The Trust's Constitution states that:

31.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

In view of the current coronavirus pandemic and governmental advice, the Board of Directors has taken the decision that members of the public are excluded from this meeting for special reasons, i.e. governmental advice re social distancing.

However, should members of the public have any questions relating to the items on the agenda, please forward these to Anna.Milanec@nhs.net by 1pm on Monday 1st June 2020.

<table>
<thead>
<tr>
<th>Time</th>
<th>Item no.</th>
<th>Page</th>
<th>Required Actions</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>176/20</td>
<td></td>
<td>verbal</td>
<td>- For noting</td>
</tr>
<tr>
<td></td>
<td>177/20</td>
<td></td>
<td>verbal</td>
<td>- For noting</td>
</tr>
</tbody>
</table>

**Procedural Items**

| 178/20 | Minutes of the previous meeting held on 5 May 2020 | Enc. 3 | For approval |
| 179/20 | Matters arising from the previous minutes (not covered elsewhere on the agenda) | Verbal - | For noting |
| 180/20 | Action Log | Enc. 14 | For approval |

**Strategy and Strategic Planning**

<p>| 181/20 | Report from the Chairman | Enc. 15 | For noting |
| 182/20 | Report from the Chief Executive | Enc. 17 | For noting |
| 183/20 | National, Integrated Care System and Rotherham Place Report | Enc. 24 | For noting |
| 184/20 | 2020/21 Transformation Plan Report | Enc. 27 | For noting |
| 185/20 | Five Year Strategy Refresh | Enc. 36 | For noting |</p>
<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Description</th>
<th>Reference</th>
<th>Page</th>
<th>Action</th>
<th>Approving Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>186/20</td>
<td>People Strategy</td>
<td>Enc.</td>
<td>37</td>
<td>For approval</td>
<td>Steve Ned, Director of Workforce</td>
</tr>
<tr>
<td><strong>Operational</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>187/20</td>
<td>COVID-19 Report</td>
<td>Enc.</td>
<td>62</td>
<td>For noting</td>
<td>George Briggs, Chief Operating Officer</td>
</tr>
<tr>
<td>188/20</td>
<td>Assurance Committee updates</td>
<td>Verbal</td>
<td>-</td>
<td>For noting</td>
<td>Committee Chairs and Lead Executives</td>
</tr>
<tr>
<td>189/20</td>
<td>Monthly Integrated Performance Report</td>
<td>Enc.</td>
<td>83</td>
<td>For noting</td>
<td>Michael Wright, Deputy Chief Executive</td>
</tr>
<tr>
<td>189/20(a)</td>
<td>Quality Report</td>
<td>Enc.</td>
<td>85</td>
<td>For noting (and approval in part)</td>
<td>Angela Wood, Chief Nurse; Dr Callum Gardner, Medical Director</td>
</tr>
<tr>
<td>189/20(b)</td>
<td>Operational Report</td>
<td>Enc.</td>
<td>114</td>
<td>For noting</td>
<td>George Briggs, Chief Operating Officer</td>
</tr>
<tr>
<td>189/20(c)</td>
<td>Workforce Report</td>
<td>Enc.</td>
<td>121</td>
<td>For noting</td>
<td>Steve Ned, Director of Workforce</td>
</tr>
<tr>
<td>189/20(d)</td>
<td>Finance Report</td>
<td>Enc.</td>
<td>127</td>
<td>For noting</td>
<td>Steve Hackett, Interim Director of Finance</td>
</tr>
<tr>
<td>190/20</td>
<td>Digital Strategy Report including Engagement and Data Quality</td>
<td>Enc.</td>
<td>136</td>
<td>For noting</td>
<td>Michael Wright, Deputy Chief Executive</td>
</tr>
<tr>
<td><strong>Assurance Framework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>191/20</td>
<td>Governance Report</td>
<td>Enc.</td>
<td>145</td>
<td>For noting (and approval in part)</td>
<td>Anna Milanec, Director of Corporate Affairs / Company Secretary</td>
</tr>
<tr>
<td>192/20</td>
<td>Board Assurance Framework</td>
<td>Enc.</td>
<td>157</td>
<td>For approval</td>
<td>Anna Milanec, Director of Corporate Affairs / Company Secretary</td>
</tr>
<tr>
<td>193/20</td>
<td>Risk Management Report</td>
<td>Enc.</td>
<td>161</td>
<td>For noting</td>
<td>Angela Wood, Chief Nurse</td>
</tr>
<tr>
<td>194/20</td>
<td>Disciplinary Policy</td>
<td>Enc.</td>
<td>171</td>
<td>For approval</td>
<td>Steve Ned, Director of Workforce</td>
</tr>
<tr>
<td><strong>Regulatory and Statutory Reporting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>195/20</td>
<td>Annual Report and Accounts 2019/20</td>
<td>Enc.</td>
<td>216</td>
<td>For approval</td>
<td>Steve Hackett, Interim Director of Finance</td>
</tr>
<tr>
<td>196/20</td>
<td>Audit Committee Annual Report</td>
<td>Enc.</td>
<td>217</td>
<td>For noting</td>
<td>Joe Barnes, Non-Executive Director Chair of Audit Committee</td>
</tr>
<tr>
<td>197/20</td>
<td>Annual Board of Directors' Self Certifications</td>
<td>Enc.</td>
<td>225</td>
<td>For approval</td>
<td>Anna Milanec, Director of Corporate Affairs / Company Secretary</td>
</tr>
<tr>
<td>198/20</td>
<td>Learning from Deaths Report (Annual)</td>
<td>Enc.</td>
<td>249</td>
<td>For noting</td>
<td>Dr Callum Gardner, Medical Director</td>
</tr>
<tr>
<td><strong>Board Governance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>199/20</td>
<td>Any other business</td>
<td>-</td>
<td>-</td>
<td>For approval</td>
<td>Martin Havenhand, Chairman</td>
</tr>
<tr>
<td>200/20</td>
<td>Date of next meeting: Tuesday 7 July 2020</td>
<td>-</td>
<td>-</td>
<td>For noting</td>
<td>Martin Havenhand, Chairman</td>
</tr>
</tbody>
</table>

In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting.
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON TUESDAY 5 MAY 2020 HELD VIRTUALLY, by ZOOM

Present: Mr M Havenhand, Chairman
Miss N Bancroft, Non-Executive Director
Mr J Barnes, Non-Executive Director
Mr G Briggs, Chief Operating Officer
Mrs H Craven, Non-Executive Director
Mr M Edgell, Non-Executive Director
Dr C Gardner, Executive Medical Director
Ms L Hagger, Non-Executive Director
Dr R Jenkins, Chief Executive
Mr S Ned, Director of Workforce
Dr R Shah, Non-Executive Director
Mr M Smith, Non-Executive Director
Ms A Wood, Chief Nurse
Mr M Wright, Deputy Chief Executive

In attendance: Mr J Garner, Divisional Director, Surgery
Ms A Milanec, Director of Corporate Affairs / Company Secretary
Dr J Reynard, Interim Divisional Director, Urgent and Emergency Care
Miss D Stewart, Corporate Governance Manager (minutes)
Mrs G Willers, Interim Divisional Director Family Health

Apologies: Dr P Jha, Divisional Director, Medicine
Mr S Sheppard, Director of Finance

Observer: Mr G Rimmer, Lead Governor
Lieutenant Colonel R MacPherson, Public Governor

141/20 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed all present with any apologies having been noted.

