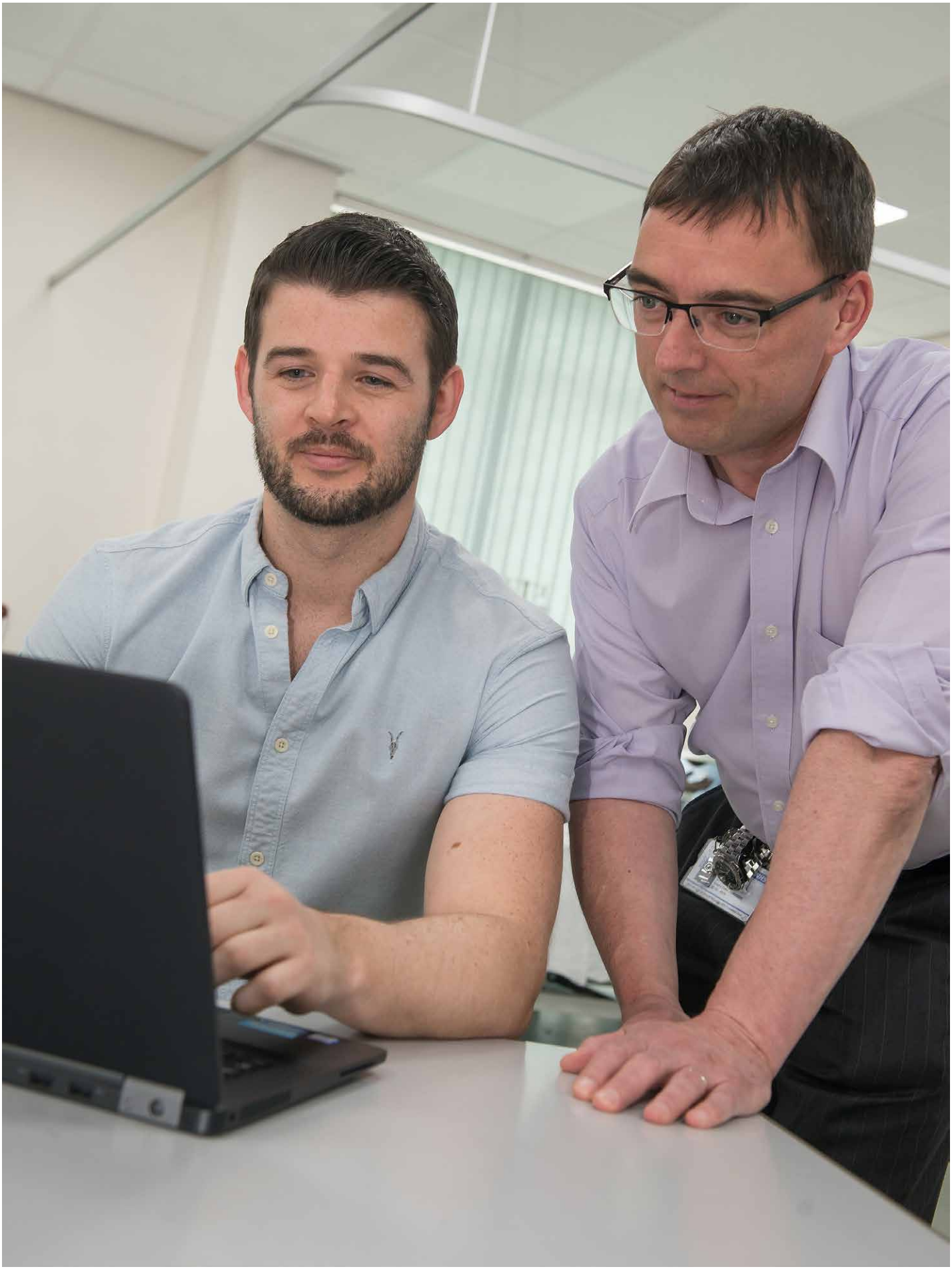
Rotherham United Football Club teamed up with the Trust's breast screening unit during October 2016's Breast Cancer Awareness Month, in a bid to encourage local women to join the fight against breast cancer and attend their screening appointments.

The Trust engaged with Rotherham Clinical Commissioning Group's Public Involvement Groups in March 2017 to provide an update on the Urgent and Emergency Care Centre as well as giving attendees the opportunity to provide feedback and influence the communications messages leading up to the opening of the new Urgent and Emergency Care Centre in the summer of 2017.

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.

> *"I have had 2 new knees replaced here at Rotherham and both Doctor and all the staff were amazing, the care you receive here before and after is 10/10. They could not do enough for you."*
>
> **Friends and Family patient feedback**
> **Fracture Clinic**

[3]MCADD is a rare genetic condition where a person has problems breaking down fat to use as an energy source



Remuneration Report

The Remuneration Report summarises the Trust's Remuneration Policy and particularly, its application in connection with the Executive Directors. The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the revised NHS Foundation Trust Code of Governance, various Acts of Parliament and accounting regulations. Sections 420 to 422 of the Companies Act 2006 and Regulation 11 and Schedule 8 (parts 3 and 5) of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") as interpreted for the context of NHS foundation trusts and parts 2 and 4 of Schedule 8 of the Regulations as adopted by NHS Improvement in the NHS Foundation Trust Annual Reporting Manual 2016/17.

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

Annual Statement on Remuneration from the Chair of the Remuneration Committee

During 2016/17 the Committee continued to use annual benchmarked data, including that provided by NHS Providers, as the pay and reward framework on which to base executive salary amounts.

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

The aims of the pay and reward framework were to:

- Facilitate the recruitment and retention of high quality senior staff;
- Ensure that remuneration reflects the extent of the role and responsibilities of individual posts and their contribution to the Trust;
- Ensure that the remuneration is justifiable and provides good value for money; and
- Provide a transparent framework for determining senior level remuneration.

An annual salary review took place for Executive Director roles during 2016/17. No pay awards were made.

Colleagues on Agenda for Change terms and conditions were subject to the following changes coming into effect 1 April 2016:

- All spine points received a 1% pay increase from 1st April 2016
- Increments were paid to those who were eligible.

The Rotherham NHS Foundation Trust has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior management and we will continue to do this going forward.

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). Each of the components detailed in the table below supports the Trust in terms of its long-term strategic objectives.

Setting and reviewing pay is not a simple matter. 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.

"NHS is a privilege we must preserve for the future generation."

Friends and Family patient feedback
ENT Outpatients

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

Guidance issued by the Cabinet Office, sets a maximum salary of £142,500 as the Civil Service threshold against which, approval for payment is required from the Chief Secretary of the Treasury. The Cabinet Office approvals process does not apply to foundation trusts. However, the figure is considered to be a suitable benchmark for trusts to disclose why they consider the remuneration is reasonable in situations where it is paid.

The figure of £142,500 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 Trust's remuneration policy is transparent and no performance related elements make up the total amount of remuneration.

Service Contracts Obligations

The contracts of employment of substantive Executive Directors are standardised and contain a notice period of six months. All such contracts are open-ended but are subject to earlier termination for cause or if notice is given under the contract.

Policy on Payments for Loss of Office

There is no entitlement to any additional remuneration in the event of early termination for any of the Executive Directors. During 2016/17 no Executive Director received additional remuneration for loss of office.

Statement of Consideration of Employment Conditions Elsewhere in the Trust

Except for 'senior managers' (as per the definition above) Trust colleagues are subject to national Agenda for Change, or national Medical and Dental Terms and Conditions.

When setting the remuneration policy for senior managers, the pay and conditions of these employee groups was taken into consideration, and the need for a transparent policy decided.

The Trust did not consult with employees when preparing the senior managers' remuneration policy, however annual benchmarked data, including that provided by NHS Providers, was used to determine the appropriate remuneration for the Executive and Non-Executive Directors during the year.

Executive salaries are in line with national executive remuneration benchmarking, and comprise a transparent process. By using benchmarking guidelines, the Trust ensures that salaries are sufficient to attract and retain high calibre candidates, and are appropriate for the benchmarked role.

No performance related bonuses or long term performance related bonuses have been paid.

No additional fees or other items that are considered to be remuneration in nature are paid.

Annual Report on Remuneration

Information not subject to audit

Service Contracts

All Executive Directors who served during the year did so on substantive contracts of employment with no end dates which include a notice period of six months. With the exceptions listed below all of the Executive Directors served for the entirety of the financial year 2016/17 (1 April 2016 to 31 March 2017).

Director of Workforce: Cheryl Clements was appointed as substantive Director of Workforce from 18 April 2016.

Chief Nurse: Tracey McErlain-Burns' role as Chief Nurse ended on 31 December 2016 when she relinquished the role. She remained in employment until January 31 2017 to provide continuity to the CQC assessment process.

Ellie Monkhouse served as Acting Chief Nurse from 1 January 2017 having previously served as Deputy Chef Nurse in the Trust.

Chris Holt, Chief Operating Officer took up his revised role as Director of Strategy and Transformation in the Trust from 1 March 2017.

Executive Directors who were in post prior to 1 April 2016:

Louise Barnett, employed substantively by the Trust since 1 April 2014

Simon Sheppard, employed by the Trust since 3 November 2014

Chris Holt, in his post as Chief Operating Officer since 6 October 2014

Tracey McErlain Burns, employed substantively by the Trust since 1 November 2013

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.

"Care and consideration. Professional staff. Confidentiality. Aware of older people's needs."

Friends and Family patient feedback
Fitzwilliam Orthopaedic Trauma

Non-Executive Directors are generally appointed on terms of three years and for up to two terms, but they can be appointed for up to one year further on an exceptional basis, as follows:

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

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
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
01.03.17 – 29.02.20

Each of the NEDs and Chairman are able to resign by giving notice.

Remuneration Committee
This committee is chaired by a Non-Executive Director, Barry Mellor, and its responsibilities are set out in its Terms of Reference, which were updated twice 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)	Lynn Hagger	Mark Edgell	Alison Legg	Joe Barnes	Gabrielle Atmarow	Martin Havenhand
12 April 2016	√	√	√	x	√	√	√
12 July 2016	√	√	x	√	√	√	√
10 Jan 2017	√	√	√	√	√	√	√
Attendance	3	3	2	2	3	3	3

Not subject to audit

Disclosures required by the Health & Social Care Act

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

Total number of Directors in office during 2016/17	Number of Directors receiving expenses during 2016/17	Aggregate sum of expenses paid to Directors during 2016/17	Aggregate sum of expenses paid to Directors during 2015/16
16	5	£2627.94	£2796.10

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

Total number of Governors in office during 2016/17	Number of Governors receiving expenses during 2016/17	Aggregate sum of expenses paid to Governors during 2016/17	Aggregate sum of expenses paid to Governors during 2015/16
27	3	£557.20	£750

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)

Single total figure table		2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16
		Salary & fees (in bands of £5k)	All taxable benefits (total to the nearest £100)	Annual performance- related bonuses (in bands of £5k)	Long-term performance-related bonuses (in bands of £5k)	All pension-related benefits (in brands of £2.5k)	Total (bands of £5k)	Salary & fees (in bands of 5k)	All taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5k)	Long-term performance-related bonuses (in bands of 5k)	All pension-related benefits (in bands of £2.5k)	Total (bands of £5k)
Name of senior manager	Job title (and period of office if relevant)	£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)	£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)
L Barnett	Chief Executive	175 - 180				62.5 - 65.0	240 - 245	175 - 180				65.0 - 67.5	240 - 245
C Wareham	Medical Director	170 - 175				515.0 - 517.5	685 - 690	115 - 120				30.0 - 32.5	145 - 150
C Holt	Chief Operating Officer	130 - 135				45.0 - 47.5	175 - 180	125 - 130				57.5 - 60.0	185 - 190
T Mclain-Burns (to 31/12/2016)	Chief Nurse	120 - 125				– - 2.5	120 - 125	115 - 120				20.0 - 22.5	135 - 140
E Monkhouse (from 01/01/2017)	Acting Chief Nurse	20 - 25				30.0 - 32.5	50 - 55	-				-	-
S Sheppard	Director of Finance	120 - 125				37.5 - 40.0	160 - 165	115 - 120				52.5 - 55.0	170 - 175
C Clements (from 18/04/2016)	Director of Workforce	110 - 115				772.5 - 775.0	885 - 890	-				-	-

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 2016/17 relates solely to his role as Medical Director.

Cash Equivalent Transfer Values

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 show 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.

Single total figure table		2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16
		Salary & fees (in bands of £5k)	All taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5k)	Long-term performance-related bonuses (in bands of £5k)	All pension-related benefits (in bands of £2.5k)	Total (bands of £5k)	Salary & fees (in bands of £5k)	All taxable benefits (total to the nearest £100)	Annual performance-related bonuses (in bands of £5k)	Long-term performance-related bonuses (in bands of £5k)	All pension-related benefits (in bands of £2.5k)	Total (bands of £5k)
Name of senior manager	Job title (and period of office if relevant)	£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)	£000s (Band of £5k)	£s (nearest £100)	£000s (Band of £5k)	£000s (Band of £5k)	£000s (Band of £2.5k)	£000s (Band of £5k)
M Havenhand	Chairman	50 - 55		-	-	-	50 - 55	50 - 55		-	-	-	50 - 55
G Atmarow	Non Executive Director	15 - 20		-	-	-	15 - 20	15 - 20		-	-	-	15 - 20
J Barnes	Non Executive Director	15 - 20		-	-	-	15 - 20	15 - 20		-	-	-	15 - 20
M Edgell	Non Executive Director	15 - 20		-	-	-	15 - 20	15 - 20		-	-	-	15 - 20
L Hagger	Non Executive Director	15 - 20		-	-	-	15 - 20	15 - 20		-	-	-	15 - 20
A Hope (to 28/02/2017)	Non Executive Director	15 - 20		-	-	-	15 - 20	15 - 20		-	-	-	15 - 20
B Mellor	Non Executive Director	15 - 20		-	-	-	15 - 20	15 - 20		-	-	-	15 - 20
H Craven (from 17/02/17)	Non Executive Director	0 - 5		-	-	-	0 - 5	-		-	-	-	-
P Smith (from 01/03/2017)	Non Executive Director	0 - 5		-	-	-	0 - 5	-		-	-	-	-

The Non-Executive Director remuneration framework, agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2016/17 has been consistent with this framework. No additional payments are made for any additional duties carried out.

The Non-Executive Directors declined to consider any pay rise during 2016/17.

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

Pension Entitlements of Executive Directors

Total Pension Entitlement		2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17
Name of senior manager	Job title (and period of office if relevant)	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accured pension at pension age at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
		£000s (Band of £2,500)	£000s (Band of £2,500)	£000s (Band of £5k)	£000s (Band of £5k)	£000s	£000s	£000s	£000s
L Barnett	Chief Executive	2.50 - 5.00	0.00 - -2.5	30.00 - 35.00	80.00 - 85.00	441	63	509	
C Wareham	Medical Director	22.50 - 25.00	57.50 - 60.00	25.00 - 30.00	55.00 - 60.00	26	596	623	
C Holt	Chief Operating Officer	0.00 - 2.50	0.00 - 2.5	10.00 - 15.00	0.00 - 0.00	92	24	117	
T Mclain-Burns (to 31/12/2016)	Chief Nurse	-12.00 - -12.50	-35.00 - -37.50	35.00 - 40.00	115.00 - 120.00	937	-203	743	
E Monkhouse (from 01/01/2017)	Acting Chief Nurse	5.00 - 7.50	12.50 - 15.00	5.00 - 10.00	10.00 - 15.00	-	74	74	
S Sheppard	Director of Finance	0.00 - 2.50	0.00 - -2.5	35.00 - 40.00	90.00 - 95.00	467	29	501	
C Clements (from 18/04/2016)	Director of Workforce	35.00 - 37.50	105.00 - 107.50	35.00 - 40.00	105.00 - 110.00	0	739	740	

Details of pension entitlements of Executive Directors are shown above.

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

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

Median salary	£24,554
Mid-Point of Highest Paid Directors Salary Band	£180,000
Ratio – Median to Highest paid Director	7:33

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.