The Chairman indicated that in order to follow COVID-19 national guidance the Board meeting was being held virtually.

The Chairman outlined the arrangements for the meeting, with it being noted that two Governors, including the Lead Governor, had been invited to join the meeting as observers. Additionally, the meeting was being recorded and would be available on the Trust’s website for the general public and Council of Governors to access.

Before commencing formalities, the Chairman once again, on behalf of the Board conveyed his appreciation to the Chief Executive, executive colleagues and all staff across the organisation for their endeavours in relation to COVID-19. It was greatly appreciated by the Board and the population of Rotherham.
142/20 **DECLARATIONS OF CONFLICTS OF INTERESTS**

Mr Ned’s interest, in terms of his joint role as Director of Workforce with both the Trust and Barnsley Hospital NHS Foundation Trust, was noted.

Additionally, Dr Jenkins interest in terms of his joint role as Chief Executive of both the Trust and Barnsley Hospital NHS Foundation Trust, was noted.

Colleagues were asked that should any further conflict of interest become apparent during discussions they should be highlighted.

**PROCEDURAL ITEMS**

143/20 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 7 April 2020 were agreed as a correct record.

144/20 **MATTERS ARISING FROM THE PREVIOUS MEETING**

There were no matters arising which were not either covered by the action log or agenda items.

145/20 **ACTION LOG**

The Board of Directors considered its action log and agreed that numbers 1, 3, 10, 14 and 17 could be closed and number 9 would be moved to the forward planner.

Dr Jenkins confirmed that in relation to number 15, the Rotherham Together Partnership had been informed of the Board’s support to the Social Value Charter. As such the Board agreed that this action could also be closed.

Log numbers 12, 13 and 16 would remain open.

**STRATEGY AND STRATEGIC PLANNING**

146/20 **REPORT FROM THE CHAIRMAN**

The Board of Directors received the report from the Chairman.

The Board noted that as a consequence of national guidance the April 2020 Council of Governors meeting had not taken place. However, the agenda and any supporting papers had been circulated, with Governors being afforded the opportunity to ask questions in relation to the reports presented. For completeness, appended to the Chairman’s Report was the response to the Council of Governors on the questions they had raised.

The Board of Directors noted the report.
REPORT FROM THE CHIEF EXECUTIVE

The Board of Directors received the report from the Chief Executive, which in the main provided an update with regard to COVID-19 and the Trust's position.

In noting the content of the report, the Board discussed the latest position in terms of national and international clinical trials on anti-viral drugs, and any emerging evidence of the success of experimental treatments for COVID-19.

It was noted that clinical trials, which had included the Trust, continued and some treatments had been of some benefit to patients. However, there remained a requirement for trials to be fully completed and so at this time there remained no widely available and effective drug to treat COVID-19.

As it was widely considered that the pandemic peak was diminishing, appended to the report was a letter from the NHS Chief Executive and NHS Chief Operating Officer outlining the second phase of the NHS response to COVID-19. Dr Jenkins indicated that the Executive Directors would review and undertake a gap analysis of the requirements, with the findings to be presented to the Board Assurance Committees prior to the Board of Directors.

ACTION – Chief Operating Officer

Mrs Craven sought insight as to the pressures being faced by colleagues, and the resumption of operational activities, particularly in the knowledge that colleagues, in due course, will potentially be seeking time off work. Dr Jenkins indicated that although COVID-19 cases were falling, a key factor in resuming normal operational activity would be the availability of sterile surgical gowns, which currently, due to limited national availability, were being reserved only for emergency surgery.

Dr Jenkins continued that the national move to ‘test, track and trace’ would reduce the impact of any second peak, enabling South Yorkshire to potentially consolidate COVID-19 activities to one designated hospital. This would enable other hospitals to resume activities, albeit dependent upon personal protective equipment (PPE) availability.

The first phase response to the pandemic had been to cease routine activities, with the exception of emergency and cancer. There had been a fall in attendances at the Emergency department, with cancer seeing a significant drop in referrals. In terms of the latter, a tiered prioritisation programme had been established for those still being referred.

Dr Garner confirmed that all urgent cancer operations continued, either at the Trust or within the private sector, as had urgent cancer diagnostics. In a number of instances, when offered a date, some patients had declined.

In terms of cancer patients already on their care pathway, who may have waited longer than 38 and 62 days (as demonstrated by later reports), Mr Edgell questioned whether the organisation could have done more to reassure those patients to continue their treatment. Dr Jenkins indicated that those patients beyond day 38 were either awaiting surgery at another organisation, which may be affected by the availability of sterile surgical gowns, or for treatment at Weston...
Park Hospital. Whilst not all cancer treatments were time sensitive, clinical colleagues continued to be proactively engaged in the patients’ care.

The Board was informed that currently there were 700 cancer patients in the system. 64 were classed as high risk and would be treated in the next few weeks, 120 classed as medium risk, 133 low risk and the remaining number having been assessed as unlikely to have cancer. The position was being monitored on a weekly basis, with welfare clinics having been established to ensure proactive communication with patients.

It remained key that cancer pathways returned to normal as soon as possible.

In terms of outpatients, virtual clinics had been held where feasible, with all specialities in the process of validating their waiting lists to support the recovery phase.

In concluding his report, Dr Jenkins commented that COVID-19 would continue until a vaccine was found and the Trust and wider NHS had to be adaptive in its response, and in many instances, was accelerating implementation of the NHS Long Term Plan.

The Board of Directors noted the report from the Chief Executive.

148/20 NATIONAL, INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP REPORT

The Board of Directors received the National, Integrated Care System (ICS) and Integrated Care Partnership (Place) report from the Deputy Chief Executive.

Mr Wright indicated that positive relationships and collaborations continued across the ICS and Place during COVID-19 pandemic.

The Board was informed that the Trust was one of fifteen national organisations selected to lead on PPE procurement. This recognition built upon the comments recorded in the minutes of the last meeting of the work of the Trust's Procurement department in this area.

The Board of Directors noted the report.

OPERATIONAL PERFORMANCE

149/20 OPERATIONAL PLAN QUARTERLY REPORT Q4 2019/20

The Board of Directors received the Operational Plan quarter four report from the Deputy Chief Executive which provided an update on progress of delivery of the operational objectives and enablers for 2019/20.

Of the 31 commitments for 2019/20, seven had been either completed or closed before the end of the quarter. An additional six had been delivered as planned, seven were behind plan with recovery actions in place, and eleven had not
delivered their full scope within the financial year. The COVID-19 response considered to have had a material effect on some of the outcomes.

Mr Wright indicated that the Trust's position had been considered by the Finance and Performance Committee, who had suggested that deliverables for future operational plan should be specific and measurable.

**ACTION – Deputy Chief Executive**

He would support the suggestion from a number of Board colleagues that there be a formal review of performance against the 2019/20 Operational Plan and analysis as to why it had not been fully delivered.

**ACTION – Deputy Chief Executive**

In terms of the specific commitment to continue to roll out Service Line Management (SLM), Mr Edgell questioned how this would be implemented post COVID-19 if it was still considered appropriate in supporting the Trust. Dr Jenkins commented that having a wider knowledge of SLM from other organisations, it did require a lot of effort to implement, and did not always result in tangible benefits. He advised that other traditional measures, which would support the Trust, could be established first in advance of implementing SLM.

The Board of Directors noted the Operational Plan Quarterly Report and the review of 2019/20 performance.

**150/20 COVID-19 REPORT**

The Board of Directors received the report which detailed the comprehensive actions taken by the Trust and provided details of how delivery of essential care, in response to COVID-19, had been managed.

As discussed as part of the Chief Executive’s Report, with the exception of urgent cancer treatment and emergency care, all other routine activities had ceased in accordance with national guidance.

Mr Briggs confirmed that the report detailed the actions taken in the initial phases of the pandemic and the response to national guidance. Future reports would detail actions taken to address subsequent national guidance, including the approach taken with regard to emergency care and cancer.

Mr Havenhand commented that it remained important to reassure patients, and the wider community, that services for cancer were being maintained during the pandemic.

In the Board of Directors noting the report, Mr Havenhand indicated that this remained an important report for both the Board and the population of Rotherham to be assured of the actions being taken in response to COVID-19.

**151/20 ASSURANCE COMMITTEE UPDATES**

The Board of Directors noted the verbal update provided by the Non-Executive
Director Chair and Lead Executive from the Board Assurance Committees held in April 2020:

i. **Quality Committee**
The main area of focus for the Committee had been in relation to COVID-19, the ethical application of treatment, and maintaining the quality of care for all patients, including those non-positive patients.

ii. **Finance and Performance Committee**
The Committee had been informed of the impact from COVID-19 and altered arrangements for issues such as waiting list management. It was anticipated that a number of new, and efficient ways of working would continue post COVID-19.

Focus had been given to the significant deterioration of the financial position in quarter four, and the actions which will be required in 2020/21 in response to the independent review of the year-end outturn. Further details on the scope of the review would be considered at the next Committee meeting.

In addition, Mr Wright indicated that he would be reviewing the cash flow position and the budget and control measures in place for capital expenditure, which had overspent in month 12, resulting in some carry forward into 2020/21.

iii. **People Committee**
At its inaugural meeting, the Committee had considered areas in which it could support the organisation during COVID-19 and moving to the next phases. This would include consideration of plans and milestones.

There remained a requirement for the Executive Directors to discuss elements of workforce activity, currently considered by Board Assurance Committees other than the People Committee, to ensure there was a clear demarcation of responsibilities and reporting, thereby avoiding duplication of work.

**ACTION – Chief Executive**

In noting the updates from each Committee, Mr Havenhand confirmed that a decision had been taken to continue to hold virtual Board Assurance Committees during the pandemic, albeit with amended agendas and work plans.

152/20 **MONTHLY INTEGRATED PERFORMANCE REPORT**

The Board of Directors received and noted the Integrated Performance Report (IPR), with detailed information on a number of matters contained within subsequent reports.

152/20(a) **QUALITY REPORT**

The Board of Directors received the Quality Report presented by the Chief Nurse and Executive Medical Director.

Ms Wood confirmed that although national reporting in relation to harm free care had been suspended, the Trust continued to monitor patient safety through the weekly Harm Free meeting.
With regard to mortality, Dr Gardner reported that 90% of all recent deaths had been reviewed by the Medical Examiner. Whilst the number of Structured Judgement Reviews had reduced, the mortality position continued to be closely monitored, with the Medical Examiner now being supported by the new ‘Learning from Deaths’ Nurse.

Dr Gardner continued to explain that, following investigations, it had become apparent that a third of all non-elective admissions had been recorded as ‘observations’ rather than ‘Non-Elective Activity’ (NELs), which had had a detrimental impact on the Hospital Standardised Mortality Ratio; ‘observations’ are not counted within HSMR data, and this is out of step with other organisations. It was noted that data recording in this area had been corrected from 1 April 2020.

However, undoubtedly COVID-19 deaths would have an impact on the Trust’s mortality statistics, although it was anticipated that there would be a national rebasing of the position, which may offset the position.

Although directly not detailed in the report, Ms Hagger as Chair of the Organ Donation Committee, questioned the position with regards to organ donation during the pandemic. Dr Gardner confirmed that whilst nationally donations had been minimised, there was no reason why the Trust’s Organ Donation Committee could not meet virtually. As such, he would make contact with the Trust’s Organ Donation lead, however as a Consultant Anaesthetist she was currently integral to the COVID-19 arrangements. **ACTION – Medical Director**

The Board of Directors noted the Quality Report.

**152/20(b) OPERATIONAL PERFORMANCE REPORT**

The Board of Directors received the Operational Performance Report presented by the Chief Operating Officer.

Mr Briggs highlighted the changing performance landscape as a result of COVID-19. There had been a significant reduction in delayed transfers of care and, although the pilot of the emergency care standards had been put on hold, attendance rates at the Urgent and Emergency Care Centre continued to be low, with, in the main, only complex cases presenting.

In terms of partnership relationship, as indicated earlier Rotherham Place were proactively working to support the Trust to ensure patients were discharged and supported within the community. It was anticipated that this level of co-operation would continue post COVID-19.

The Board of Directors noted the report.

**152/20(c) WORKFORCE REPORT**

The Board of Directors received the Workforce Report presented by the Director of Workforce.
In response to a question relating to the number of new colleagues joining the Trust to specifically support COVID-19, Dr Gardner confirmed that twenty-six medical students had joined the Trust. Each had completed a two-day training programme and had been allocated to a specific service, with named supervisor. All had been offered personal support by Dr Gardner, with the ability to raise any concerns they may have.

Ms Wood additionally confirmed that the forty-two third year student nurses in their final six months of training had joined the Trust. They had each chosen the areas they wished to support, had undergone a three-day induction and allocated a support buddy. Whilst 50% of these nurses would already be substantively joining the Trust at the end of their training, it was anticipated that in working with the Trust over the coming months, the number could increase.