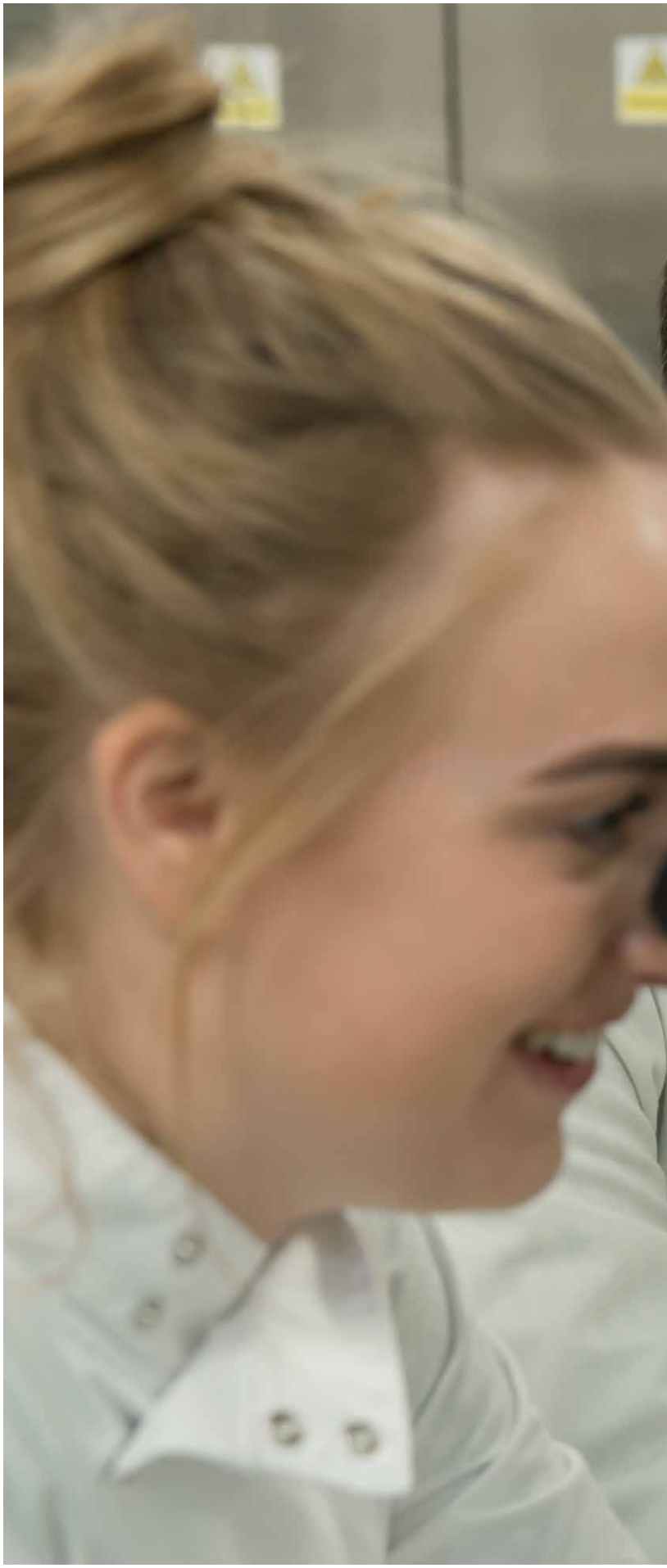
This Remuneration Report covers all individuals who hold, or have held, office as Chairman, Non-Executive Director or Executive Director for The Rotherham NHS Foundation Trust during 2016/17, whether or not they were substantively appointed.

Senior Managers with Additional Duties
There were no payments made during 2016/17 to Senior Managers for additional duties.

Payments for Loss of Office
There were no payments made during 2016/17 to Senior Managers for loss of office.

Payments to Past Senior Managers
There were no payments made during 2016/17 to past Senior Managers.

Louise Barnett
Chief Executive
26 May 2017




BINO PHOTO
Nikon

Staff Report Analysis of Staff Costs

Employee Expenses	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2015/16	2015/16	2015/16
		Permanently employed			Other													Total	Perma-nently employed	Other
	Total	Perma-nently employed total	Business with other WGA bodies	Business with bodies external to Govern-ment	Other total	Business with NHS FTs	Business with NHS Trusts	Business with DH	Business with Pub-lic Health England	Business with Health Education England	Business with CCGs and NHS England	Business with Special Health Authorities	Business with NDPBs	Business with other DH bodies	Business with other WGA bodies	Business with Local Authori-ties	Business with bodies external to Govern-ment			
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries & wages	126,849	126,849		126,849	0													125,656	125,656	
Social security costs	12,928	12,928	12,928		0													8,675	8,675	
Pension cost - defined contribution plans employer's contributions to NHS pensions	15,284	15,284	15,284		0													14,952	14,952	
Pension cost - other	25	25	25		0													18	18	
Other post-employment benefits	0	0			0													0		
Other employment benefits	0	0			0													0		
Termination benefits	0	0			0													0		
Temporary staff - external bank	0				0													0		
Temporary staff - agency/ contract staff	12,518				12,518												12,518	15,540		15,540
NHS charitable funds staff	0	0		0	0													0	0	
TOTAL GROSS STAFF COSTS	**167,604**	**155,086**	**28,237**	**126,849**	**12,518**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12,518**	**164,841**	**149,301**	**15,540**
Recoveries from DH Group bodies in respect of staff cost netted off expenditure	0	0			0													0		

Employee Expenses	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2015/16	2015/16	2015/16
		Permanently employed			Other													Total	Perma-nently employed	Other
	Total	Perma-nently employed total	Business with other WGA bodies	Business with bodies external to Govern-ment	Other total	Business with NHS FTs	Business with NHS Trusts	Business with DH	Business with Pub-lic Health England	Business with Health Education England	Business with CCGs and NHS England	Business with Special Health Authorities	Business with NDPBs	Business with other DH bodies	Business with other WGA bodies	Business with Local Authori-ties	Business with bodies external to Govern-ment			
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0			0													0		
TOTAL STAFF COSTS	167,604	155,086	28,237	126,849	12,518	0	0	0	0	0	0	0	0	0	0	0	12,518	164,841	149,301	15,540
Included within:																				
Costs capitalised as part of assets	0	0			0													0		
Analysed into operating expenditure (7.Op. Exp)																				
Employee expenses - staff	166,510	153,992	28,237	125,755	12,518	0	0	0	0	0	0	0	0	0	0	0	12,518	163,755	148,215	15,540
Employee expenses - executive directors	1,094	1,094		1,094	0													1,086	1,086	
Research & development	0	0			0													0		
Redundancy	0	0			0													0		
Internal audit costs	0	0			0													0		
Early retirements	0	0			0													0		
Special payments	0	0			0													0		
NHS charitable funds: Employee expenses	0	0		0	0												0	0	0	0
Total employee benefits excl. capitalised costs	167,604	155,086	28,237	126,849	12,518	0	0	0	0	0	0	0	0	0	0	0	12,518	164,841	149,301	15,540

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

	Permanent Number	Other Number	2016/17	2015/16
			Total Number	Total Number
Medical and dental	281		281	292
Ambulance staff	-		-	-
Administration and estates	955	4	959	1,015
Healthcare assistants and other support staff	770	13	783	682
Nursing, midwifery and health visiting staff	1,154		1,154	1,118
Nursing, midwifery and health visiting learners	5		5	-
Scientific, therapeutic and technical staff	387		387	411
Healthcare science staff	86		86	72
Social care staff			-	-
Agency and contract staff		147	147	181
Bank staff		125	125	183
Other			-	-
Total average numbers	**3,638**	**289**	**3927**	**3,954**
Of which:				
Number of employees (WTE) engaged on capital projects		13	13	-

Analysis of Staff: Gender of Staff

As at end March 2017 the breakdown of Trust employed staff by gender was as follows:

	Male	Female	Total
Executive Directors	3	3	6
Non-Executive Directors	5	3	8
Employees	805	4071	4876
Total	813	4077	4890

"Care given was good, doctors arranged test fast, nurses very kind. I felt well looked after."

Friends and Family patient feedback
Ward A1

Sickness Absence Data

The Trust's sickness absence data for the 2016/17 financial year; the overall sick absence level for the year was 4.65%. The Trust reduced sickness absence over the year despite a winter peak of 5.49% in November.

Figures showing average sick days per FTE, rather than overall sickness absence as a percentage, are below, with data having been provided by NHS Digital, and based on the 2016 calendar year:

Figures converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2016	Adjusted FTE days lost to Cabinet Office Definitions	Average Sick Days per FTE	FTE - Days Available	FTE - Days Lost to Sickness Absence
3,671	38,430	10.5	1,340,049	62,341

Note:
Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse
Period covered: January to December 2016

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).

As part of its workforce strategy, the Trust has adopted targets in relation to sickness rates. The objective is to have sickness absence at 3.95% by the end of the new financial year 2017/18, reducing to 3.45% by 2018/19.

Sickness absence has remained a high priority for the Trust as a caring responsible employer and each division closely manages sickness rates through the year, providing support and early interventions for colleagues has been a key aim.

Despite the challenges that the winter months bring the Trust has managed over the final quarter of the financial year 2016/17 to reduce absence levels. Over the last three months of the year the Trust also reduced sickness absence rates by circa 1.5% which represents approximately sixty colleagues extra at work per day providing health care to the Rotherham public.

To build on the Trust's success, the policy for managing sickness has been reviewed to ensure that colleagues are both supported and appropriately managed during periods of sickness.

We have also refocused our occupational health (OH) service to support colleagues attendance which has included initiatives such health MOT's, successful 'flu vaccination programme achieving over 80% of all front line staff being vaccinated, training for managers on how to deal with mental health issues, plus proactive support through a Mindfulness approach.

The Trust is currently working on developing an Employee Assistance Programme to work holistically with existing OH services to support colleagues and their families in times of personal or family stresses, or at difficult times.

"Efficient and friendly staff very quick re-appointment"

Friends and Family patient feedback
Dermatology Outpatients

“It’s a great service. Someone to offer advice.”

Friends and Family patient feedback
Community Matrons

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

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

Improving opportunities and maximising workforce opportunities for all colleagues in 2017/18:

- The Trust is aiming to become a Disability Confident Employer and will embark on the scheme during 2017/18 with the aim to successfully employ and retain disabled people and those with health conditions. Being Disability Confident is a unique opportunity to lead the way in our community, and identify someone our business can't do without. It was developed by employers and disabled people's representatives to make it rigorous but easily accessible.
- The introduction of the Workforce Disability Equality Standard (WDES). This is a positive step forward for disabled people working in the NHS / 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 TRFT's equality agenda over the next year.

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

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

Our policy and practise for staff undertakes that our Learning and Development department will act as a contact point for special requirements for training provided by the Trust. We ensure that reasonable adjustments are made to support staff who disclose a disability which may mean they require extra support with their learning and development.

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

The Trust consults with our employees and their representatives in a number of ways, through our Joint Partnership Forum which is our joint meeting with our union colleagues and directly with colleagues via consultations that they are affected by.

During the financial year the Trust has entered into twenty seven consultations with colleagues and their representatives with the vast majority reaching a mutually agreeable way forward.

We also engage with colleague views as a result of the national staff survey with each of the Trust's divisions running a number of sessions designed for colleagues to provide feedback through a series of 'Over to You', and LiA meetings. Each division has then produced an action plan to help improve the working life of their colleagues

The Trust won a third consecutive gold award for preventing accidents on its hospital and community sites as awarded by the Royal Society for the Prevention of Accidents (RoSPA), as part of their RoSPA Occupational Health and Safety Awards 2016/17. Only organisations that maintain continued high standards in health and safety achieve the gold award.

There are a number of committees and working groups with responsibility for key aspects of the quality agenda, including the Health and Safety Committee, Hospital Infection Prevention and Control Committee, Harm Free meeting; Family Health Quality Governance and Assurance Group and the Clinical Effectiveness and Research Group.

The Workplace Health & Well Being (WH&WB) service offers professional specialist nurse, counselling and proactive occupational health services.

During 2016/17 the WH&WB service has continued to deliver high quality interventions to all employees, supporting a healthier, fitter workforce and supporting the Trust's objective to reduce sickness absence. It successfully retained the Safe, Effective Quality Occupational Health Services (SEQOHS) accreditation.

Other highlights include:

- Individual support on proactive health care and lifestyle choices.
- Training for line managers on how to deal with Mental Health issues plus training on "a Proactive approach to dealing with stress"; plus a very successful launch of Mindfulness sessions.
- Increased counselling opening hours to accommodate more clients.
- Triage referral service to help prioritise employee appointments.
- Delivery of staff health MOT's.
- The High Five training programme that includes sessions on diet and exercise, dealing with work place pressures and stress, smoking cessation and also a session on back care.

Countering fraud, bribery and corruption

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

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

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

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

Where fraud is identified or suspected it is formally investigated in accordance with the Trust's Fraud, Bribery and Corruption policy. During 2016/17, seven referrals of suspected fraud, bribery or corruption were made to the CFS.

The Trust robustly investigates all allegations of fraud, bribery and corruption and works very closely with our designated specialist counter fraud team. In conjunction with the specialist counter fraud team the Trust has updated the 'Counter Fraud, Bribery and Corruption Policy' during 2016/17 year.

The Trust also proactively raises fraud awareness to colleagues in a number of ways through:

- The quarterly publication of 'Fraudulent Times'
- E-learning;
- Face to face training – delivered by the counter fraud team;
- Workbook based training;
- Information leaflets;
- Information publicised on the intranet;
- Communication of local and national alerts;
- Posters throughout the Trust;
- Social media.

"The care was second to none. Staff excellent and caring, nothing too much for them."

Friends and Family patient feedback
Coronary Care Unit

Staff Survey - Commentary

Colleague Engagement – Together We Can

The Trust is committed to harnessing the energy and skills of its workforce through encouraging a culture of openness and inclusivity. To reflect this, there are a number of strands that make up our engagement strategy. The Trust responded to feedback from our colleagues during the Listening into Action sessions and as a result, reviewed its vision, mission and values this year, reflecting on the breadth and depth of services provided at home, in the community and in our hospitals.

Our three new core Values; Ambitious, Caring and Together (act), were developed through direct engagement with colleagues, patients and carers during our values week in the summer. Following feedback from colleagues we have developed our Colleague Forum which is helping us shape our organisation and provide a channel enabling colleagues to identify and drive meaningful dialogue and action to improve our working environment and patient care.

We have revised our approach to appraisal to ensure that our organisational values are represented and that it is more meaningful for colleagues.

Further work has been undertaken to ensure our engagement platform and methodology is accessible and relevant to a wider audience. Development of our Together We Can (TWC) methodology has helped us integrate our approach to ensure colleagues are at the heart of change. The TWC programmes have replaced LiA and utilises the in-house '5 Factors to Success' Toolkit.

Throughout the year teams will embrace this new model of engagement to help shape change putting colleagues at the heart of the change. Successes will be shared throughout the organisation and with our partners and stakeholders in our publications. We have also developed a bespoke colleague newsletter embracing the qualities and successes of our workforce.

Summary of performance – Results from the NHS staff survey

The Trust National Staff Survey was facilitated through the Picker Institute Europe. The Picker Institute was commissioned by 20 Trusts classified as Acute Community Trusts. The Trust undertook a full census of eligible employees. The Trust saw a 41% response rate (a reduction of 1% from last year) two thirds of which were completed on line and one third using hardcopy.

The areas of improvement from the prior year and deterioration

Our overall staff engagement score has identified a slight improvement from last year however; the Trust recognises that this trends needs to continue in order to be comparable with other similar Trusts.

Where the Trust has focused on local change, areas such as the reporting of bullying harassment and abuse, there has been improvement. We have also seen a positive response in the number of colleagues experiencing harassment, bullying and abuse from patients. Colleagues have also reported an improvement in fairness and effectiveness in procedures of reporting errors, near misses and incidents, in addition to an increase in staff confidence and security in reporting unsafe clinical practice.

Key areas of improvement

The Trust has experienced most improvement in:

- Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse (positive increase from 31% to 45%)
- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (positive decrease from 63% to 57%)
- Effective use of patient / service user feedback (increase from 3.58 to 3.72)
- Percentage of staff satisfied with the opportunities for flexible working patterns (increase from 47% to 50%)
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (positive decrease from 23% to 20%)

Areas of deterioration

There are no significant statistical areas identified from the Staff Survey where the Trust's performance has deteriorated, however, it is recognised that there is still room for improvement in order attain national benchmark/upper quartile performance.

This is attributed to the increased focus throughout the year on effective reporting, training, inception of mediation services and focus on Freedom to Speak up Guardians.

	2015/16 (previous year)	2016/17 (current year)		Trust improvement / deterioration
	Trust	Trust	Benchmarking group (trust type) average	
Response rate	42%	41%	Picker 42%	Decrease in 1% points

Top 5 ranking scores				
	2015/16 (previous year)	2016/17 (current year)		Trust improvement / deterioration
	Trust	Trust	Benchmarking group (trust type) average	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	24%	20%	26%	Improvement
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	24%	24%	29%	No change
Percentage of staff appraised in last 12 months	94%	93%	86%	1% decrease
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	12%	10%	13%	Improvement
Percentage of staff working extra hours	68%	68%	71%	No change

Bottom 5 ranking scores				
	2015/16 (previous year)	2016/17 (current year)		Trust improvement / deterioration
	Trust	Trust	Benchmarking group (trust type) average	
Staff motivation at work	3.80	3.82	3.94	Improvement
Staff satisfaction with level of responsibility and involvement	3.83	3.85	3.92	Improvement
Percentage of staff reporting good communication between senior management and staff	24%	28%	32%	Improvement
Percentage of staff able to contribute towards improvements at work	65%	66%	71%	Improvement
Staff recommendation of the organisation as a place to work or receive treatment	3.52	3.54	3.71	Improvement

Areas of Concern and Action Plans to Address

The Strategic Workforce Committee agreed that they would undertake a deep dive analysis into the staff survey results for the Pharmacy service as this service was an outlier in relation to the Trust's overall survey results and identified areas of concern. This session will take place in quarter 2 of 2017/18 and mirror the approach taken with Estates & Facilities during 2016/17; which was deemed very successful, generating a significant improvement in results across all domains of the staff survey.