With regard to the ‘Bringing Back Staff’ national scheme, which had seen a good response for Rotherham, Mr Ned agreed to circulate a breakdown of the twenty-nine workers who had signed up. ACTION – Director of Workforce

The report additionally highlighted the new ways of working, in such as provision of virtual training, as a result of COVID-19, which it was anticipated could continue to be taken forward.

The Board of Directors noted the Workforce Report.

152/20(d)  FINANCE REPORT

The Board of Directors received the month twelve Finance Report presented by the Deputy Chief Executive.

As discussed at the previous meeting, a review of the 2019/20 financial outturn would be undertaken, with Mr Edgell seeking clarity as to the timescales as to when this would be completed in order to support the Trust in 2020/21. Dr Jenkins confirmed that the terms of reference for the independent external review were currently being developed with input from colleagues and the regulator.

However, whilst acknowledging that it would be beneficial for the review to be completed within the period that the Trust remained protected due to the COVID-19 financial regime, there may be a requirement for a formal procurement process to be undertaken. A further update on the matter would be provided for the June 2020 meeting. ACTION – Chief Executive

In turning to 2020/21, there was concern that the intended bank and agency cost-savings following implementation of NHS Professional, had not materialised. Instead, costs had increased in the final quarter of 2019/20, with a potential that they could continue into the new financial year.

In order to address this concern, Mr Wright confirmed that the Bank and Agency Group, which met on a weekly basis, were reviewing the detail in this area, with more robust systems and processes in place for bank and agency. Although there may be other factors such as COVID-19, bank and agency costs for April 2020 were £250k less than March 2020. In addition, Mrs Craven confirmed that
the post implementation review of the NHS Professionals business case was scheduled for review by the Finance and Performance Committee.

In terms of cash management, Mr Wright indicated that a Cash Committee had been established, meeting on a weekly basis to monitor the position, assess the background to the historic loans and identify any underlying matters.

As discussed at the April 2020 meeting, the Trust had agreed to post a year end deficit of £3.9m. Subsequent to that meeting, as the South Yorkshire & Bassetlaw Integrated Care System were in aggregate balance, the Trust would receive additional non-recurrent funding to clear the deficit resulting in a breakeven position via national Financial Recovery Fund monies. The draft out-turn position therefore was an in-year deficit of £4.9m against a planned break even position.

As a result, the Trust would achieve its annual control total and secure its quarter 4 Provider Sustainability Fund/Financial Recovery Fund monies of £5,170K, which was already included within the draft position, plus a further £50K, and remove one of the significant financial risks.

The Board of Directors noted the month twelve Finance Report.

153/20 NHS RESOLUTIONS MATERNITY INCENTIVE SCHEME FOR TRUSTS YEAR 3 – QUARTERLY REPORT

The Board of Directors received and noted the report which provided an update on the requirements of the NHS Resolutions Maternity Incentive Scheme Year 3.

154/20 ANNUAL COMPLAINTS REPORT

The Board of Directors received the Complaints Annual Report 2019/20 introduced by the Chief Nurse.

The Board commented that whilst there were examples of learning from complaints documented within the Annual Report, there remained a challenge to ensure that learning was embedded across the organisation to reduce future complaints. This was particularly relevant for reoccurring themes and trends, such as communication. Additionally, there remained a requirement to improve response rates within the agreed timescales.

In response to the comments from colleagues, Ms Wood confirmed that the capacity of the Patient Experience Team had been expanded to enable more detailed triangulation of information from complaints or concerns. Through closer working, this would enable learning to be embedded by the Divisions. Whilst disappointing that the response deadlines had not been achieved, as documented within the report, it was anticipated that following closer working with the Divisions, the position would improve.

In order to support the comments from Ms Wood, as Chair of the Audit Committee, Mr Barnes highlighted that the Annual Report documented that the
Internal Auditor had reviewed processes to identify learning from complaints, with key findings and an action plan to strengthen systems and processes.

The Board considered that it remained important that learning from complaints was embedded across the organisation and there was a timely response to complaints going forward.

The Board of Directors approved the Complaints Annual Report 2019/20 which would be included in the Quality Account.

In addition, as an aide memoir to ensure that the quarterly complaints review reports from the Non-Executive Directors formed part of the Complaints Annual Report, as previously agreed by the Board but not included in the version presented, the requirement would be added to the Board’s forward work plan for 2020/21.

**ACTION – Director of Corporate Affairs**

### ASSURANCE FRAMEWORK

#### 155/20 GOVERNANCE REPORT

The Board of Directors received the Governance Report presented by the Director of Corporate Affairs/Company Secretary.

In response to the section of the report detailing the ability for staff to speak up during the pandemic Ms Wood, as Executive Lead for Freedom to Speak Up, confirmed that colleagues were actively being encouraged to highlight any concerns they may have in order that they could be addressed and as necessary the position communicated to the rest of the organisation.

Ms Milanec informed the Board that since the report had been written, new guidance had been received confirming that the Quality Account would not now be required to be submitted until December 2020.

The Board of Directors noted the report.

#### 156/20 PEOPLE COMMITTEE – TERMS OF REFERENCE

The Board of Directors received the terms of reference for the new People Committee which had held its inaugural meeting in April 2020.

Dr Jenkins confirmed the expectation that Executive Director attendees would be present, where possible, at each of the Board Assurance Committees, to increase the level of Executive contribution at these meetings.

In supporting the comment from Miss Bancroft in relation to the Committee giving attention to matters such as leadership, talent management and succession planning, Mr Ned confirmed that the Committee’s forward work plan would give the level of detail in this area.
As this was a new Committee, it was noted that there would need to be further consideration of what would be reported to this and other Board Assurance Committees as agreed under agenda item 151/20.

The Board of Directors approved, subject to minor grammatical amendment, the People Committee terms of reference.

**BOARD GOVERNANCE**

**157/20 ANY OTHER BUSINESS**

The Chairman at this point asked the Divisional Directors if there was anything they would wish to highlight to the Board, with all confirming that there was not, with some matters already having been discussed by the Board.

There were no items of any other business.

**158/20 DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on 2 June 2020.

Before closing the meeting, the Chairman asked the Governors observing the meeting if they had any comments or questions relating to the business which had been conducted. Both confirmed that there was nothing they wished to raise.

Martín Havenhand
Chairman  date
<table>
<thead>
<tr>
<th>Log No</th>
<th>Meeting</th>
<th>Report/Agenda title</th>
<th>Minute Ref</th>
<th>Agenda item and Action</th>
<th>Lead Officer</th>
<th>Timescale/Deadline</th>
<th>Comment/ Feedback from Lead Officer(s)</th>
<th>Open /Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>03-Mar-20</td>
<td>Governance Report</td>
<td>64/20</td>
<td>Identification of a patient safety specialist</td>
<td>CN</td>
<td>01-Jun-20</td>
<td>Head of Patient Safety has now been identified as Patient Safety Specialist</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>13</td>
<td>03-Mar-20</td>
<td>Governance Report</td>
<td>64/20</td>
<td>Recirculate guidance (x2) relating to year end and Annual Report and Accounts at the appropriate time pre approval</td>
<td>CoSec</td>
<td>05-May-20</td>
<td>Circulated on 18 May 2020 to all NEDs</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>16</td>
<td>07-Apr-20</td>
<td>Quality Report</td>
<td>105/20</td>
<td>Care hours per day data to be discussed with DoF, in order to triangulate finances, activity and quality of care.</td>
<td>CN</td>
<td>05-May-20</td>
<td>Discussion held with DCEO as part of staffing reviews and usage fill rates and staff movement</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>18</td>
<td>05-May-20</td>
<td>CEO Report</td>
<td>147/20</td>
<td>Second Phase’ letter from Simon Stevens (2020.04.29) to be considered by the Executive, and outcome presented through board committees in May.</td>
<td>COO</td>
<td>13-May-20</td>
<td>Presented to board seminar on 13 May 2020, with additional details provided via agenda item 187/20</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>19</td>
<td>05-May-20</td>
<td>Operational Plan Quarterly Report</td>
<td>149/20</td>
<td>The 2020/21 Plan objectives should reflect deliverables that are specific and measurable (&quot;SMART&quot;)</td>
<td>DCEO</td>
<td>07-Jul-20</td>
<td>On board planner</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>20</td>
<td>05-May-20</td>
<td>Operational Plan Quarterly Report</td>
<td>149/20</td>
<td>Review and analysis of why 2019/20 plan objectives had not been fully delivered.</td>
<td>DCEO</td>
<td>07-Jul-20</td>
<td>On board planner</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>21</td>
<td>05-May-20</td>
<td>Assurance Committee update</td>
<td>151/20</td>
<td>Exec to discuss which elements of workforce activity, currently overseen by other Board Committees, should be presented to the new People Committee (to avoid duplication).</td>
<td>CEO</td>
<td>02-Jun-20</td>
<td>See appendix B to agenda item 191/20</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>22</td>
<td>05-May-20</td>
<td>Assurance Committee update</td>
<td>151/20</td>
<td>Contact to be made with Trust's Organ Donation Lead with view to setting up online meetings.</td>
<td>MD</td>
<td>02-Jun-20</td>
<td>Complete. Next virtual meeting is scheduled for 30 June 2020.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>23</td>
<td>05-May-20</td>
<td>Workforce Report</td>
<td>152/20</td>
<td>Circulate a breakdown of the 29 colleagues responding to the Bringing Back Staff national scheme</td>
<td>Dow</td>
<td>02-Jun-20</td>
<td>Updated details included in agenda item 189/20(c)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>25</td>
<td>05-May-20</td>
<td>Finance Report</td>
<td>152/20</td>
<td>Update on the 2019/20 financial outturn review to be provided</td>
<td>CEO</td>
<td>02-Jun-20</td>
<td>See agenda item 209/20</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>26</td>
<td>05-May-20</td>
<td>Annual Complaints Report</td>
<td>155/20</td>
<td>Stipulate on board planner that future iterations of the report should include the NED reviews carried out during the year</td>
<td>Co Sec</td>
<td>02-Jun-20</td>
<td></td>
<td>Recommend to close</td>
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</tbody>
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Open
To be carried forward to a date TBC

Recommend to close

Complete
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>181/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Public Report from the Chairman</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Presenter: Martin Havenhand, Chairman</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>The Chairman’s report reflects various elements of the BAF</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note [✓] Approval [ ] For information [ ]</td>
</tr>
</tbody>
</table>

The report covers the following issues:

- Covid-19. Our colleagues have continued to provide excellent care to our patients at this challenging time.
- Financial Position. The review of our end of year financial position is progressing. Several improved controls and procedures have been implemented. Further reports will be presented to the board over the next few months.
- Interim Director of Finance. The Trust has appointed Mr S Hackett for a temporary 3 month period on a part time basis.
- Rotherham Town Deal Board. Mike Smith NED represents the TRFT on the board and a brief update on the last meeting is provided.

Recommendations

The Board is asked to note this report.

Appendices

None
1.0 **Introduction**

1.1 This report provides an update since the last Board Meeting on 5 May 2020.

2.0 **Covid-19**

2.1 Our colleagues, particularly those working directly with our patients who have been affected by Covid-19, continue to work incredibly hard to ensure that they receive the best care possible.

2.2 On behalf of the Board, I wish to thank our colleagues for the tremendous efforts they are making, and for their commitment to the safe and compassionate care that they are providing our patients.

3.0 **Financial Position**

3.1 The review of our end of year financial position is progressing. Several improved controls and procedures have been implemented. Further reports will be presented to the board over the next few months.

4.0 **Interim Director of Finance**

4.1 The Nominations Committee met on 12 May 2020, and the interim appointment of Steve Hackett as the Acting Executive Director of Finance, was approved, following recommendation from the Chief Executive.

4.2 Mr Hackett is currently the Director of Finance, Contracting and Performance for Rotherham, Doncaster and South Humber NHS Foundation Trust and will be undertaking the temporary role on a part-time basis.

5.0 **Governors’ Forum**

5.1 The Non-Executive Directors, the Chief Executive and I, met virtually with the members of the Council of Governors as part of their regular, informal, Forum Meeting on 13th May 2020.

5.2 We were able to provide updates on a number of issues that had recently arisen, including the position with regard to the end of year finances.

6.0 **Rotherham Town Deal Board**

6.1 Mike Smith NED represent TRFT on the Rotherham Town Deal Board. The Town Deal has funding of £25m and is focussed on helping to regenerate Rotherham. The focus is on three areas of the town, Eastwood, Templeborough and the new, primarily housing development at Bassingthorpe Farm.

6.2 Mike was recently interviewed by consultants WYG concerning priorities. He was able to give some thoughts on all the areas from his local knowledge and previous involvement as Vice Chair of Rotherham Renaissance (a project funded by Regional Development Agency). With regard to the NHS, he stressed the need for good transport links to the hospital from all areas of Rotherham.

**Martin Havenhand**
**Chairman**
**May 2020**
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>182/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Public Report from the Chief Executive</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Presenter: Dr Richard Jenkins, Chief Executive</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>The Chief Executive’s report reflects various elements of the BAF</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note √ Approval ☐ For information ☐</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>This report addresses the following issues: This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and highlight a number of items of interest. The items are not reported in any order of priority.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>The Board is asked to note this report.</td>
</tr>
<tr>
<td>Appendices</td>
<td>1. SY &amp; B Chief Executive Report</td>
</tr>
</tbody>
</table>
1.0 COVID-19

1.1 Current Situation

Staff have continued to respond magnificently. The numbers of staff off work due to self-isolating has fallen. The Trust has not run out of PPE at any stage and has actively engaged in mutual support across Rotherham and South Yorkshire.