At a local / operational level, each division will develop three key priority action areas to focus on in response to their divisional staff survey feedback, supported by the HR Business Partners and leadership teams. The progress of this work will be reviewed at monthly divisional performance meetings; regular updates to the Trust Management Committee and via the Strategic Workforce Committee reporting to Board as required.

Future Priorities and Targets - Statement of Key Priorities

The Trust will focus on leadership, culture, health and wellbeing of our colleagues, continuing to ensure colleagues have opportunity to participate in meaningful engagement events using the Together We Can methodology to support and deliver effective change supported by our executive team.

The ambition to continue to build on effective engagement remains the focus for 2017/18 during which detailed work will be undertaken using the NHS Improvement (NHSI) Culture Tool alongside the continued adoption of our Together We Can engagement methodology.

Application of the NHSI culture tool kit, phase 1, will be implemented in quarter 1 of 2017/18 and will be aligned to the Trust's strategy. The ambition is that the full deployment of the NHSI toolkit will be delivered over an operational time line of two to three years.

The first Together We Can (TWC) teams are already underway and will deliver against their key objectives by the end of June 2017. The next wave of TWC teams will commence in July 2017 with an expected completion date of January 2018.

Performance against priority areas

The Trust's performance against the staff survey priorities will be reported each month to the Operational Workforce Committee. Additionally, elements of the survey (staff health and wellbeing, flu vaccination uptake, health food, access to MSK support and workplace stress) will be monitored via the Trust's CQUIN steering group. The expectation is for a 5% improvement against the wellbeing elements and 70% flu vaccination uptake of frontline workers.

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 action of 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 the HR Business Partners. The progress of this work will form part of the monthly divisional performance meetings with regular updates to the Trust Management Committee and Board of Directors as required.

Equality Reporting

Workforce Race Equality (WRES) and Public Sector Equality Duty (PSED) data, staff survey data, data from NHS jobs and census data all provide assurance in this area. Alongside WRES, the Trust uses the Equality and Diversity Systems (EDS2) to help in discussions with local partners including local populations, to review and improve their 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 improvement opportunity in how the organisation records equality data for training and development; an improved process for the collection of this data during 2017/18 will enable the Trust to potentially consider an improved WRES rating in this area. Feedback in relation to the application process for dual sensory loss applicants would indicate further work is required in this area and also further work could be undertaken to encourage and support applications from applicants with learning difficulties and these will be areas for priority action in the new financial year. This work will be progressed by the Trust's Equality & Diversity Steering Group which reports to the Operational Workforce Committee.

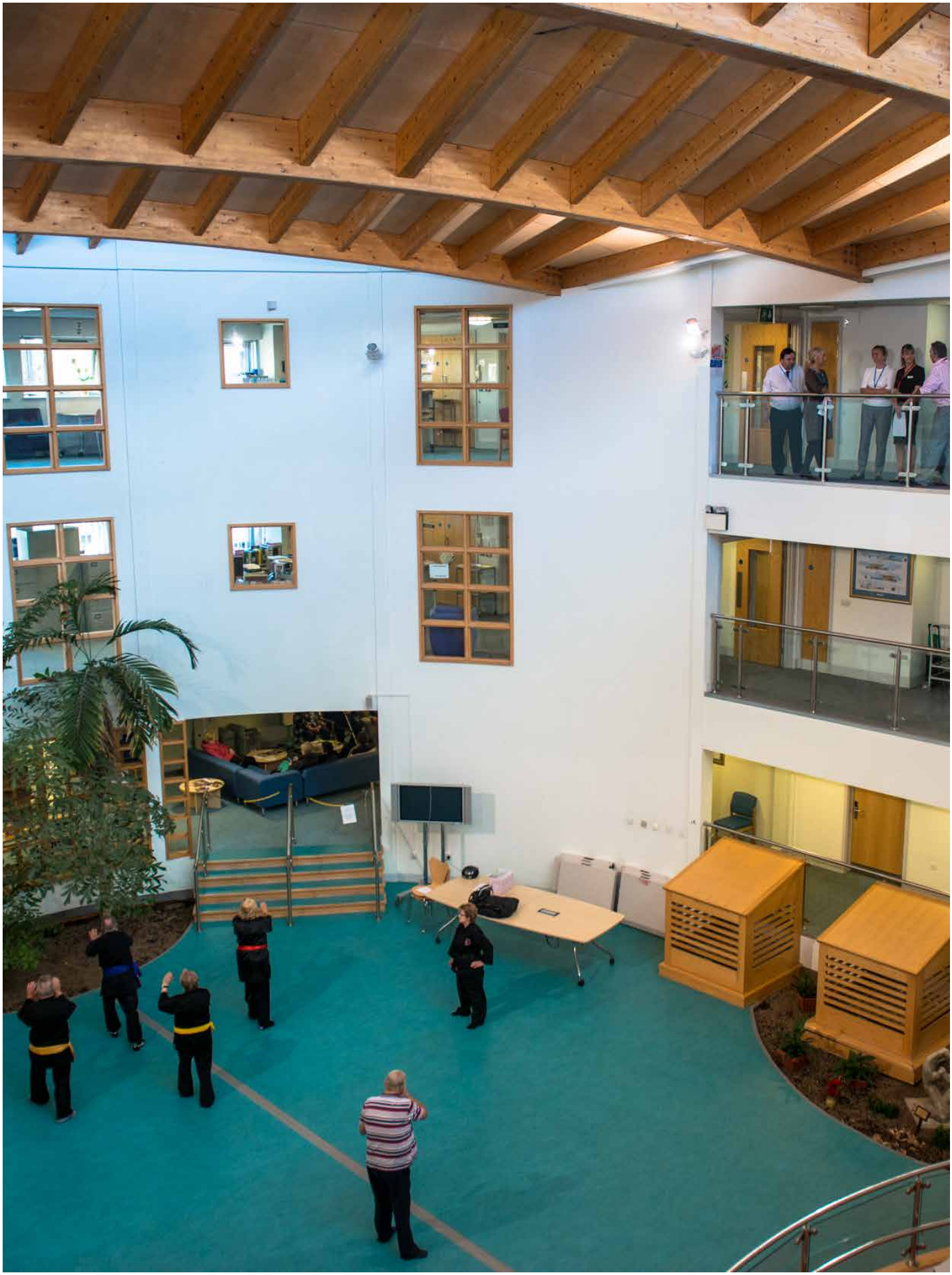
Training is available for all staff and covers all protected groups with bespoke training available for gender reassignment. This training allows middle managers to support colleagues in creating and maintaining a culturally competent work environment which is ultimately free from discrimination.

Expenditure on Consultancy

During 2016/17 the Trust spent £144,826. A number of consultancy costs were amalgamated to produce the total figure. Projects ranged from IT support services, Business Development, Building and Engineering to Catering Contract.

"Staff are wonderful."

Friends and Family patient feedback
Critical Care Follow-up



Staff Exit Packages

No exit packages were utilised during 2016/17.
The following exit packages were utilised during 2015/16:

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	0	1
£10,00 – £25,000	1	0	1
£25,001 – £50,000	2	0	2
£50,001 – £100,000	0	0	0
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	4	0	0
Total resource cost	£100,513	£0	£100,513

	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	1	31
Exit payments following Employment Tribunals or court orders	1	1
Non-contractual payments requiring HMT approval *	0	0
Total	2	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

The contents of the table above reflects two payments made by the Trust this year, these relate to:

- Pay In Lieu Of Notice (PILON), which was a contractual payment and totalled £30,822.58.
- A remedy judgment following an employment tribunal which totalled £730.07.

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 Trust can confirm that where off-payroll engagements are required all such appointments are fully scrutinised by the Executive.

For all off-payroll engagements as of 31 Mar 2017, for more than £220 per day and that last for longer than six months:

Number of existing engagements as of 31 Mar 2017	4
Of which:	
Number that have existed for less than one year at the time of reporting	2
Number that have existed for between one and two years at the time of reporting	2
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-

The standard process during 2016/17 was to seek assurance for all off payroll workers that they were compliant with IR35 and that all relevant taxes were being paid.

For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months:

Number of existing engagements as of 31 Mar 2017	
Number of new engagements, or those that reached six months in duration between 01 April 2016 and 31 March 2017	2
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	2
Number for whom assurance has been requested	2
Of which:	
Number for whom assurance has been received	2
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

The Trust has not engaged any individual without including contractual clauses allowing the Trust to seek assurance as to their tax obligations.

Any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017:

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	nil

"Prompt, seen on time. Dr explained thoroughly and listened to my questions excellent follow up procedure."

Friends and Family patient feedback
Dermatology Outpatients

"All staff were brilliant, nothing was a problem and we got discharged no problems or delays. Would highly recommend labour ward and not think twice about coming back."

Friends and Family patient feedback
Labour and Delivery Suite

Governance and Organisational Structure

Board of Directors

The Board of Directors uses best practice standards as part of its governance framework. It is a unitary Board with collective responsibility for all aspects of the performance of the Trust, including financial performance, clinical and service quality, management and governance.

The Board is legally accountable for the services provided by the Trust, and key responsibilities include:

- Setting the strategic direction (having taken into account the Council of Governors' views)
- Ensuring that adequate systems and processes are maintained to deliver the Trust's Annual Plan
- Ensuring that its services provide safe, clean, professional care for patients
- Ensuring robust governance arrangements are in place supported by an effective assurance framework that supports sound systems of internal control including the appointment and dismissal of Board Committees
- Ensuring rigorous performance management which ensures that the Trust continues to achieve all local and national targets
- Seeking continuous improvement and innovation
- Measure and monitor the Trust's effectiveness and efficiency
- Approving proposed expenditure above specified financial limits
- Ensuring that the Trust, at all times, is compliant with its Licence, as issued by NHS Improvement
- Exercising the powers of the Trust established under statute, as described within the Trust's Constitution.

The Board is also responsible for establishing the values and standards of conduct for the Trust and colleagues in accordance with NHS values and accepted standards of behaviour in public life, including selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Matters Reserved for the Board and Scheme of Delegation.

The Board receives monthly updates on performance and delegates management, through the Chief Executive, for the overall performance of the organisation which is conducted principally through the setting of clear objectives and ensuring that the organisation is managed efficiently, to the highest standards and in keeping with its values.

Composition of the Board of Directors

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

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

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 incorporates a mixture of skills, knowledge and experience which is considered appropriate, balanced and complete for the challenges facing its members. Taking into account the wide experience of the whole Board of Directors, the balance and completeness of the Board of Directors is considered to be appropriate.

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

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

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

The Board Assurance Framework, which has undergone further development throughout 2016/17, provides a comprehensive review of the performance of the Trust against the agreed plans and strategic objectives.

Meet the Board of Directors

The descriptions below of each Director's expertise and experience demonstrates the balance and relevance of the skills, knowledge and expertise that each of the Directors bring to the Trust. Details provided for those in post as at 31 March 2017.

Non-Executive Directors

All Non-Executive Directors of the Board of Directors are considered to be independent. The Trust's policy in relation to Non-Executive Directors is that they are appointed for up to a three year term of office as per the Trust's Constitution with one month's notice on either side. The initial three-year term of office may be renewed once to mean a Non-Executive Director may 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 would be subject to annual review in accordance with the Code of Governance.

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

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

During 2016/17, he was working as a Non-Executive Director at Yorkshire Water Services Limited although his term of office came to an end on 31 March 2017.

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 later in this section.

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.

The Chairman chairs the Board of Directors and Council of Governors meetings. He is also chair for the Governors' Nominations Committee, the Board Nominations Committee, and the Strategic and Transformation Assurance Committee.

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.

As a former Non-Executive Director of the West Yorkshire Workforce Development Confederation and former Honorary Senior Lecturer / Lecturer at the Universities of Sheffield and Leeds, Gabrielle has long held a keen interest in the education and development of those who wish to realise their full potential. Since 2009 she has been a member of the Board of Governors of Leeds Metropolitan University.

Gabrielle was appointed as a Justice of the Peace in 2008 and serves as a magistrate on the Leeds Adult Bench. She views this responsibility as both humbling and a privilege.

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 Gabrielle 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.

Gabrielle is the Trust's Senior Independent Director. She is also chair of the Charitable Funds Committee (The Rotherham Hospital and Community Charity) and is a member of the Strategic Workforce Committee, the Finance and Performance Committee, the Remuneration Committee and is Vice Chair of the Quality Assurance 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. She is Chair of the Finance and Performance Committee, a member of the Quality Assurance Committee, and 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; he is a qualified accountant and provides consultancy services (on a very small scale) to businesses and pension funds.

In July 2016 the Council of Governors re-appointed Joe for a further three year term of office from September 2016.

Joe is the Chair of the Audit Committee and a member of the Finance and Performance 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.

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

Through his role at the Trust and his passion for ensuring local people enjoy high quality public services that effectively meet their needs, Mark will seek to help The Rotherham NHS Foundation Trust meets its challenges, both now and in the future.

Mark is chair of the Quality Assurance Committee and member of the Strategy and Transformation Assurance Committee and Vice Chair of the Board's Nomination Committee.

Lynn Hagger
Non-Executive Director and Vice Chair

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

Lynn has published extensively in this area including two books: *The Child as Vulnerable Patient: Protection and Empowerment* and *A Good Death: Law and Ethics in Practice*. In parallel with these activities, Lynn has been involved in the NHS for over 25 years, mostly as a Non-Executive Director of acute hospital boards, and including as Chair of Sheffield Children's NHS Foundation Trust and Non-Executive Director at Leeds Teaching NHS Trust.

Lynne is 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.

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 and procurement and logistics.

He is no stranger to the NHS or The Rotherham NHS Foundation Trust, in his previous role as Chief Executive of NHS Logistics (later NHS Supply Chain). He says that one of his proudest moments was NHS Logistics winning the Health Service Journal Award for Improving Patient care with E-technology. Barry's recent position has been as Commercial Director for Sheffield City Council and as Chair of the Yorkshire & Humber Strategic Procurement Group, he has been actively involved in the transfer of Public Health and has worked closely with Rotherham Council.

In November 2016 Barry also became a Non-Executive Director at Derbyshire Healthcare NHS Foundation Trust.

Barry is Chair of the Remuneration Committee, Vice Chair of the Strategic Workforce Committee and a member of the Strategy and Transformation Assurance Committee.

Paul Smith
Non-Executive Director

Paul is a Professor at a university business school, having retired after many years as a partner in one of the world's largest professional service firms. He is a chartered accountant, chartered tax adviser, and has an MBA and Doctorate from Manchester Business School. He has delivered consulting projects to a wide array of private and public organisations.

Paul grew up in Rotherham and has a large family still living here. Paul is married with two children.

Paul joined the Trust in March 2017. He is Vice Chair of the Audit Committee, Vice Chair of the Strategy and Transformation Assurance Committee and a member of the Strategic Workforce Committee and 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 November 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.

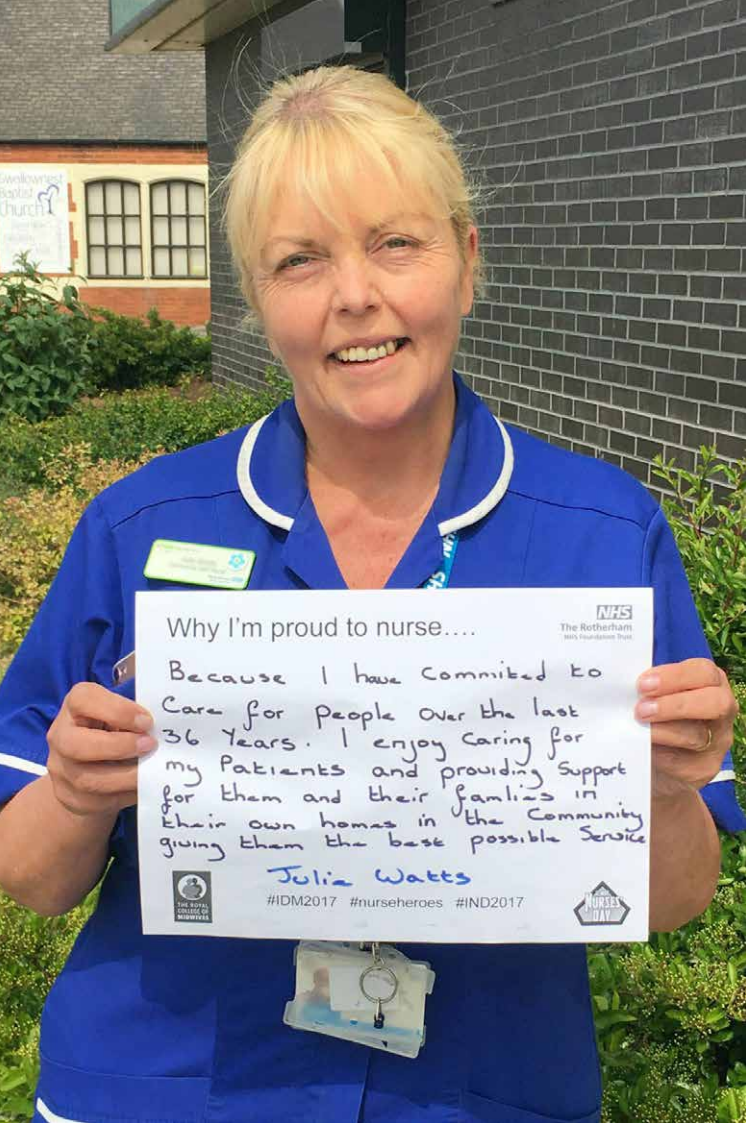
Louise has held a number of NHS board positions, including Non-Executive Director at Sherwood Forrest Hospitals NHS Foundation Trust, Interim Chief Executive at Peterborough and Stamford Hospitals NHS Foundation Trust and Director of Human Resources and Organisational Development.

Louise is a Chartered Fellow of the Chartered Institute of Personnel and Development, a Fellow of the Chartered Management Institute and is currently Chair of the Yorkshire and Humber Regional Leadership Council.

Chris Holt
Director of Strategy & Transformation and Deputy Chief Executive
(Formerly Chief Operating Officer)

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

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



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.

Ellie Monkhouse
Acting Chief Nurse (from 1 January 2017)
Ellie joined The Rotherham NHS Foundation Trust in November 2015 as Deputy Chief Nurse and moved into the Acting Chief Nurse role in January 2017.

Prior to joining the Trust, Ellie was Director of Nursing and Quality at Leeds North and Leeds South & East CCGs. During this time, she was the Executive Lead for Quality and Safeguarding as well as being the Deputy Chair and Interim Chair of the Leeds Adult Safeguarding Board.

One of Ellie's biggest interests is in the development of the nursing profession and workforce – contributing to this at local, regional and national levels.

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' Meeting 2016/17

	Martin Havenhand (Chair)	Gabrielle Atmarow	Joe Barnes	Mark Edgell	Lynn Hagger	Alison Hope (Legg)	Barry Mellor	Heather Craven	Paul Smith	Louise Barnett	Chris Holt	Tracey McErlain-Burns	Simon Shepherd	Conrad Wareham	Cheryl Clements	Ellie Monkhouse
2016																
April (Extra)	Y	Y	N	N	N	Y	N			Y	N	Y	Y	N		
April (Extra)	Y	Y	Y	N	Y	Y	Y			Y	Y	Y	Y	N		
April	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	
May	Y	Y	Y	Y	Y	Y	N			Y	Y	Y	Y	N	Y	
June	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	
July	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	
August (Extra)	Y	N	Y	N	N	Y	Y			N	N	Y	Y	Y	Y	
August	Y	Y	Y	N	Y	N	Y			Y	Y	Y	N	Y	Y	
September	Y	Y	Y	Y	Y	Y	N			Y	Y	Y	Y	Y	Y	
October (Extra)	Y	Y	N	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	
November (October meeting)	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	N	N	Y	
November	Y	Y	Y	N	Y	Y	N			Y	Y	Y	Y	Y	Y	
December (Extra)	N	Y	Y	Y	Y	Y	N			Y	Y	Y	Y	Y	Y	
December	Y	Y	Y	Y	N	Y	Y			Y	Y	N	Y	Y	Y	
2017																
January (Extra)	Y	Y	Y	Y	Y	Y	Y			Y	Y		Y	Y	Y	
January	Y	Y	Y	N	Y	Y	Y			Y	Y		Y	Y	Y	Y
February	Y	Y	Y	Y	Y	Y	Y	N		Y	Y		Y	Y	N	Y
March (Extra)	Y	Y	Y	N	Y		N	N	Y	Y	Y		Y	Y	Y	Y
March	Y	Y	N	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y
Attendance	18/19	18/19	18/19	16/19	12/19	16/17	13/19	1/3	2/2	18/19	17/19	13/14	17/19	15/19	16/17	4/4

Directors' Register of Interests

The Directors' Register of Interests is available to view on the Trust's website (http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Our_Board_of_Directors/) or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec,
Company Secretary,
General Management Department Level D,
The Rotherham NHS Foundation Trust
Moorgate Road,
Rotherham, S60 2UD
The contact details above may be used by members who wish to communicate with directors.

Committees of the Board

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

Audit Committee

The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA) and the Department of Health.

The Committee was chaired throughout the year by Joe Barnes, a Non-Executive Director with relevant financial experience. 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 2016/17

Audit Committee	Joe Barnes (Chair)	Lynn Hagger	Alison Hope (formerly Legg)
2016			
April	Y	Y	N
May	Y	Y	Y
July	Y	Y	Y
October	Y	Y	Y
2017			
January	Y	N	Y
Attendance	5/5	4/5	4/5

The following areas were the significant issues considered by the Audit Committee during 2016/17:

- Annual Governance Statement 2015/16
- Annual Report and Accounts 2015/16
- Quality Account and Quality Report 2015/16
- Head of Internal Audit Opinion 2015/16
- External Audit ISA 260 review 2015/16 including new Value for Money arrangements (KPMG)
- Internal Audit (TIAA) annual work plan 2017/18
- Counter Fraud (provided by 360 Assurance) Annual Report for 2015/16, annual work plan 2016/17 and risk assessment for 2016/17
- External Audit (PwC) annual work plan 2016/17
- Board Assurance Framework 2016/17
- 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
- Governance arrangements for any additional audit work undertaken by the former External Auditors (KPMG) and our current External Auditors (PWC)

Exceptional items considered were:

- Process for the appointment of External Auditors
- Single Tender Actions process review
- Draft Trusted, Open Governance strategy

Review of:

- Internal Auditor effectiveness

The significant risks identified in the External Auditor's (PwC) audit plan for 2016/17 were:

- Risk of management override of controls
- Risk of fraud in revenue recognition
- Risk of fraud in expenditure recognition
- Financial standing and sustainability

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

Internal Auditors

During the financial year 2016/17 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.

During the 2016/17 financial year the contract for the Trust's External Auditors was renewed. The appointment of PricewaterhouseCoopers LLP (PwC) as External Auditors was approved at the July 2017 Council of Governors meeting.

The contract with PwC started on 1 October 2016 and 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).

Due to the change in External Auditors part way through the year the annual review of the effectiveness of the External Audit function was deferred to the 2017/18 year.

The Council of Governors, responsible for appointing the external auditors, accepted the Audit Committee's recommendations for appointment.

Nominations Committee

The Trust has two Nominations Committees. The Board of Directors committee has responsibility for Executive Directors' appointments and the Council of Governors Committee has responsibility for Non-Executive Director appointments. The Trust's Chairman chairs both Nomination Committees.

Executive Director Appointments

The Nominations Committee identifies suitable candidates to fill Executive Directors' vacancies as they arise. The Committee makes recommendations to the Chairman, the other Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive.

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

"Great communication by the consultant explaining fully what he thinks the problem is."

Friends and Family patient feedback
Musculoskeletal Service

Attendance at Nominations Committee (Executive Director appointments) 2016/17

	Martin Havenhand (Chairman)	Gabrielle Atmarow	Joe Barnes	Mark Edgell	Lynn Hagger	Alison Hope	Barry Mellor	Louise Barnett
December 2016	Y	Y	Y	Y	N	Y	Y	Y
January 2017	Y	Y	Y	Y	Y	Y	Y	Y
Attendance	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2

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

The recruitment process (December 2016 – April 2017) undertaken to appoint a new Chief Nurse was as follows:

- Meetings of the Nominations Committee to discuss long term and interim arrangements, the requirements for the post and timelines;
- Applications invited by external search agency and advertising in national and local media;
- Shortlisting takes place, with approval for shortlisted applicants by Nominations Committee members;
- Formal interviews undertaken in April 2017. The Trust did not appoint on this occasion.

Non-Executive Director 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 Governors' Nomination 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 three occasions during 2016/17.
One meeting considered the outcomes of the Chair and Non-Executive Directors' annual appraisal and objective setting process, the reappointment of three Non-Executive Directors for a further three-year term of office (to the maximum six-year term), the reappointment of one Non-Executive Director for a further one-year term of office above the maximum six year term.

This meeting also considered the skills and composition of the Non-Executive members of the Board of Directors and commenced the succession planning process through open recruitment.

The second and third meetings considered the Non-Executive Director recruitment process, with the third meeting also considering the appointment of the Senior Independent Director.

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.


NHS

The recruitment process undertaken to appoint the two Non-Executive Directors in 2016/17 was as follows:

- Governors' Nomination Committee met to discuss existing skills and experience of existing Non-Executive Directors and other Directors and to identify any gaps. They also discussed and agreed the attributes required from the new Non-Executive Directors;
- Procurement of external recruitment firm to support appointment process;
- Applicants shortlisted by approval of a selection of Governors;
- Informal sessions undertaken with a panel of Governors and Non-Executive Directors with the shortlisted candidates;
- Formal interviews undertaken by the Chair and several Governors;
- Governor Nomination Committee made a recommendation to the Council of Governors in January 2017 to approve the appointment of the two successful candidates.

In July 2016 the Council of Governors approved the recommendation that remuneration for the Non-Executive Directors would remain unchanged in 2016/17. The Council of Governors also approved the recommendation of a revised Non-Executive Director job description. In early 2016/17 the Governors' Committee undertook the annual review of the remuneration, allowances and other terms and conditions of office of the Trust Chair and other Non-Executive Directors.

Non-statutory Committees of the Board:

Quality Assurance Committee
Finance and Performance Committee
Strategic Workforce Committee
Strategy and Transformation Assurance Committee (first meeting in March 2017).

In the summer of 2016 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 led by the Chairman and Chief Executive in conjunction with the Executive Lead and Non-Executive Lead of each of the Board committees.

This effectiveness review led to the revision of the terms of reference of the board committees undertaken in the summer of 2016.

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 constituencies it represents.

Other statutory duties of the Council of Governors include providing their views to the Board of Directors on the Trust's strategy, to respond to the Board of Directors when consulted and to undertake functions as requested by the Board of Directors, and to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

Should any disagreements between the Board of Directors and the Council of Governors arise the manner in which these will be resolved is described in Annex 3 of the Trust's Constitution which is available on the Trust's internet site.

"Staff very friendly. My mum suffers with severe anxiety and they helped and supported her through her time at the hospital."

Friends and Family patient feedback
Dermatology Outpatients

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

During 2016/17 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)	Mrs Ann Ashton	01.06.2013 to 31.05.2016
	Vacancy (x1)	01.04.2016 to 31.05.2016
	Mr Tyrone Lee Finney	01.06.2016 to 31.05.2019
	Mrs Lynn Flather	01.06.2016 to 31.05.2019
Wentworth South (Covering the electoral wards of Rawmarsh, Silverwood, Valley)	Mrs Clair Brierley	01.06.2015 to 31.05.2018 Stood down 11.08.2016
	Vacancy (x1)	12.08.2016 to 31.05.2017
	Mr Leslie Hayhurst	01.06.2014 to 31.05.2017
Wentworth Valley (Covering the electoral wards of Hellaby, Maltby, Wickersley)	Vacancy (x1)	01.04.2016 to 31.05.2016
	Mr Nicholas Ward	01.06.2016 to 31.05.2019
	Mr Graham Barry Jenkinson	re-elected 01.06.2014 to 31.05.2017
Rotherham South (Covering the electoral wards of Boston Castle, Rotherham East, Sitwell)	Mr Terry Barker	01.06.2013 to 31.05.2016
	Vacancy (x1)	01.04.2016 to 31.05.2016
	Mrs 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)	Vacancy (x2)	01.04.2016 to 31.05.2016
	Mrs Valerie Lindsay	01.06.2016 to 31.05.2019
	Vacancy (x1)	01.06.2016 to 31.03.2017
Rother Valley South (Covering the electoral wards of Anston & Woodsetts, Dinnington, Wales)	Mrs Bridget Dixon	re-elected 01.06.2014 to 31.05.2017
	Mr Gavin Rimmer	01.06.2014 to 31.05.2017
Rother Valley West (Covering the electoral wards of Brinsworth & Catcliffe,Holderness, Rother Vale)	Mr David Vickers	01.06.2015 to 31.05.2018 Stood down 31.01.2017
	Vacancy (x1)	01.02.2017 to 31.03.2017
	Mr Dennis Wray Lead Governor	re-elected 01.06.2014 to 31.05.2017
Rest of England (Covering those who live outside the borough)	Ms Jan Frith	01.06.2015 to 31.05.2018
	Vacancy (x1)	01.04.2016 to 31.05.2016
	Mr Bryn Kinsey	01.06.2016 to 31.05.2019

Constituency	Name	Term of Office
Staff Governors (elected):		
Professional Nurses and Midwives	Vacancy	01.04.2016 to 31.05.2016 01.06.2016 to 31.03.2017
Other Health Professionals	Mrs Catherine Ripley	01.06.2013 to 31.05.2016 Re-elected 01.06.2016 to 31.05.2019
Medical and Dental	Dr Firas Al-Modaris	re-elected 01.06.2014 to 31.05.2017
Other Directly Employed Staff	Mrs Sandra Lewis	01.06.2013 to 31.05.2016 Re-elected 01.06.2016 to 31.05.2019
Support Staff to Health Professionals	Mrs Tina Senior	01.06.2014 to 31.05.2017
Partner Governor Organisations (nominated/appointed):		
Sheffield Hallam University	Dr Christopher Low	01.08.2015 to 31.07.2018
Sheffield University	Prof Arshad Majid	14.11.2013 to 13.11.2016 14.11.2016 to 13.11.2019
Rotherham Partnership	Mrs Carole Haywood	01.09.2013 to 31.08.2016 01.09.2016 to 31.08.2019
Voluntary Action Rotherham	Mrs Janet Wheatley	01.06.2011 to 31.05.2014 01.06.2014 to 31.05.2015 01.06.2015 to 31.05.2016 01.06.2016 to 31.05.2016
Rotherham Metropolitan Borough Council	Cllr Emma Hoddinott	01.09.2015 to 31.08.2018 Stood down 06.02.2017
	Cllr Patricia Jarvis	06.02.2017 to 05.02.2020
Barnsley and Rotherham Chamber of Commerce		
Rotherham Ethnic Minority Alliance		

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 below:

Council of Governors meeting	Number of meetings held during tenure	Number of meetings attended
Dr Firas Al-Modaris	4	3
Mrs Anne Ashton	1	1
Mr Terry Barker	1	0
Mrs Beverly Bennett	3	2
Mrs Clair Brierley	2	0
Mrs Jo Brookes	3	3
Mrs Bridget Dixon	4	4
Mr Tyrone Finney	3	0
Mrs Lynn Flather	3	2
Miss Jan Frith	4	4
Mr Leslie Hayhurst	4	4
Mrs Carole Haywood	4	3
Cllr Emma Hoddinott	4	3
Cllr Patricia Jarvis	0	n/a
Mr Graham Barry Jenkinson	4	4
Mr Bryn Kinsey	3	3
Mrs Sandra Lewis	4	1
Mrs Valerie Lindsay	3	3
Dr Christopher Low	4	1
Prof Arshad Majid	4	2
Mr Gavin Rimmer	4	2
Mrs Catherine Ripley	4	3
Mrs Tina Senior	4	1
Mr David Vickers	4	3
Mr Nicholas Ward	3	2
Mrs Janet Wheatley	4	4
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 governor's interests is available to view on the Trust's website (www.therotherhamft.nhs.uk) or by requesting a copy from the Company Secretary.

Ms Anna Milanec, 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

"Lovely team of ladies on the Wharncliffe ward."

Friends and Family patient feedback
Wharncliffe

The Foundation Trust Membership

At the end of 2016/17 there were over 16,875 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 applicant must be at least 16 years of age and live within the Trust's constituency area (consisting of seven local electoral wards and a 'Rest of England' constituency), not be a Member of the staff constituency and have made an application for membership to the Trust.

To become a staff Member, the applicant must be at least 16 years of age, be employed by the Trust with a permanent contract or have worked at the Trust 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 (Kepple, Rotherham West, Wingfield)
- Wentworth South (Rawmarsh, Silverwood, Valley)
- Wentworth North (Hoober, Swinton, Wath)
- Wentworth Valley (Hellaby, Maltby, Wickersley)
- Rother Valley West (Brinsworth, Catcliffe, Holderness, Rother Vale)
- Rother Valley South (Anston and Woodsetts, Dinnington, Wales)
- Rest of England (covers all areas not within RMBC boundaries)

The Rotherham NHS Foundation Trust constituency boundaries reflect the Rotherham Metropolitan Borough Council area assembly boundaries.

"Good support and the Paediatric Audiologist agreed to see her even though we had come to the wrong Centre. Excellent rapport with her."