COVID-19 activity has continued, albeit at a slowly falling rate. The numbers of inpatients remain significant such that it will continue to be necessary to maintain the current COVID-19 positive and negative pathways within the hospital for now. This situation will be kept under active review.

Non-COVID-19 activity has slowly increased through the UECC but remains constrained in other areas. Video and telephone consultations are being used increasingly in outpatients. Resumption of more routine surgery has been limited due to a national shortage of sterile surgical gowns but has started to increase over the last few weeks. Some patients have received their care through partnership with the private Kinvara Hospital in Rotherham.

The Trust has been developing its response to the Simon Stevens Phase 2 letter in conjunction with local partners and coordinated by Rotherham CCG. As part of moving into a more routine approach to COVID-19, the Gold/Silver command approach has been stepped down somewhat with Gold now being incorporated into the weekly Executive Team Meeting and Silver meeting less frequently.

1.2 Next Phase

The duration of the COVID-19 pandemic is uncertain but in the absence of a mechanism to end it, such as a vaccine or an effective treatment, it is likely that the Trust will be operating in an environment in which COVID-19 remains prevalent. This means we will need to find ways to safely adapt and deliver effective care across the broad range of our services for an extended period which may well be for more than a year hence. This will be an area of major focus over the coming weeks and months.

1.3 Capturing the learning from the response so far

The Trust and the wider NHS and public sector has made enormous changes to ways of working over a short period of time. Many of the changes would serve us well during more normal times and we will be actively reviewing how we capture these innovations and embed them as the norm. This includes embracing video communication both with service users, in meetings and as ways of keeping staff engaged and informed. A number of exercises will be undertaken to ensure we take a top-down and bottom-up approach to capturing innovations that we would wish to embed as normal practice.

2.0 Staff Engagement

2.1 New approach to Team Brief

COVID-19 has prevented the traditional face-to-face approach to Team Brief and so the May Team Brief was carried out using Microsoft Teams. The format was a verbal update accompanied by slides followed by a live Q&A using the ‘Chat’ function. A recording of the session was made available to staff and will remain so until replaced by the next month’s video. Live attendees were circa 150 and at least 250 views of the recording occurred later. This new approach reached considerably more people than the traditional
approach (>400 versus <50), allowed a much broader range of staff to ‘attend’ and was much easier for community staff and shift working staff to access. Feedback was extremely positive and this will now be the default approach regardless of the need for social distancing. The Communications Team did an excellent job in making this possible.

2.2 Community services

I spent a morning visiting Community staff at Woodside and I am grateful to Rachel Wilkinson-Potter (Head of Nursing) for facilitating this socially-distanced visit. The staff were extremely positive and proud of the services they are delivering despite the challenges of COVID-19.

2.3 Pathology services

I have had a range of meetings with pathology staff and had a brief tour of the pathology labs. These services do not always capture the headlines but form a vital underpinning for most other clinical services and have continued to do so despite the challenges of COVID-19. The long established BRILS partnership remains effective.

3.0 New colleagues

I am delighted to welcome Mr Ian Hinitt as the Trust’s new Director of Estates and Facilities and also Mr Steve Hackett as Interim Director of Finance for a 3-month period.

Dr Richard Jenkins
Chief Executive
June 2020
<table>
<thead>
<tr>
<th><strong>Author(s)</strong></th>
<th>Andrew Cash, Chief Executive Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sponsor</strong></td>
<td></td>
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<tr>
<td><strong>Is your report for Approval / Consideration / Noting</strong></td>
<td>For noting and discussion</td>
</tr>
<tr>
<td><strong>Links to the STP (please tick)</strong></td>
<td><img src="image" alt="Checkmarks for various initiatives" /></td>
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<tr>
<td>Reduce inequalities</td>
<td>Join up health and care</td>
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<tr>
<td>Standardise acute hospital care</td>
<td>Simplify urgent and emergency care</td>
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<tr>
<td>Create financial sustainability</td>
<td>Work with patients and the public to do</td>
</tr>
<tr>
<td>Invest and grow primary and community care</td>
<td>Treat the whole person, mental and physical</td>
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<tr>
<td>Develop our workforce</td>
<td>Use the best technology</td>
</tr>
<tr>
<td><strong>Are there any resource implications (including Financial, Staffing etc)?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Summary of key issues</strong></td>
<td>This monthly paper from the Chief Executive of the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) provides a summary update on the work of the SYB ICS for the month of April 2020.</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
<td>The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.</td>
</tr>
</tbody>
</table>
South Yorkshire and Bassetlaw Integrated Care System

CHIEF EXECUTIVE REPORT

May 2020

1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System Chief Executive provides an update on the work of the South Yorkshire and Bassetlaw Integrated Care System for the month of April 2020.

2. Summary update for activity during April 2020

2.1 Coronavirus (Covid-19): The South Yorkshire and Bassetlaw position

There is increasing evidence, both nationally and regionally, that the first peak of Covid-19 has now passed. The numbers of patients needing critical care facilities across the hospitals in South Yorkshire and Bassetlaw (SYB) appear to have now plateaued. There is consensus among partners that the immediate Phase One response to Covid-19 is drawing to a close. Attention is now turning to recovery, restoration and resetting health and care services.

Simon Stevens and Amanda Pritchard’s letter to the NHS, issued on Wednesday 29th April, helpfully summarised the next steps for Phase Two, setting-out the current position and proposing new ways for the NHS to remodel health and care services in the coming days and weeks.

The NHS remains in a Level 4 National Incident with all the altered operating disciplines that requires. There will be a gradual shift away from this in May as the Phase Two stabilisation period begins which will be in place until the end of June. During this stabilisation phase we will consider how best to restart urgent NHS services across SYB taking into account the needs of the population and the clinical priority of patients that need to be treated the soonest.

Phase Three will be August to the end of March 2020. During this period we will conduct a comprehensive planning review and focus on building elective services and managing a potential further Covid-19 spike during the winter. Partners are already starting to take stock of the learning from the changes in ways of working since March as well as the experiences from patients, the workforce, SYB partners and the public. These findings will help to develop a framework to shape future working. Phase Four will be from April 2021 and will focus on recovering and developing the NHS towards the 'new normal'.

To support the early thinking on the SYB approach, a strategic workshop with Chief Executives, Accountable Officers, GPs, Primary Care Networks and the NHS England and Improvement Locality Director took place on 29th April. The basis of the discussions was to set out key principles for the reset process whilst working to ensure the prevention of System inequalities in any reconfiguration of services. It was a helpful exercise with insights and informative contributions from across sectors and the feedback is being used to work up the System response. Special thanks to Major Sam McEvoy, the SYB ICS Military Planner who formulated and facilitated the session.

2.2 Phase One reflections

As consideration turns to Phase Two and beyond, it is important to reflect on the enormous strides that have been made during Phase One. These have been in key areas such as workforce, critical care capacity, extensive partnership working and entering new terrain such as working side-by-side with the military.