Friends and Family patient feedback
Primary Ear Care/Audiology

Membership composition to 31 March 2017

Public	
Rotherham South	2,092
Rotherham North	1,595
Wentworth South	1,746
Wentworth North	1,235
Wentworth Valley	1,763
Rother Valley West	1,367
Rother Valley South	1,088
Rest of England	1,609
Out of trust area	4
Total	12,499
Staff	
Medical and Dental	271
Professional Nurses and Midwives	1335
Other Health Professionals	556
Support Staff to Health Professionals	902
Other Directly Employed NHS Staff	1312
Total	4376

Total TRFT Membership: **16,875**

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.

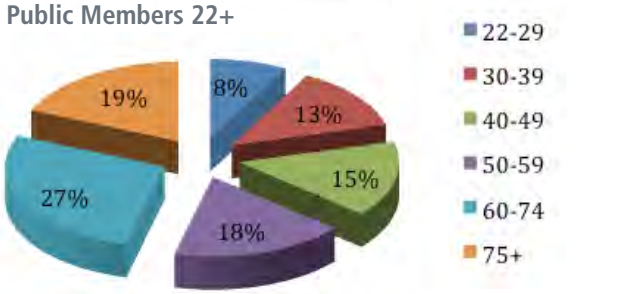
The Trust values the continued support and engagement of its Membership and recognises the importance of a Membership that is representative of all the communities it services. The Trust strives to ensure that its Membership is as representative of the population as possible.

The Board of Directors monitors the extent to which the Trust's membership is representative of the population its serves. As at 31 March 2017 the Trust's membership was composed as follows

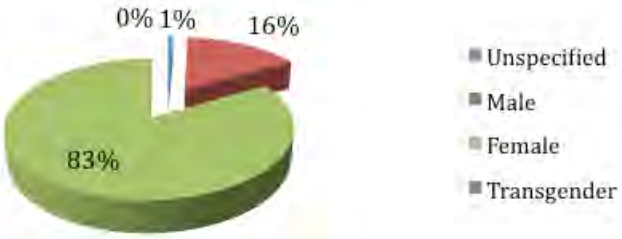
Public Member Gender chart

Public Member Age Range chart

Public Members 22+

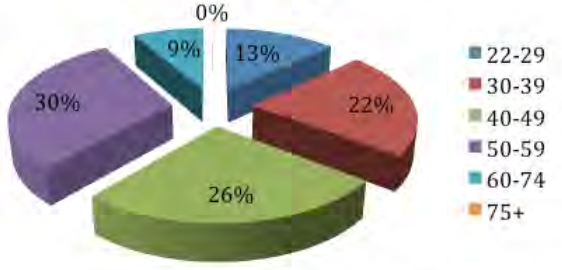


Staff Member Gender chart



Staff Member Range chart

Staff Members Age Range chart 22+



Membership Breakdown	Public	Staff	Total
Ethnicity. Breakdown below	12,499	4,376	16,875
White - English, Welsh, Scottish, Northern Irish, British	4,310	3,329	7,639
White - Irish	17	12	29
White - Gypsy or Irish Traveller	0	0	0
White - Other	15	33	48
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	7	15
Asian or Asian British - Indian	37	64	101
Asian or Asian British - Pakistani	179	31	210
Asian or Asian British - Bangladeshi	3	2	5
Asian or Asian British - Chinese	6	8	14
Asian or Asian British - Other Asian	20	25	45
Black or Black British – African	24	28	52
Black or Black British - Caribbean	6	10	16
Black or Black British - Other Black	13	6	19
Other Ethnic Group – Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	69	32	101
Not stated	7,788	770	8558

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

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.

Our annual edition of 'Your Choice' continues to be the traditional method of communication with our entire membership base. Produced in February each year it provides information on service developments, Proud Awards for staff which include a Public Recognition category, and The Rotherham Hospital and Community Charity. Its publication is timed to showcase the role of the Governor and announce the forthcoming annual Council of Governor Elections, encouraging Members to stand for election as Governors and to vote in the elections.

We also continue 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.

"Always like Rotherham. Found it good. Doctors were magnificent"

Friends and Family patient feedback
Ward A2

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 complaint: 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[5] 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 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)

[5]This requirement is also contained in paragraph 7.45 as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Compliant. Included in the Governance & Organisational Structure section (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)
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)
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 2017/18 including its objectives, priorities and strategy via their Governors' Surgeries and Governors' Forum meetings and their views have been communicated to the Board of Directors including at the Governors Forum meeting in December 2017.
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 2016/17 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

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Compliant. Included in Governance & Organisational Structure section (Composition of the Board of Directors section) for committee evaluation and Board members' evaluation. At the end of every Board of Directors meeting one of the Executive or Non-Executive Directors provides feedback evaluating the meeting
2: Disclose	Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	No external evaluation of the Board of Directors or the governance of the trust was undertaken during the year. An external review is planned for 2017/18.
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 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 Section
2: Disclose	Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Compliant. Included in Governance & Organisational Structure section (Audit Committee section)
2: Disclose	Audit Committee / Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Compliant. Included in Governance & Organisational Structure section (Audit Committee section) No non audit services were provided during 2016/17 by either of the Trust's external auditors during the year (KPMG and PwC) during their respective tenures as External Auditors to the Trust
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	Complaint: None of the Trust's Executive Directors were released, for example to serve as a Non-Executive director elsewhere, during 2016/17
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 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 FT Membership section of Governance & Organisational Structure section
Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Compliant. Included in FT Membership section of Governance & Organisational Structure section

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
Additional requirement of FT ARM (based on FReM requirement)	Board / Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 0 as directors' report requirement.	Compliant. Included in Governance & Organisational Structure section: • Board of Directors section • At end of Council of Governors section
6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery	Compliant.
6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	Compliant.
6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.	Compliant.
6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions.	Compliant.
6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life	Compliant.
6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	Compliant.
6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Compliant.
6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	Compliant.
6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.	Compliant.
6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.	Compliant
6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
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.
6: Comply or explain	Council of Governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Compliant
6: Comply or explain	Council of Governors	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.	Compliant.
6: Comply or explain	Council of Governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Compliant.
6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	Compliant.
6: Comply or explain	Board / Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	Compliant.
6: Comply or explain	Board / Council of Governors	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).	Compliant.
6: Comply or explain	Nomination Committee(s)/ CoG	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.	Compliant
6: Comply or explain	Nomination Committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
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.	
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.
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.	During 2016/17 the Council of Governors did not assess their collective performance in accordance with this provision, this is planned for 2017/18 alongside the effectiveness review to be undertaken of the Board.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
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.	During 2016/17 one Executive Director left the employment of the Trust in 2016 and the potential risks associated with this, were discussed by the Board's Nomination Committee in December 2016.
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. Included in Performance Report (Preparation of Accounts and Going Concern section)
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
6: Comply or explain	Board	C.1.4	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	Compliant.
6: Comply or explain	Board / Audit Committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Council of Governors / Audit Committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Compliant
6: Comply or explain	Council of Governors / Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Compliant
6: Comply or explain	Council of Governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Compliant
6: Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Compliant
6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Compliant
6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Compliant
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Compliant
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 Provider's annual salary report has been considered and the Non-Executive Directors expressed their intentions to decline any proposed pay award for 2016/17
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

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
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 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.

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 2017. 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. Please note: finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, and therefore, the segmentation of the Trust disclosed does not reflect the overall finance score here.

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score
Financial Sustainability	Capital service capacity	4	4
	Liquidity	4	4
Financial Efficiency	I&E margin	4	4
Financial Controls	Distance from financial plan	4	4
	Agency spend	2	2
Overall Scoring		4	4

During 2016/17, breaches remained in place against the Trust's Licence, resulting 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 Monitor (now NHS Improvement) 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 2016/17.

The allocation of a segment 3 sector rating by NHSI in October 2016, reflected the regulatory position.

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 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
26 May 2017

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 2017 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The Board of Directors is accountable for internal control. The Board of Directors is also accountable for the oversight of the risk management strategy and its implementation throughout the Trust.

Overall leadership for the Trust risk management process is provided by the Chief Nurse, with Executive Directors providing leadership of key areas of risk commensurate with their roles.

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

The Director of Finance is responsible for the leadership of management of risk in relation to finance and contracting issues. The Medical Director and Chief Nurse are responsible for ensuring leadership of management of risk for all clinical matters, and the Director of Workforce is responsible for the leadership of management of risks relating to workforce matters, health and wellbeing.

For the majority of this year, operational performance has been overseen by the Chief Operating Officer and from 1 March 2017, the Operations Director. The Senior Information Risk Owner (SIRO) is responsible for leading the management of risk relating to information governance, and is supported by the Caldicott Guardian where appropriate.

Whilst leadership of risk management is led by the executive directors, all colleagues have a role to play in the identification of risks and the Trust aims to facilitate a pro-active approach to risk management, training 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, and to share feedback from incidents, alongside other feedback and information to facilitate learning and quality improvement.

There are internal processes to ensure that incidents which fit the national criteria for serious incidents are reported on the Department of Health Strategic Executive Information System (STEIS). Serious incidents are also reported to NHSI and the CQC. The Quality Assurance Committee has oversight of serious incidents and a monthly report on serious incidents is provided to the Board.

We recognise the importance of training colleagues to be able to recognise and manage key risks in the organisation in areas 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 in order to strengthen controls.

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 clinical service unit is required to identify, manage and control local risks, whether clinical or non-clinical, 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, Central Alerting System (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, whilst maintaining oversight through reporting and management arrangements.

The risk management strategy, approved by the Board, sets out the organisation's approach to risk, the executive and Non-Executive director responsibilities, and the framework that is in place for the management of risk throughout the organisation. Risk appetites are determined by the Board of Directors and are reviewed on a regular basis.

The risk management strategy also includes details of the role of Board Committees – the Audit Committee, Quality Assurance Committee, Strategic Workforce Committee and the Finance and Performance Committee – in providing assurance that risks are being managed effectively.

The introduction of a new Risk Management Committee during the year, has provided a more robust process through which older low level risks are reviewed in a timely manner. All risks scoring 16 and above are reviewed by the Committee on a regular basis. These risks are also reviewed monthly by the Trust Management Committee and quarterly by Board committees and the Board of Directors, to provide assurance that operational requirements to mitigate and control risks, are being kept current.

Key elements of the quality governance arrangements
The Trust's quality priorities are set out in the Quality Report (page 39) and they reference and build on three domains of quality (patient experience, patient safety and clinical effectiveness), and also reflect the CQC's five quality domains (safe, effective, caring, responsive and well-led).

Compliance with CQC standards is monitored internally through a sequence of service-level and Trust-level self-assessments and quarterly presentation to the Medical Director and Chief Nurse, reporting ultimately to the Quality Assurance Committee and the Board.

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

The Board receives a monthly quality report containing quality information (supplemented by additional information appearing in the monthly integrated performance report and various dashboards). Additional steps are in the process of being identified which will strengthen existing processes.

Whilst the CQC re-inspection in 2016 demonstrated considerable improvement since the previous inspection in 2015, the Trust received three requirement notices, relating to governance, staffing and DNA CPR. The CQC rated 'well-led' as 'requires improvement' which reflects the need for the Trust to further strengthen quality governance arrangements in the organisation.

Actions are being taken to further strengthen the quality assurance framework, which will be supported by an external review in 2017/18, led by the Chief Nurse.

How risks to data security are being managed
All Trust colleagues are subject to confidentiality requirements through a range of Trust policies, and access to data held on IT systems is restricted to authorised users. The Trust's IT department maintains up-to-date technical security measures to minimise the threat to Trust network resources from outside threats and inappropriate access.

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

The Trust has implemented the Department of Health Guidance, 'Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents'. Information security forms part of the Trust's risk management strategy and the management of Information Governance Serious Incidents (SIRIs) is documented in local IG policies.

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

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

A brief description of the organisation's major risks
The major risks for the Trust in-year and in the immediate future are:

Finance: Underlying deficit, increasing cost pressures including the ongoing reliance on agency staffing, significant investment required to support transformation of services, and the availability of funding to support the required liquidity position.
Reflecting the situation throughout the provider sector, the financial position of the Trust remains challenging and the Trust did not achieve its financial plan, resulting in a year end deficit of £6.5M.

The year-end performance has been reviewed and clear actions have been identified which will be taken to strengthen financial performance in 2017/18. In particular, the Trust will continue take actions to strengthen workforce and financial controls, governance and accountability, financial reporting, and forecasting

The Board of Directors has approved a deficit financial plan of £13.6M for 2017/18 which will require further financial support to be provided to support the cash position. This will be agreed with NHSI on a monthly basis.

The Trust recognises that has an underlying deficit and is committed to working with partners, stakeholders and regulators to achieve long term financial sustainability, and compliance with its licence.

The Trust will continue to set challenging CIP targets above the national requirement - striving to improve effective, efficient and economic use of resources. Detailed annual planning, enhanced performance management and reporting, and robust oversight by the Board and its committees will help to mitigate the position.

Quality of care: Failure to deliver high quality patient care, leading to poor patient experience and avoidable harm, poor clinical outcomes.

Whilst the Trust made some good progress, which has been recognised by the CQC, a number of concerns arose during the year: reporting of four never events, increase in mortality rates, declining performance in harm free care and one incidence of MRSA. These issues illustrate the importance of the Trust continuing to make its quality governance

framework more robust. It is partly for this reason that the Trust has procured an external provider to carry out a full Trust quality review during 2017/18.

An extensive Quality Improvement Plan has also been developed to address some of the identified issues, and has also incorporated outstanding issues arising from the CQC inspections. Progress against this will be tracked throughout the year and will be regularly reported to the Board.

Mortality rates have continued to be elevated during the financial year and a number of measures and controls have been put in place by the Medical Director who continues to lead actions to improve mortality rates.

Workforce: Leadership capacity and capability, failure to recruit to key posts and modernise the workforce and improve pay productivity.

The Trust has an over-reliance on premium agency / locum staffing to fill vacancy and other workforce gaps (e.g. sickness absence / vacancies) in order to maintain safe staffing levels. National workforce shortages are reflected in the local region with a number of hospitals and healthcare organisations competing to fill similar roles. This has been particularly reflected in a number of specialties where the Trust has experienced medical workforce shortages and absence resulting in a high reliance on locums, and increased financial pressures.

The Trust has successfully implemented eRostering during 2016/17 and invested in the provision of an internal Staff Bank model to reduce the over reliance on Agency workers. This will enable the Trust to modernise our workforce structure and improve efficiency, economy and effectiveness.

Regulatory Risk: Breach of NHS Improvement, CQC and ICO requirements.

During the year, breaches remained in place against the Trust's Licence, resulting 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.

Whilst the latter two breaches were lifted during the 2014/15 financial year, and progress made in relation to the outstanding financial planning breaches, 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 at the end of the 2016/17 business year. The allocation of a segment 3 sector rating by NHSI in October 2016, reflected the regulatory position.

The CQC carried out a re-inspection of the Trust in September 2016, and found fourteen breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and 2014. The Trust was served with three regulatory notices. Action plans have been drawn up to address the breaches and to ensure that our services are safe for our patients. Progress against the action plans will be monitored through the Board of Directors and its committees.

More details concerning the breaches found by the CQC can be found on their website at www.cqc.org.uk/provider/RFR/reports

Operational delivery: Failure to achieve quality and operational targets, and associated financial penalties, and failure to deliver transformation programmes.

Achievement of the 95% A&E four hour access standard remains a key risk to the organisation, and has not been achieved since August 2016. Action plans have been put in place to address areas of risk and additional support has been accessed through regulatory bodies, however, factors such as the national workforce shortages in key roles continue to present a risk to the Trust in the delivery of services. In addition, the emergency department has been operating out of a temporary facility throughout 2016/17, which has created further challenges. However, with the support of RCCG, a new Urgent and Emergency Care Centre has been commissioned and built, and is due to open in July 2017 providing significantly improved facilities and an enhanced model of care.

The risks relating to the transition to the new UECC have been identified with plans in place to mitigate these risks during the coming months.

External environment: Changing regulatory regime and new collaborative working arrangements, increased reliance on partners and shared governance through new working relationships.

The Five Year Forward View has introduced new structures and models that the sector must adapt to in order to remain sustainable and robust for the future. This means that the Trust must leverage the opportunities provided to it through collaborative working with partners to address mutual service issues and to build on the transformation and integration of services that has already started.

Licence Condition 4 compliance

The risks associated with failing to comply with NHS Trust Condition 4 (FT Governance) relate to poor corporate governance arrangements, including poor board assurance, ineffective performance management and information to inform decision making, lack of an appropriate board and committee structure, and insufficient clarity of role resulting in the inability to hold to account.

In addition, without the effective governance systems and processes in place, there is a risk of failing to achieve the required Trust performance (including quality, operational, workforce and financial standards) and a risk of failing to use resources efficiently, economically and effectively, and to meet all legal requirements.

Therefore, the Trust assesses compliance with the NHS Foundation Trust Condition 4 (FT Governance) on a regular basis.