In SYB, a complex cross-regional development of a new Nightingale Hospital in Harrogate was co-
ordinated and the realignment of the FlyDSA Arena Sheffield as a local PPE storage facility was supported. In addition, new mobile testing sites in Barnsley, Sheffield and Doncaster opened, alongside the drive-through coronavirus testing facilities at Doncaster Sheffield Airport (DSA) for South Yorkshire and Bassetlaw key workers in health and care, including those employed in the independent sector, police, fire, local authorities and LRF partner organisations.

NHS staff testing expanded with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and The Rotherham NHS Foundation Trust joining Sheffield Teaching Hospitals NHS Foundation Trust laboratory capacity to provide up to 2000 tests a day. Together with the key worker facility at DSA and mobile sites, the region is in a good position to maximise testing and allow staff currently unable to return to work because they or a member of their family or household have symptoms of coronavirus to know whether they do have the virus. The SYB System is also in a good position to widen community testing, especially to organisations that are fundamental to the local economy such as universities and colleges.

More than 600 final-year nursing and allied health students from Sheffield Hallam University volunteered to join the NHS workforce and support the Covid-19 pandemic. This includes 376 nursing students who are joining NHS colleagues sooner than anticipated as part of the UK’s response to the virus. The healthcare students are in the final six months of their degrees and will be paid volunteers.

In addition to work led by NHS England and supported by the ICS Procurement Hub to source PPE, the Mayor of the Sheffield City Region, Dan Jarvis, issued a call to South Yorkshire businesses to join the efforts to help make life-saving medical equipment. This initiative has seen around 50 businesses come forward, many of which are now supporting ongoing requirements for PPE for the region.

### 2.3 Supporting care homes

In Phase Two the NHS will continue to partner with Local Authorities and Local Resilience Forums to provide mutual aid for care homes. In SYB this will build on work that has been taking place since the beginning of the outbreak. While the numbers of cases and deaths in hospitals are showing a downward trend, it is the opposite in care homes.

NHS England is working with all regional providers including the North East and Yorkshire and the Humber Region to implement a new Enhanced Universal Support Offer to Care Homes. This is built around four key Principles: Leadership, Prevention, Additional Clinical Support and Workforce. The Enhanced Offer has been developed in conjunction across a number of key stakeholder groups; CCG Directors of Nursing, Directors of Adult Social Services in Local Authorities, Skills for Care, Primary Care, Public Health, Care Home Providers and others across the region. It provides a clear framework for support to care homes which will complement and, where appropriate, strengthen the support currently offered by these organisations.

One of the first additional steps being taken, with regional senior nursing support, is for CCGs to quickly identify clinical leads to work alongside each care home. They will explore practical areas where additional support can be offered such as infection control, PPE training, staff not coming in to work if unwell, staff testing and pausing family visiting.

### 3. Finance update

Based on draft year end results the System has exceeded its financial plan for the year. This has brought in £19m of cash support that would not otherwise have been available had the system not been in balance. This is a very creditable performance for the SYB System which has now exceeded its financial plan in each of the last three years.
4. Next steps

An announcement is expected on Sunday 10\textsuperscript{th} May from the Prime Minister on the Covid-19 lockdown exit strategy. We will use this to underpin our approach building on the transformation work seen in the last few months in SYB to reset the NHS over the coming year in four phases which are outlined above.

Andrew Cash
Chief Executive, South Yorkshire and Bassetlaw Integrated Care System

Date 7 May 2020
# Board of Directors’ Meeting
2 June 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>183/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>National, Integrated Care System and Rotherham Place Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Michael Wright, Deputy Chief Executive</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B7, B10 and B11</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note ✓ Approval ☐ For information ☐</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>The purpose of this report is to provide the Trust Board with an update on national developments and also developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Integrated Care Partnership (Rotherham Place). The key message is that during the COVID-19 emergency, both the ICS and Place partners have continued to collaborate and provide mutual support during these very challenging times. National guidance is reviewed and discussed, at ICS, Place and Trust level. The whole system is now starting to focus on the recovery stage.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>The Board is asked to note the content of this paper.</td>
</tr>
<tr>
<td>Appendices</td>
<td>None</td>
</tr>
</tbody>
</table>
1.0 Introduction

1.1. This report provides an update on developments across the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and Integrated Care Partnership (Rotherham Place). As expected, the focus throughout April has been on delivering the most appropriate, coordinated response to the national and global COVID-19 emergency.

2.0 National Update

2.1. The Chief Executive and Chief Operating Officer of NHS England and NHS Improvement issued a second letter to NHS Trusts, CCGs, GP Practices and Community Health services on 29th April 2020. This outlines phase 2 of the Government’s response to the COVID-19 emergency. The Trust commenced work on the requirements upon receipt of the letter.

2.2 National advice and guidance continues to be received at the Trust, which is logged and acted upon.

2.3. On 14th May, the Government announced an additional £600 million to support providers through a new Infection Control Fund. The fund will support adult social care providers to reduce the rate of transmission in and between care homes and support wider workforce resilience. This will be allocated to Local Authorities and is in addition to the funding already provided to support Adult Social Care sector during the COVID-19 pandemic. The Government want to ensure the social care system is taking all possible steps to stop the spread of COVID-19. It was made clear that this is not the responsibility of any one part of the system but a joint endeavour between national and local government, the NHS and the care sector. The additional steps undertaken by local authorities will go hand in hand with extra support that is provided by the NHS, Public Health England and the Department of Health and Social Care.

3.0 South Yorkshire and Bassetlaw Integrated Care System (System)

3.1 As reported previously, the ICS continues to hold the weekly COVID-19 Strategic Health Co-ordination Group. The group focuses on the COVID-19 position with partners providing details of the challenges they face together with sensible coordinated responses and solutions.

3.2 Throughout May, the group focussed on the following:

- A continued system wide approach to swabbing and how this is embedding.
- The latest public health assessments and forecasts that provide a valuable assessment on the likely increase in cases and feedback on how the lockdown measures have impacted on infection rates, noting the recent changes to lockdown measures.
- Continued collaboration and support of members with challenging levels of PPE stock.
- The next phases in terms of response to the COVID-19 emergency, including phase 2, a period of stabilisation.
- Support to Care Homes, noting the work undertaken at a Place level.
- ICS partners providing continued mutual support in relation to capacity challenges across it’s member base.
- Links with and support from the independent sector.
4.0 Rotherham Integrated Care Partnership (Place)

4.1 The Rotherham Place decision to pause a number of key work streams as a consequence of COVID-19 has continued. However, discussions have commenced in relation to recovery. The Place partners are continuing to engage on a regular basis to provide mutual support to each other at this challenging time.