The Board sets the strategic direction of the Trust and is responsible for overseeing its performance. It has governance structures and procedures in place to manage the organisation, including assurance committees. The Board agrees its strategy and objectives annually, which are set out in the annual report. The Trust believes that effective systems and processes are in place to assess and monitor the

effectiveness of governance arrangements in the Trust and is committed to strengthening these in areas where required and work is ongoing to achieve this.

A monthly governance report, prepared by the Company Secretary, is provided to the Trust Board, and highlights internal governance issues and external matters which may affect the Trust's compliance with those principles, systems and standards of good corporate governance which would be regarded as appropriate for a supplier of health care services to the NHS.

Throughout the year the Chairman, myself and members of the Executive Team have met regularly with public stakeholders, Rotherham Clinical Commissioning Group, members of the Rotherham Working Together Partnership and also with members of the South Yorkshire and Bassetlaw Sustainability and Transformation Partnership to engage in discussions to ensure transparency and engagement regarding the Trust's strategy and plans, to achieve high quality care and sustainability of services for the population we serve.

Governors and Members provide vital channels of communication with the general public and are encouraged to bring issues of concern swiftly to the attention of the Trust; the Trust support them in this task by facilitating Governors' Surgeries where patients, families and members of the public can raise any issues with the Governors, who then raise those issues with the Board of Directors.

The Council of Governors receives regular updates on clinical and financial performance and reports relating to service delivery. Governors also input to the annual plan and met with the non-executive directors during the year. This enables the governors to discharge their statutory duties of holding the non-executive directors to account for the performance of the Board.

The Board is collectively responsible for the performance of the Trust. Its focus is on patient safety, outcomes and experience, operational performance and financial probity, strategic direction, corporate and clinical governance and internal control. It has five assurance committees, each chaired by a non-executive director. Details of committee membership are included in the directors' descriptions on pages 172 -173.

However, the scale and complexities of the board agenda has become more complex in the face of significant challenges and uncertainties for the NHS. The Trust will undergo a board well-led review in 2017 to evaluate the way that the Board and its committees work; to ensure it continues to be effective, efficient and economic in managing its agenda.

Validity of the Corporate Governance Statement

A report is submitted to the Board of Directors on an annual basis regarding the validity of the Corporate Governance Statement and is supplemented by further assurances gained from oversight of the Annual Planning process, (including involvement of the Council of Governors), quarterly presentation of risks scoring 16+ and above from the corporate risk register, the Board Assurance Framework and other assurance reports and papers provided to the Board and its committees.

Risk Management

The Board Assurance Framework and Risk Management

The BAF evidences that the Board has a system of control relating to the delivery of its strategic objectives. Each strategic risk on the BAF has been allocated for oversight by one of the executive directors, and Board assurance committees review related mitigation controls and seek assurance that the controls are appropriate to manage the risk.

The BAF will continue to be reviewed and improved upon, with further training provided to the board during 2017/18.

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, and also to ensure it assimilates learning identified by other external healthcare organisations. 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. 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 receives, on a monthly basis, an Integrated Performance Report ("IPR"), containing information on an extensive range of performance related KPIs, national priority indicators, statutory and regulatory requirements and local priorities.

Operational committees report through the monthly Trust Management Committee (TMC) which is attended by all the Trust's senior leadership team which includes all executive directors. The TMC provides the conduit between organisational and Board level governance processes.

Public stakeholders are involved in managing risks which impact on them via various forums:

- Council of Governor Meetings which provide an opportunity to hold the Non-Executive Directors to account for the performance of the Board, including quality and risk. Governors receive details of board papers including the monthly IPR. The also participate in walk rounds, hold 'Governors' Surgeries' at both the Trust and Community Centre. We are seeking to re-commence 'community meetings' during 2017/18 which we had tried previously, without success.
- The Trust's engagement with commissioners, Joint Health Scrutiny Committee and HealthWatch
- Consultation on the Quality Report involves key stakeholders and is evidenced through inclusion of their feedback.
- Patient surveys
- Consultation on transformational change with key stakeholders.
- Our staff colleagues take part in the annual NHS staff survey, attend/ receive monthly Team Brief sessions led by the executive directors, receive Colleague Bulletins three times a week by email, and a weekly message from the Chief Executive – who has an email address where colleagues can contact her directly, called 'Dear Louise'.

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

The Trust is required to have proper arrangements in place for securing economy, efficiency and effective use of its resources.

The Trust's financial plan is approved by the Board and submitted to the regulator. The plan, including forward projections, is monitored in detail by the Finance and Performance Committee, on a monthly basis, with key performance indicators and metrics reviewed by the Board and its committees. The Board of Directors also holds a monthly board seminar where issues such as finance, business planning, quality of care, and strategic issues are discussed in detail.

The Trust's resources are managed within the framework set by the Standing Financial Instructions, Matters Reserved for the Board and Standing Orders. All of these documents will be updated in 2017/18 to reflect work that has been ongoing to ensure that this framework is fit for purpose in supporting improved financial governance.

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

Clinical and corporate divisions are responsible for the delivery of financial and other performance measures via a performance management framework incorporating monthly reviews with the Executive team.

An external review of the quality governance framework has been procured and will take place in 2017/18. The outcome from this review will contribute to strengthening quality governance in the Trust.

A quality improvement plan has been developed which brings together the quality priorities set out in the quality report, together with the actions identified as a result of the CQC re-inspection.

The Trust has successfully implemented E-Rostering across number of clinical areas during the financial year. There is further work to be undertaken to ensure that workforce systems and controls are fully implemented and properly embedded. This is a key priority for the Trust as it is considered that the use of the new arrangements is necessary to support more robust workforce planning and improved efficiency including a decrease in the reliance in the use of agency workforce across the Trust.

Information governance

The Trust has an Information Governance Committee, which is chaired by the Senior Information Risk Owner and reports to the Trust Management Committee.

Data security risks are managed via an information governance framework, which comprises an information governance policy, related policies and guidance and the IGC. In particular, the information risk policy sets out a structured approach to information risk management which is integrated with our broader risk management arrangements. This includes the appointment of the SIRO, information asset owners and information asset administrators. (See also the Performance Report on page 10)

On the basis of the reporting requirements, one Serious Incident Requiring Investigation (SIRI) reporting 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 incident.

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 on this occasion.

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 2016/17 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. Governors are consulted on the content of the document and provide details of an indicator on which they seek external assurance from the auditors. Other stakeholders receive a draft copy for comment and feedback, which helps to provide a balanced view.

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 mandatory indicators and comments from Trust stakeholders, is subject to review by the Trust's external auditors.

There are a number of assurances and controls in place to ensure the quality of data within the quality report, including:

- Quality performance is monitored through governance structures from CSU level to board level (with presentation of a quarterly quality data report), including through the Quality Assurance Committee and Trust Management Committee
- Data quality is audited internally and externally
- Data quality is scrutinised routinely by commissioners
- External assurance statements on the quality report are provided by our local commissioners Rotherham Clinical Commissioning Group, Rotherham Health Select Commission and Rotherham Healthwatch as required by the quality account regulations.

One of the Trust's priorities is to improve data quality across the organisation, the external auditors during their annual audit, highlighted potential risks relating to the process and timeliness of reporting of the 18 week referral to treatment standard and four hour access standards. These issues will be examined and actions taken to strengthen data quality and reporting going forwards. The Trust has developed a kitemark approach which will form the basis upon which this priority will be progressed.

We have an extensive range of clinical and quality governance policies and these are reviewed at appropriate intervals to ensure our operating policies reflect the best practice. These include:

Being Open and Duty of Candour Policy
Claims Handling Policy
Incident and Serious Incident Management Policy
Clinical Audit Policy
Handover Policy
Medical Devices Policy
Information Governance Policy
Data Protection Policy

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 Trust has an underlying deficit and is committed to working with partners, stakeholders and regulators to achieve long term financial sustainability, and compliance with its licence.

The Trust's financial statements have been prepared on a going concern basis, with an emphasis of matter relating to material uncertainty surrounding the nature and extent of future funding required.

In addition, the Trust remains in breach of its licence relating to strategic financial planning. Whilst the Trust has and continues to take steps to address this, being in breach of the licence represents an ongoing risk to the Trust's duty to implement systems and / or processes to ensure compliance with its duty to operate economically, efficiently and effectively, and deliver value for money.

In September 2016, the Trust had a focussed follow up Care Quality Commission (CQC) inspection. The outcome of the inspection was received on 2 March 2017 which reported that the Trust had made considerable improvement since the last inspection with notable progress in some key areas. Whilst no overall Trust rating was provided, the Trust Well Led domain was re-rated and remains 'requires improvement' and three requirement notices were issued relating to governance, staffing and DNACPR. The Trust welcomes the feedback from the CQC and remains committed to driving quality improvements for the benefit of patients, and to achieve improved CQC ratings in the future.

One of the Trust's priorities is to improve data quality across the organisation. The external auditors during their annual audit, highlighted potential risks relating to the process and timeliness of reporting of the 18 week referral to treatment standard and four hour access standards. This has resulted in the two mandated indicators in the 2016/17 quality report, being qualified. These issues will be examined and a task and finish group has been established to specifically look at the issues raised. This work will take place alongside the Trust's ongoing work to continually improve the quality of all data used, and progress will be monitored through the Trust's committee structure. The Trust has developed a kitemark approach which will form the basis upon which this priority will be progressed.

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 work of the internal auditors found that there is insufficient evidence to confirm that the controls were working effectively. The one example where the assurance was not sufficient or controls were not adequate when subject to routine audits during the year, was:

Review and Tracking and Security of Patient Notes audit, which provided limited assurance.

Extensive work has been undertaken to implement the recommendations made by the internal auditors regarding this audit, with only minor actions remaining to be taken before completion. However, it is also recognised that there is still work to be done to ensure that everyone in the organisation is fully IG aware, and that security of personal data is one element of an IG culture of 'business as usual' in the ward environment.

Recommendations made by the internal auditors for all other audits, and action plans, have been agreed. Progress against the recommendations is followed in the audit action tracker which is presented to each Audit Committee meeting. Some work has been undertaken to reduce the number of outstanding recommendations that remain on the tracker to ensure that none are outstanding for more than three months where appropriate.

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

The 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.

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

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

The Trust's Standing Financial Instructions and Scheme of Delegation are in the process of review and are due to be approved by the Board of Directors in 2017/18.

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

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

Conclusion

Whilst an element of residual risk remains in a number of areas which have been highlighted in this document, there are no significant control issues that have been identified. The Board has in place governance assurance processes which enable the identification and control of risks reported through the Assurance Framework, and continues to review and update these on a regular basis to further strengthen and enhance the identification and mitigation of risk.

Signed:
Louise Barnett
Chief Executive
26 May 2017

Annual Accounts for the year ended 31 March 2017

Foreword to the Accounts

The Rotherham NHS Foundation Trust

These accounts, for the year ended 31 March 2017, 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.

Name Louise Barnett
Job title Chief Executive
Date 26 May 2017

Statement of Comprehensive Income for year ended 31 March 2017

	Note	2016/17 £000	2015/16 £000
Operating income from patient care activities	3	224,236	221,582
Other operating income	4	24,086	19,407
Total operating income from continuing operations		**248,322**	**240,989**
Operating expenses	5, 6	(251,873)	(247,026)
Operating surplus/(deficit) from continuing operations		**(3,551)**	**(6,037)**
Finance income	9	25	51
Finance expenses	10	(809)	(551)
PDC dividends payable		(2,168)	(2,296)
Net finance costs		**(2,952)**	**(2,796)**
Surplus/(deficit) for the year		**(6,503)**	**(8,833)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations and impairments of property, plant and equipment	13	-	(594)
Total comprehensive income/(expense) for the period		**(6,503)**	**(9,427)**
Allocation of profits / (losses) for the period:			
Surplus / (Deficit) for the year attributable to the Foundation Trust		**(6,503)**	**(8,833)**
Total comprehensive income (expense) for the year attributable to the Foundation Trust.		**(6,503)**	**(9,427)**

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	11	10,352	9,489
Property, plant and equipment	12	110,838	105,830
Trade and other receivables	16	43	56
Total non-current assets		**121,233**	**115,375**
Current assets			
Inventories	15	3,184	3,101
Trade and other receivables	16	12,727	13,231
Cash and cash equivalents	17	1,503	3,609
Total current assets		**17,414**	**19,941**
Current liabilities			
Trade and other payables	18	(24,524)	(22,836)
Other liabilities	20	(1,324)	(1,553)
Borrowings	21	(3,406)	(3,517)
Other financial liabilities	19	(96)	(96)
Provisions	23	(79)	(1,073)
Total current liabilities		**(29,429)**	**(29,075)**
Total assets less current liabilities		**109,218**	**106,241**
Non-current liabilities			
Borrowings	21	(34,983)	(25,608)
Other financial liabilities	19	(1,842)	(1,938)
Provisions	23	(1,159)	(958)
Total non-current liabilities		**(37,984)**	**(28,504)**
Total assets employed		**71,234**	**77,737**
Financed by			
Public dividend capital		73,403	73,403
Revaluation reserve		19,668	19,700
Income and expenditure reserve		(21,837)	(15,366)
Total taxpayers' equity		**71,234**	**77,737**

The following notes 1 - 29 form part of these accounts.

Signed

Name
Position **Chief Executive**
Date **26th May 2017**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£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	**-**
Public dividend capital received	1,138	-	-	**1,138**
Public dividend capital repaid	(1,138)	-	-	**(1,138)**
Taxpayers' and others' equity at 31 March 2017	**73,403**	**19,668**	**(21,837)**	**71,234**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**73,403**	**20,458**	**(6,697)**	**87,164**
Surplus/(deficit) for the year	-	-	(8,833)	**(8,833)**
Other transfers between reserves	-	(30)	30	**-**
Revaluations	-	(594)	-	**(594)**
Transfer to retained earnings on disposal of assets	-	(134)	134	**-**
Taxpayers' and others' equity at 31 March 2016	**73,403**	**19,700**	**(15,366)**	**77,737**

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 2017

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(3,551)	(6,037)
Non-cash income and expense:			
Depreciation and amortisation	5.1	6,096	5,907
(Increase)/decrease in receivables and other assets		846	(1,931)
(Increase)/decrease in inventories		(83)	29
Increase/(decrease) in payables and other liabilities		1,187	(418)
Increase/(decrease) in provisions		(793)	(500)
Other movements in operating cash flows		(96)	(96)
Net cash generated from/(used in) operating activities		**3,606**	**(3,046)**
Cash flows from investing activities			
Interest received		25	51
Purchase of intangible assets		(1,815)	(580)
Purchase of property, plant, equipment and investment property		(9,881)	(11,178)
Net cash generated from/(used in) investing activities		**(11,671)**	**(11,707)**
Cash flows from financing activities			
Public dividend capital received		1,138	-
Public dividend capital repaid		(1,138)	-
Movement on loans from the Department of Health		9,406	12,375
Capital element of finance lease rental payments		(142)	(351)
Interest paid on finance lease liabilities		(12)	(32)
Other interest paid		(797)	(519)
PDC dividend paid		(2,496)	(2,458)
Net cash generated from/(used in) financing activities		**5,959**	**9,015**
Increase/(decrease) in cash and cash equivalents		**(2,106)**	**(5,738)**
Cash and cash equivalents at 1 April		**3,609**	**9,347**
Cash and cash equivalents at 31 March	17.1	**1,503**	**3,609**

Notes to the Accounts

Note 1 Accounting policies and other information

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, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trusts' Annual Reporting Manual the financial statements have been prepared on a going concern basis as the Trust does not either intend to apply to the Secretary of State for the dissolution of the Trust without the transfer of the services to another entity, or consider that this course of action will be necessary. The Trust is also required to disclose material uncertainties in respect of events or conditions that cast doubt upon the going concern ability of the Trust and these are disclosed below.

The Trust has delivered a financial outturn for 2016/17 of £6,503k deficit (including £3,250k STF) against a planned surplus of £6,600k plan (Including £6,500k STF), showing an adverse variance excluding STF of £9.753k, the performance in the year required working capital loan financing support to be provided of £12,781k.

The Board of Directors has approved a deficit financial plan of £13,601k for 2017/18, which will require further financial 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, although these are agreed on a monthly basis and at the year-end there is no formal agreement in place.

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. In the current climate the Trust does not see itself as an outlier in the NHS financial framework and has aspirations to get back to a break-even position on its income and expenditure account within the next five years as a minimum.

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.

Note 1.1 Income

Income is accounted for applying the accruals convention. The income is shown gross except where administrative arrangements exists, whereby the associated income is netted off with the corresponding expenditure in accordance with the DH GAM. In recognising income in the current financial year, the Trust has considered and followed IAS18.

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 healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Where income has not been received prior to the year end, but the provision of a healthcare service has commenced, i.e. partially completed patient spells, then the income relating to the patient activity is accrued. The closing accrued income is estimated based on the number of days of incomplete spells at an average daily tariff adjusted to reflect the case mix.

The Foundation Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts using the national recommended rate of 22.94%.

Note 1.2 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. 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 1.3 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 1.4 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have 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.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Land and buildings used for the Trust's services or for administrative purposes are shown in the Statement of Financial Position at their revalued amounts, being the fair value at the date of the revaluation less any subsequent accumulated depreciation and impairment losses. It is the Trust's policy to perform a revaluation after there has been significant movements in the building cost index, and this could mean annual revaluations. If there are no significant movements then the Trust will perform a full valuation every five years with an interim valuation in the third year. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors' 'Red Book' (RICS) Appraisal and Valuation Manual. Fair values are determined as follows:

- Land and non-specialised buildings - modern equivalent asset valuation
- Specialised buildings - depreciated modern equivalent asset valuation
- Non-operational property and surplus land - modern equivalent asset valuation

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	3	88
Dwellings	24	24
Plant & machinery	-	-
Transport equipment	7	13
Information technology	5	18
Furniture & fittings	-	-

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 1.5 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

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
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - internally generated		
Information technology	-	-
Development expenditure	-	-
Other	-	-
Intangible assets - purchased		
Software	5	20
Licences & trademarks	5	10
Patents	-	-
Other	-	-
Goodwill	-	-

Note 1.6 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 1.7 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 1.8 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 seperately.

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 seperate 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.

Cash and Cash Equivalents
Cash and cash equivalents includes cash in hand, deposits held at call with banks and other short-term highly liquid investments with original maturities of three months or less.

Note 1.9 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 1.10 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
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA 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 1.11 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 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24, 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 1.12 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the 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 1.13 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 1.14 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 1.15 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 1.16 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 1.17 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 1.18 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the Trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

Accounting standards that have been issued but have not yet been adopted.

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. 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 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.
● IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018

Note 1.21 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

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 2015, 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 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. Similarly, the large majority of the Trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust Board of Directors, which includes senior professional 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**	
	2016/17	2015/16	**2016/17**	**2015/16**
Income	**248,322**	**240,989**	**248,322**	**240,989**
Retained Deficit	**(6,503)**	**(8,833)**	**(6,503)**	**(8,833)**
Segment net assets	**71,234**	**77,737**	**71,234**	**77,737**

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2016/17 £000	2015/16 £000
Elective income	34,457	34,883
Non elective income	52,344	49,068
Outpatient income	37,107	34,577
A & E income	8,709	8,491
Other NHS clinical income*	49,189	50,497
Community services income from CCGs and NHS England*	42,187	42,639
Private patient income	61	55
Other clinical income	182	1,372
Total income from activities	**224,236**	**221,582**

** Income streams recategorised in 2016/17 have been restated in 2015/16 . A movement of £6,399k between 'Other NHS Clinical Income and 'Community Services income' is therefore shown in prior year figures.*

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2016/17 £000	2015/16 £000
CCGs and NHS England	211,275	208,251
Local authorities	9,957	7,970
NHS trusts	1	-
NHS other	735	1,815
Non-NHS: private patients	61	55
Non-NHS: overseas patients (chargeable to patient)	54	4
NHS injury scheme (was RTA)*	4	1,201
Non NHS: other	2,149	2,286
Additional income for delivery of healthcare services	-	-
Total income from activities	**224,236**	**221,582**
Of which:		
Related to continuing operations	224,236	221,582
Related to discontinued operations	-	-

**NHS injury scheme income is subject to a provision for doubtful debts of 22.94% in 2016/17 (21.99% in 2015/16) to reflect expected rates of collection.*

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS Trust)

	2016/17 £000	2015/16 £000
Income recognised this year	54	4
Amounts written off in-year	-	24

Note 4 Other operating income

	2016/17 £000	2015/16 £000
Research and development	360	408
Education and training	6,618	6,501
Receipt of capital grants and donations	-	7
Charitable and other contributions to expenditure	5	-
Non-patient care services to other bodies	2,979	2,487
Sustainability and Transformation Fund income	3,250	-
Rental revenue from operating leases	319	339
Rental revenue from finance leases	96	96
Other income	10,459	9,569
Total other operating income	**24,086**	**19,407**
Of which:		
Related to continuing operations	24,086	19,407
Related to discontinued operations	-	-
Analysis of other Operating Revenue - 'Other'		
Car Parking	566	589
Estates Recharges	447	283
IT Recharges	222	299
Pharmacy Sales	843	364
Clinical Tests	742	667
Catering	-	15
Staff Recharges	1,147	1,109
Non clinical (SLA)	3,791	3,827
Non clinical (Non SLA)	1,248	1,194
Staff Accommodation Rentals	58	52
Staff Contributions to Employee Benefit Schemes	632	592
Property Rentals	763	578
Other		
	10,459	**9,569**

Note 4.1 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:

	2016/17 £000	2015/16 £000
Income from services designated (or grandfathered) as commissioner requested services	223,993	220,153
Income from services not designated as commissioner requested services	24,329	20,836
Total	**248,322**	**240,989**

Note 5.1 Operating expenses

	2016/17 £000	2015/16 £000
Services from other NHS bodies	-	28
Employee expenses - executive directors	1,094	1,086
Remuneration of non-executive directors	164	162
Employee expenses - staff	166,510	163,755
Supplies and services - clinical	26,807	27,725
Supplies and services - general	3,981	3,997
Establishment	1,745	2,027
Research and development	28	27
Transport	1,437	1,358
Premises	11,589	9,361
Increase/(decrease) in provision for impairment of receivables	(405)	263
Change in provisions discount rate(s)	161	-
Drug costs	18,761	18,154
Rentals under operating leases	3,452	2,885
Depreciation on property, plant and equipment	5,144	4,935
Amortisation on intangible assets	952	972
Audit fees payable to the external auditor		
audit services- statutory audit	72	58
other auditor remuneration (external auditor only)	8	18
Clinical negligence	8,462	7,693
Legal fees	131	125
Consultancy costs	145	275
Internal audit costs	94	97
Training, courses and conferences	352	515
Patient travel	105	154
Redundancy	-	101
Hospitality	4	6
Insurance	231	294
Other services, eg external payroll	763	839
Losses, ex gratia & special payments	12	26
Other	74	90
Total	**251,873**	**247,026**
Of which:		
Related to continuing operations	251,873	247,026
Related to discontinued operations	-	-

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.

	2016/17	2015/16
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	8	18
Total	**8**	**18**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2015/16: £1m).

Note 6 Employee benefits

	2016/17	2015/16
	£000	£000
Salaries and wages	126,849	125,656
Social security costs	12,928	8,675
Employer's contributions to NHS pensions	15,284	14,952
Pension cost - other	25	18
Temporary staff (including agency)	12,518	15,540
Total gross staff costs	**167,604**	**164,841**
Recoveries in respect of seconded staff	-	-
Total staff costs	**167,604**	**164,841**
Of which		
Costs capitalised as part of assets	-	-

Note 6.1 Retirements due to ill-health

During 2016/17 there were 5 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £185k (£326k in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 6.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2016/17	2015/16
	£000	£000
Salary	1065	1085
Taxable benefits		
Performance related bonuses		
Employer's pension contributions	95	95
Total	**1,160**	**1,180**

The above table outlines payments made for the benefit of the Directors and as such excludes Employers NI.
Further details of directors' remuneration can be found in the remuneration report.

Note 7 Pension costs

The default scheme is the NHS pension scheme, however some employees are not eligible to join and therefore to meet auto enrolment legislation an alternative pension scheme must be provided. Like most NHS providers this Trust procured the government backed, defined contribution, National Employment Savings Trust ("NEST") as the alternative pension scheme. Pension costs for defined contribution schemes are disclosed in Note 6.

Note 8 Operating leases

Note 8.1 The Rotherham NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

	2016/17 £000	2015/16 £000
Operating lease revenue		
Minimum lease receipts	319	339
Total	**319**	**339**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease receipts due:		
- not later than one year;	319	337
- later than one year and not later than five years;	793	943
- later than five years.	777	941
Total	**1,889**	**2,221**

Note 8.2 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

	2016/17 £000	2015/16 £000
Operating lease expense		
Minimum lease payments	3,452	2,885
Total	**3,452**	**2,885**

	31 March 2017 £000	31 March 2016 £000
Future minimum lease payments due:		
- not later than one year;	2,140	2,447
- later than one year and not later than five years;	1,074	1,384
- later than five years.	841	1,889
Total	**4,055**	**5,720**
Future minimum sublease payments to be received	-	-

Note 9 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17	2015/16
	£000	£000
Interest on bank accounts	22	48
Interest on loans and receivables	3	3
Total	**25**	**51**

Note 10.1 Finance expense

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17	2015/16
	£000	£000
Interest expense:		
Loans from the Department of Health	795	519
Finance leases	12	32
Interest on late payment of commercial debt	2	-
Total interest expense	**809**	**551**
Other finance costs	-	-
Total	**809**	**551**

Note 10.2 The late payment of commercial debts (interest) Act 1998

	2016/17	2015/16
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	2	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 11.1 Intangible assets - 2016/17

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2016 - brought forward	**17,689**	**494**	**18,183**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Additions	1,122	693	**1,815**
Reclassifications	-	-	**-**
Gross cost at 31 March 2017	**18,811**	**1,187**	**19,998**
Amortisation at 1 April 2016 - brought forward	**8,694**	**-**	**8,694**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Provided during the year	952	-	**952**
Reclassifications	-	-	**-**
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 11.2 Intangible assets - 2015/16

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - as previously stated	**17,620**	**-**	**17,620**
Prior period adjustments	-	-	**-**
Gross cost at 1 April 2015 - restated	**17,620**	**-**	**17,620**
Gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Additions	86	494	**580**
Reclassifications	(17)	-	**(17)**
Valuation/gross cost at 31 March 2016	**17,689**	**494**	**18,183**
Amortisation at 1 April 2015 - as previously stated	**7,739**	**-**	**7,739**
Prior period adjustments	-	-	**-**
Amortisation at 1 April 2015 - restated	**7,739**	**-**	**7,739**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Provided during the year	972	-	**972**
Reclassifications	(17)	-	**(17)**
Amortisation at 31 March 2016	**8,694**	**-**	**8,694**
Net book value at 31 March 2016	**8,995**	**494**	**9,489**
Net book value at 1 April 2015	**9,881**	**-**	**9,881**

Note 12.1 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 - brought forward	**6,450**	**85,880**	**1,908**	**7,211**	**29,097**	**202**	**3,841**	**180**	**134,769**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	1,416	-	8,172	361	14	189	-	**10,152**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
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 - brought forward	**-**	**4,308**	**571**	**-**	**21,690**	**153**	**2,217**	**-**	**28,939**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	3,343	68	-	1,078	19	617	19	**5,144**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	-	-	-	-	**-**
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 25.

Note 12.2 Property, plant and equipment - 2015/16

	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 2015 - as previously stated	**6,450**	**81,754**	**1,908**	**1,559**	**27,484**	**197**	**4,098**	**-**	**123,450**
Prior period adjustments	-	839	-	-	61	(11)	(830)	-	**59**
Valuation/gross cost at 1 April 2015 - restated	**6,450**	**82,593**	**1,908**	**1,559**	**27,545**	**186**	**3,268**	**-**	**123,509**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	3,938	-	5,837	1,470	-	469	180	**11,894**
Reclassifications	-	-	-	(185)	82	16	104	-	**17**
Revaluations	-	(651)	-	-	-	-	-	-	**(651)**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2016	**6,450**	**85,880**	**1,908**	**7,211**	**29,097**	**202**	**3,841**	**180**	**134,769**
Accumulated depreciation at 1 April 2015 - as previously stated	**-**	**406**	**501**	**-**	**20,480**	**121**	**2,477**	**-**	**23,985**
Prior period adjustments	-	839	-	-	61	(11)	(830)	-	**59**
Accumulated depreciation at 1 April 2015 - restated	**-**	**1,245**	**501**	**-**	**20,541**	**110**	**1,647**	**-**	**24,044**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	3,065	68	-	1,201	26	575	-	**4,935**
Reclassifications	-	(2)	2	-	-	17	-	-	**17**
Revaluations	-	-	-	-	(52)	-	(5)	-	**(57)**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2016	**-**	**4,308**	**571**	**-**	**21,690**	**153**	**2,217**	**-**	**28,939**
Net book value at 31 March 2016	**6,450**	**81,572**	**1,337**	**7,211**	**7,407**	**49**	**1,624**	**180**	**105,830**
Net book value at 1 April 2015	**6,450**	**81,348**	**1,407**	**1,559**	**7,004**	**76**	**1,621**	**-**	**99,465**

Contractual capital commitments not otherwise disclosed in the Accounts are disclosed in Note 25.

Note 12.3 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									
Owned	6,450	78,486	-	15,383	6,654	44	1,196	161	**108,374**
Finance leased	-	1,159	1,269	-	36	-	-	-	**2,464**
NBV total at 31 March 2017	**6,450**	**79,645**	**1,269**	**15,383**	**6,690**	**44**	**1,196**	**161**	**110,838**

Note 12.4 Property, plant and equipment financing - 2015/16

	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 2016									
Owned	6,450	80,355	-	7,211	7,299	49	1,624	180	**103,168**
Finance leased	-	1,217	1,337	-	108	-	-	-	**2,662**
NBV total at 31 March 2016	**6,450**	**81,572**	**1,337**	**7,211**	**7,407**	**49**	**1,624**	**180**	**105,830**

Note 13 Revaluations of property, plant and equipment

During 2014/15 and in line with IAS 16 The Trust's land and buildings were revalued as at the 31 March 2015 by an independent valuer. Since that date management review and asset verification exercises have assessed the need for impairments. As per our policy the next interim revaluation will take place at 31st March 2018.

Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. Non operational property, including land was valued to market value. Valuations are undertaken by an independent valuer.

In order to meet the underlying objectives established by International Financial Reporting Standards and the application of IAS 16 changes to the assumptions when valuing specialised operational assets were applied.

In particular, those buildings which qualify as specialised operational assets and therefore, fall to be assessed using the depreciated replacement cost approach have been valued on a modern substitute basis i.e. the valuation approach assumed that the existing asset will be replaced by an asset of modern design and size which is suitable for delivering those services currently being provided where appropriate.

Note 14 Disclosure of interests in other entities

The Rotherham Hospitals Charity

The Trust has considered the need to consolidate Charitable Funds (The Rotherham Hospital 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 2017 £000	31 March 2017 £000
Total incoming resources	107	86
Resources expended	(177)	(154)
(Losses)/Gains on revaluation and disposals	(16)	(8)
Net movement in funds	**(86)**	**(76)**
Total Assets	369	467
Total Liabilities	(1)	(13)
Total Charitable Funds	**368**	**454**

The 2016/17 Charitable Funds accounts have not yet been subject to independent review.

Note 15 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	523	684
Work In progress	-	-
Consumables	2,530	2,285
Energy	131	132
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	**3,184**	**3,101**

Inventories recognised in expenses for the year were £13,112k (2015/16: £30,880k). Write-down of inventories recognised as expenses for the year were £0k (2015/16: £0k).

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Note 16.1 Trade and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	2,408	2,458
Other receivables due from related parties	2,526	3,759
Provision for impaired receivables	(656)	(1,308)
Prepayments (non-PFI)	2,878	3,126
Accrued income	4,083	3,839
PDC dividend receivable	332	4
VAT receivable	642	857
Other receivables	514	496
Total current trade and other receivables	**12,727**	**13,231**
Non-current		
Other receivables	43	56
Total non-current trade and other receivables	**43**	**56**

Note 16.2 Provision for impairment of receivables

	2016/17	2015/16
	£000	£000
At 1 April as previously stated	**1,308**	**1,895**
Increase in provision	(405)	729
Amounts utilised	(247)	(850)
Unused amounts reversed	-	(466)
At 31 March	**656**	**1,308**

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. RTA debts are provided for at 22.94% per the guidance.

Note 16.3 Analysis of financial assets

	31 March 2017		31 March 2016	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	0	1	156	-
30 - 60 Days	12	6	5	3
60 - 90 days	1	8	5	6
90 - 180 days	37	32	92	30
Over 180 days	606	457	305	707
Total	**656**	**504**	**563**	**746**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	281	4	1,003	-
30 - 60 Days	430	21	336	11
60 - 90 days	104	26	54	22
90 - 180 days	225	109	479	107
Over 180 days	271	1,535	147	1,755
Total	**1,311**	**1,695**	**2,019**	**1,895**

The majority of the debts owed to the Trust fall within the Whole of Government Accounts Boundary (i.e. the United Kingdom Public Sector). As such the credit risk associated with receivables neither past their due date or not impaired is not viewed as a high risk by the Trust as it is unlikely that institutions within these sectors will not be able to pay their debts.

Note 17.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2016/17	2015/16
	£000	£000
At 1 April	**3,609**	**9,347**
Prior period adjustments	-	-
At 1 April (restated)	**3,609**	**9,347**
Net change in year	(2,106)	(5,738)
At 31 March	**1,503**	**3,609**
Broken down into:		
Cash at commercial banks and in hand	119	338
Cash with the Government Banking Service	1,384	3,271
Total cash and cash equivalents as in SoFP	**1,503**	**3,609**
Total cash and cash equivalents as in SoCF	**1,503**	**3,609**

In 2016/17 the Trust did not have an overdraft (2015/16 Nil)

The Trust's cash balance are held in the Government Banking Service (RBS) and HSBC which are considered low risk institutions.

Note 17.2 Third party assets held by the NHS foundation trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2017	31 March 2016
	£000	£000
Bank balances	-	1
Total third party assets	**-**	**1**

Note 18 Trade and other payables

	31 March 2017 £000	31 March 2016 £000
Current		
Receipts in advance	820	-
NHS trade payables	1,295	576
Amounts due to other related parties	2,085	2,124
Other trade payables	5,010	4,185
Capital payables	1,344	1,073
Social security costs	1,763	1,433
VAT payable	95	37
Other taxes payable	1,350	1,303
Other payables	71	58
Accruals	10,691	12,047
PDC dividend payable	-	-
Total current trade and other payables	**24,524**	**22,836**

Note 19 Other financial liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	96	96
Total	**96**	**96**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	1,842	1,938
Total	**1,842**	**1,938**

Note 20 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Other deferred income	1,324	1,553
Total other current liabilities	**1,324**	**1,553**

Note 21 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Loans from the Department of Health	3,375	3,375
Obligations under finance leases	31	142
Total current borrowings	**3,406**	**3,517**
Non-current		
Loans from the Department of Health	34,969	25,563
Obligations under finance leases	14	45
Total non-current borrowings	**34,983**	**25,608**

Note 22 Finance Leases

Obligations under finance leases where the Trust is the lessee.

	31 March 2017 £000	31 March 2016 £000
Gross lease liabilities	**45**	**187**
of which liabilities are due:		
- not later than one year;	31	142
- later than one year and not later than five years;	14	45
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	**45**	**187**
of which payable:		
- not later than one year;	31	142
- later than one year and not later than five years;	14	45
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

There are no sublease or contingent rent arrangements.

Note 23.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Other	Total
	£000	£000	£000
At 1 April 2016	**1,037**	**994**	**2,031**
At start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Change in the discount rate	161	-	**161**
Arising during the year	-	(32)	**(32)**
Utilised during the year	(79)	-	**(79)**
Reclassified to liabilities held in disposal groups	-	-	**-**
Reversed unused	-	(843)	**(843)**
Unwinding of discount	-	-	**-**
At 31 March 2017	**1,119**	**119**	**1,238**
Expected timing of cash flows:			
- not later than one year;	79	-	**79**
- later than one year and not later than five years;	314	-	**314**
- later than five years.	726	119	**845**
Total	**1,119**	**119**	**1,238**

The pensions provision relates to the ongoing costs of making early payment of pensions. The "other" category relates to liabilities to third parties/property expenses (administered by the NHS Litigation Authority) plus the cost of annual leave carried forward. The latter provision has been fully reversed to income and expenditure account on the basis that staff have been instructed to utilise all their annual leave in year. 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 23.2 Clinical negligence liabilities

At 31 March 2017, £45,544k was included in provisions of the NHSLA in respect of clinical negligence liabilities of the Trust (31 March 2016: £39,511k).

Note 24 Contingent assets and liabilities

	31 March 2017 £000	31 March 2016 £000
Value of contingent liabilities		
NHSLA legal claims	(119)	(73)
Gross value of contingent liabilities	**(119)**	**(73)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(119)**	**(73)**
Net value of contingent assets	**-**	**-**

Note 25 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment*	956	3,921
Intangible assets	-	-
Total	**956**	**3,921**

**The Trust's capital scheme to continue the work on the new Emergency Care Centre. Costs disclosed here are committed to under contract, but so far not already included within these accounts.*

Note 26 Financial instruments

Note 26.1 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 2017 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 26.2 Financial assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	6,608	-	-	-	**6,608**
Cash and cash equivalents at bank and in hand	1,503	-	-	-	**1,503**
Total at 31 March 2017	**8,111**	**-**	**-**	**-**	**8,111**

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total £000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	5,461	-	-	-	**5,461**
Cash and cash equivalents at bank and in hand	3,609	-	-	-	**3,609**
Total at 31 March 2016	**9,070**	**-**	**-**	**-**	**9,070**

Note 26.3 Financial liabilities

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	38,344	-	**38,344**
Obligations under finance leases	45	-	**45**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	20,546	-	**20,546**
Other financial liabilities	-	-	**-**
Provisions under contract	1,238	-	**1,238**
Total at 31 March 2017	**60,173**	**-**	**60,173**

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	28,938	-	**28,938**
Obligations under finance leases	187	-	**187**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	20,063	-	**20,063**
Other financial liabilities	-	-	**-**
Provisions under contract	2,031	-	**2,031**
Total at 31 March 2016	**51,219**	**-**	**51,219**

Note 26.4 Maturity of financial liabilities

	31 March 2017	31 March 2016
	£000	£000
In one year or less	24,151	25,657
In more than one year but not more than two years	3,468	3,375
In more than two years but not more than five years	17,828	6,937
In more than five years	14,726	15,250
Total	**60,173**	**51,219**

Note 27 Losses and special payments

	2016/17		2015/16	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	-	12	1
Bad debts and claims abandoned	5	34	144	780
Total losses	**6**	**34**	**156**	**781**
Special payments				
Compensation payments	6	11	-	-
Ex-gratia payments	17	9	33	47
Total special payments	**23**	**20**	**33**	**47**
Total losses and special payments	**29**	**54**	**189**	**828**
Compensation payments received	-	-	-	-

Note 28 Events after the reporting period

There have been no significant events after the reporting period date.

Note 29 Related parties

This note discloses organisations with which the Trust has income and expenditure balances over £500K within the DH group, with the Department of Health being our parent body; along with the associated receivables and payables at the year end for those same related parties.

	Income		Expenditure	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Barnsley Hospital NHS Foundation Trust	621	892	4,649	5,963
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	520	917	1,262	1,349
Rotherham, Doncaster and South Humber NHS Foundation Trust	720	640	168	124
Sheffield Teaching Hospitals NHS Foundation Trust	2,384	1,837	4,531	4,219
Sheffield Children's NHS Foundation Trust	78	71	1,090	1,111
NHS Barnsley CCG	12,531	13,235	-	-
NHS Bassetlaw CCG	661	626	-	-
NHS Doncaster CCG	4,791	4,394	-	-
NHS North Derbyshire CCG	528	561	1	2
NHS Rotherham CCG	172,573	168,722	10	14
NHS Sheffield CCG	5,492	5,407	25	-
Health Education England	6,189	6,047	-	-
NHS England	19,495	16,793	6	-
Rotherham Borough Council	10,262	8,584	1,477	565
HM Revenue & Customs	-	-	12,928	8,675
NHS Pension Scheme	-	-	15,284	14,952
NHS Blood and Transplant	13	16	892	863
NHS Litigation Authority	-	-	8,680	7,944
NHS Property Services	25	206	2,661	2,479
Total	**236,883**	**228,948**	**53,664**	**48,260**

	Receivables		Payables	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Barnsley Hospital NHS Foundation Trust	614	559	1,646	2,588
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	391	939	824	1,093
Rotherham, Doncaster and South Humber NHS Foundation Trust	-	93	9	-
Sheffield Teaching Hospitals NHS Foundation Trust	470	377	1,222	607
Sheffield Children's NHS Foundation Trust	49	57	141	111
NHS Barnsley CCG	72	70	852	52
NHS Bassetlaw CCG	4	4	-	-
NHS Doncaster CCG	1	-	102	98
NHS North Derbyshire CCG	-	68	-	1
NHS Rotherham CCG	3,044	1,778	1,240	1,278
NHS Sheffield CCG	38	447	41	33
Health Education England	32	-	-	-
NHS England	143	743	-	335
Rotherham Borough Council	396	385	719	356
HM Revenue & Customs	642	857	3,113	2,773
NHS Pension Scheme	-	-	-	-
NHS Blood and Transplant	-	-	3	-
NHS Litigation Authority	-	-	-	13
NHS Property Services	-	-	1,256	811
	5,896	**6,377**	**11,168**	**10,149**

The Rotherham Hospital Charity is also considered a related party. Transactions between the charity and the trust are currently immaterial.

Independent auditors' report to the Council of Governors of The Rotherham NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion, The Rotherham NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health Group Accounting Manual 2016/17.

Emphasis of Matter - Going Concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of disclosures made in note 1 (Accounting Policies) to the financial statements concerning the Trust's ability to continue as a going concern.

The Trust has produced a plan for 2017/18 which indicates a deficit of £13.6m, however, as at the date of writing this report, the Trust has not yet agreed a control total with NHS Improvement for the 2017/18 financial year. 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 and will be agreed on a monthly basis.

These conditions, along with the other matters documented in note 1 to the financial statements, indicate the existence of 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 was unable to continue as a going concern.

What we have audited

The financial statements comprise:

- the Statement of Financial Position as at 31 March 2017;
- the Statement of Comprehensive Income for the year ended 31 March 2017;
- the Statement of Cash Flows for the year ended 31 March 2017;
- the Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

Certain required disclosures have been presented elsewhere in the Annual Report and Accounts (the "Annual Report"), rather than in the notes to the financial statements. These are cross-referenced from the financial statements and are identified as audited.

The financial reporting framework that has been applied in the preparation of the financial statements is the Department of Health Group Accounting Manual 2016/17 (the "GAM 16/17").

Our audit approach

The Rotherham NHS Foundation Trust Context

The 2016/17 financial year audit is the first year that PwC LLP have audited the Trust. In the year the Trust experienced financial pressure delivering a £6.5m deficit for the year, whilst also requiring working capital financial loan support of £12.8m. The licence condition placed on the Trust on 23 April 2013 by Monitor, regarding financial planning remains in force. Within the year the Trust has also 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.

Overview

- Overall materiality: £4,968,000 which represents 2% of total revenue.
- This was our first 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. We were also mindful of the risks identified by the predecessor auditor in developing our approach.
- Principal areas of focus and risk were:
  - 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 and our areas of focus

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"), and International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").

We designed our audit by determining materiality and assessing 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.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

Areas of focus	***How our audit addressed the area of focus***
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 £6.5m, 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.	*Revenue* recognition and found it to be consistent with the requirements of the GAM 16/17. For income/receivable transactions close to the year-end we tested, on a sample basis that the transactions and the associated income had been posted to the correct financial year by tracing them to invoices or other documentary evidence. Our testing did not identify any items incorrectly recorded. We obtained the five largest contracts across Clinical Commission Groups ("CCG") and NHS England and management's reconciliations of the contract value to the income received in year. We tested material reconciling

Area of focus

- In order to receive Sustainability and Transformation Funding of £6.5m, the Trust needed to achieve its control total for 2016/17 of £0.1m surplus, providing further incentive to manipulate timing of both revenue and expenditure.
- For 2017/18 the Trust Board has agreed a financial plan resulting in a deficit of £13.6m, 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.

How our audit addressed the area of focus

items within management's contract reconciliations, we did not identify any material errors in these reconciliations.

We tested a sample of income to patient data (where relevant) or invoices and subsequent cash received (for NHS and non-NHS income) to check whether it had been correctly recorded, and this did not identify any items requiring amendment in the financial statements.

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) and a sample of balances between £100k and £250k.

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;

Area of focus

Financial standing and sustainability

Refer to the Annual Governance Statement, note 1 to the financial statements and the Annual Report.

We focussed on this area due to the Trust's current financial position and its deterioration in the current year against its financial plan, and reliance on financial support, leading to uncertainty over the Trust's ability to continue as a going concern.

The current year's deficit of £6.5m (excluding STF: £9.6m deficit) compares to an original plan of £6.6m surplus (excluding STF: £0.1m surplus), meaning an adverse variance of £9.7m.

The £6.5m deficit is after the achievement of £9.8m of Cost Improvement savings against a plan of £10.5m, (approximately 5% of controllable costs) with the full year effect of schemes being £12.6m.

At the end of 2016/17 the Trust had a cash balance of £1.5m, largely due to the drawdown of working capital loans in the year of £12.8m.

For 2017/18 the Trust Board has agreed a financial plan that has a deficit of £13.6m

Based on the financial plan for 2017/18, the Trust will require further financial support from the Department of Health. 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 NHSI on a monthly basis.

In addition, the Trust's licence condition in relation to financial performance remains in place.

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.

A valuation was last carried out as at 31 March 2015, by a professionally qualified valuer in accordance with the Royal

How our audit addressed the area of focus

- deferred income; and
- Property, Plant and Equipment Valuation (see specific area of focus below).

We evaluated and challenged the key accounting estimates on which management's estimates were based and the basis of their calculation on a sample basis by:

- comparing the assumptions used by management in the calculation of their estimate with independent assumptions and investigating any differences.

Our testing identified no matters that required amendment within the financial statements of the Trust.

In considering the appropriateness of the Going Concern basis in the preparation of the financial statements we obtained the 2017/18 financial plan and cashflow 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 £8.5m, of which 60% is anticipated to be delivered in the last half of the year;
- 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 2017/18 plan, which at the time of approval of the financial statements the nature and amount had not been agreed.

Given the results of our testing we have included an Emphasis of Matter paragraph in our report as noted above.

We obtained an impairment assessment undertaken by the Trust, evaluated the assumptions therein and tested where appropriate to source documentation. This considered:

- The predecessor auditor working papers, understanding procedures performed by them on the last valuation exercise in March 2015 and agreeing this to the financial statements.
- Movement in the Building Cost Information Service Public Sector Tender Price indices between 1 April 2015 and 1 April 2017 (whilst this is not 31 March 2017, it would not be materially different);
- Asset maintenance, any demolition, back log maintenance (through obtaining the estates strategy); and
- Insurance valuation.

The impairment assessment undertaken by the Trust did not

Area of focus	*How our audit addressed the area of focus*
Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In 2016/17 the Trust has carried out an impairment assessment, which has not indicated any impairment to the Land and Buildings held by the Trust.	indicate a risk of impairment. Based on our work, we agreed with this determination. 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.

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 structure of the trust, the accounting processes and controls, and the environment in which the trust operates. As this was our first year auditing the financial statements of the Trust, we also reviewed the working papers of the predecessor auditor to inform our approach.

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	£4,968,000
How we determined it	2% of revenue
Rationale for benchmark applied	We 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 £240,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Other reporting

Opinions on other matters prescribed by the Code of Audit Practice

In our opinion:

- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- 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 2016/17.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code we are required to report to you if we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Basis of adverse conclusion

Licence condition

On 23 April 2013 (amended June 2013, September 2013 and January 2015), Monitor issued enforcement undertakings to the Trust in respect of breaches relating to financial planning, governance and Electronic Patient Records (EPR). Compliance certificates, in relation to Electronic Patient Records and governance breaches, were subsequently issued by Monitor in July 2014 and January 2015 respectively, however as at 31 March 2017 the Trust still remains subject to enforcement action in relation to financial planning breaches. The issued enforcement action states that the Trust had not demonstrated that it had established and effectively implement systems and/or processes to ensure compliance with its duty to operate economically, efficiently and effectively.

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

Financial Performance

In 2016/17 the Trust originally planned a budget surplus of £0.1m excluding Sustainability and Transformation Funding ('STF') of £6.5m. The Trust experienced financial pressure during the year that resulted in not meeting the control total from Q3 onwards. This position was not recovered in the latter part of the year and the Trust delivered a £9.7m deficit (£6.5 including STF received in year of £3.2m), representing a £9.8m negative variance from the planned budget deficit. In addition the deterioration of the financial position at the end of 2016/17, also impacts the 2017/18 performance given the adverse run rate into 2017/18.

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

CQC Inspection Results

In September 2016, the Trust had a focussed follow up Care Quality Commission (CQC) inspection. The outcome of the inspection was received on 2 March 2017, with an overall 'requires improvement' rating being determined. The CQC reported that whilst improvements had been made, there still remained areas that required further improvement.

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 the matters above, 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 2017.

Other matters on which we report by exception

We are required to report to you if:

- information in the Annual Report is:
  - materially inconsistent with the information in the audited financial statements; or
  - apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
  - otherwise misleading.
- the statement given by the directors within the Accountability Report, 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 Group and Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the Accountability Report section of the Annual Report, 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 2016/17 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 no matters to report in relation to these responsibilities.

Respective responsibilities of the Directors and the Auditor

As explained more fully in the Accountability Report the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the Department of Health Group Accounting Manual 2016/17.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Code of Audit Practice, and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. 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.

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.

What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice

Ian Looker (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Leeds

30 May 2017

(a) The maintenance and integrity of The Rotherham NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Acknowledgements

The Rotherham NHS Foundation Trust would like to thank everyone who provided the information for this report, who gave their consent to be photographed, who gave permission for their comments to be included, and to everyone who assisted in ensuring clarity throughout this publication.