4.2 The Rotherham Place established a Place Level Gold Command, chaired by the Chief Officer for Rotherham CCG or the Chief Executive of Rotherham Metropolitan Borough Council. The key areas of focus continue to be testing, PPE and support to Care Homes. Mortuary capacity at a Place level has also been very closely monitored and managed.

4.3 Place partners continue to work collectively in responding to Simons Steven’s recent letter covering phase 2 of the response to COVID-19.

4.4 The level of cooperation between all Place partners continues to be exceptionally positive.

Michael Wright
Deputy Chief Executive
May 2020
### Board of Directors’ Meeting
#### 2 June 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>184/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>2020/21 Transformation Plan Report</td>
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<tr>
<td>Executive Lead</td>
<td>Michael Wright, Interim Deputy Chief Executive</td>
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<td>Link with the BAF</td>
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<td>Purpose</td>
<td>Decision ⬜ To note ✅ Approval ⬜ For information ⬜</td>
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**Executive Summary (including reason for the report, background, key issues and risks)**

The purpose of this paper is to present to the Board a review of progress against the revised Operational Plan for Month 1 as at April 2020. It summarises progress to date against the emerging operational objectives and priorities within the plan and contextualises our overarching ambitions, indicating high level outcomes and next steps.

Given the Covid-19 pandemic and the extraordinary situation we continue to face, the revised Operational Plan is intended as an internal document providing a high-level perspective of the likely priorities for 2020/21, recognising that these may change or develop as the impact of the Covid-19 virus becomes clearer.

There is a significant risk that as we progressively develop our response to the ongoing Covid-19 pandemic and the changing requirements of the Department of Health, NHS England / Improvement and our system partners, we will need to continually balance operational demands against our ability to deliver our wider objectives and priorities.

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<thead>
<tr>
<th>Recommendations</th>
<th>To note</th>
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<tbody>
<tr>
<td>Appendices</td>
<td>None</td>
</tr>
</tbody>
</table>
1. Introduction

1.1. At its meeting of February 2020, subsequently endorsed March 2020, the Trust Board of Directors approved the Trust Five Year Plan and the associated 2020/21 Operational Objectives and Enablers. Detailed work was underway to establish the resulting programme structure to deliver the Operational Objectives and Enablers and the related metrics, baselines, milestones and outputs.

1.2. As a result of the Covid-19 Pandemic the normal routine of operational planning was paused to allow the health service to instead focus its efforts on preparation for the likely influx of Covid-19 patients to the acute sector over the next few months. Whilst formal planning is no longer required, as a provider, we need to be as prepared as possible for the upcoming developments and ensure we are aligned as an organisation to the activities we will intend to deliver in 2020/21 whilst acknowledging that there are many which will no longer remain priorities for the year.

1.3. Subsequently, a revised 2020/21 Operational Objectives and Enablers paper detailing new organisational priorities for the coming year was approved by April’s Trust Board of Directors.

1.4. Given the Covid-19 pandemic and the extraordinary situation we continue to face, this was not designed as a formal operational plan. Rather, it is intended as an internal document providing a high-level perspective of the likely priorities for 2020/21, recognising that these may change or develop as the impact of the Covid-19 virus becomes clearer.

1.5. The plan defined 4 core objectives for the Trust, as well as 7 priorities for delivery within 2020/21, as set out below:

1.5.1. Objectives

1. Mortality
   Ensure TRFT Mortality rates are being counted and reported correctly

2. Operational Performance
   Comply with national requirements around operational standards

3. Workforce
   Increase the substantive establishment of our staff, including through improving our staff engagement

4. Financial Stewardship
   Deliver our financial plan based on revised Covid-19 expectations; ensure improved financial stewardship across the organisation

1.5.2. Priorities

1. Optimising Flow
   Optimise flow through the hospital by developing resilient emergency pathways, shoring up Same Day Emergency Care provision, increasing early discharge and implementing appropriate streaming and on-site GP OOH services
2. Outpatient Transformation
Deliver a step change reduction in the number of face to face appointments, lowering the overall number and utilising technology solutions where appropriate

3. Staff Engagement
Improve staff engagement and morale by driving a fundamental change in the volume and impact of staff engagement activity in the Trust

4. Senior Leadership Effectiveness
Maximise the effectiveness of the senior leadership within the organisation, empowering staff to work collectively to make informed decisions

5. Recruitment and Retention
Increase the proportion of our workforce who are substantively employed by the Trust and in doing so, reduce the vacancy rate and ensure a minimum 10% in-year reduction in agency cost

6. Estates Moves
Complete Ophthalmology move to RCHC and relocate existing Greenoaks services (ante and post-natal care) and Cystoscopy services to the Oakwood Community Unit

7. Gastroenterology Service
Implement joint Gastroenterology service with Barnsley Hospital NHS Foundation Trust, including a joint GI bleed rota and joint ward cover

1.6. An assurance matrix is currently under development to assign each Board Committee oversight and assurance responsibilities against one or more of these new operational objectives and priorities. Through this report and its relevant committees, the Board will have monthly oversight of the seven transformational priorities:

1.6.1. Objective 2: Operational Performance
   1.6.1.1. Priority 1: Optimising Flow
   1.6.1.2. Priority 2: Outpatient Transformation
   1.6.1.3. Priority 6: Estates Moves
   1.6.1.4. Priority 7: Gastroenterology Service

1.6.2. Objective 3: Workforce
   1.6.2.1. Priority 3: Staff Engagement
   1.6.2.2. Priority 4: Senior Leadership Effectiveness

1.6.3. Objective 4: Financial Stewardship
   1.6.3.1. Priority 5: Recruitment and Retention

1.7. There is a significant risk that as we progressively develop our response to the ongoing Covid-19 pandemic and the changing requirements of the Department of Health, NHS England / Improvement and our system partners, we will need to continually balance operational demands against our ability to deliver our wider objectives and priorities.

1.8. We will need to be prepared to take an agile approach to the proposed programmes of delivery, refining and reprioritising as necessary throughout the course of the year.
2. **Progress against Operational Objectives and Priorities**

2.1. For each of our objectives and priorities, we need to have a robustly developed programme of delivery so that we can be assured that our prioritised activities will lead to the required outcomes whilst ensuring that we maintain our capacity and capability to deliver the same.

2.2. Progress thus far has therefore concentrated on defining the overarching objectives and priorities and commencing the establishment of high level outcome measures. We now need to develop the specific programmes of delivery in order to establish our underpinning programme structure and its specific project plans, metrics, baselines, milestones and outputs. This will be undertaken in a similar manner to that already developed for the original objectives and enablers.

2.3. The following gives the context within which the specific objectives and priorities have been developed and updates the Board on our start position, what needs to be developed and an indication of high-level metrics and outcomes:

2.4. **Objective 2: Operational Performance**

2.4.1. 2019/20 was a challenging operational year for TRFT when we consider the four core constitutional operational standards and our focus going forward will be on getting the basics right within our operational processes and practices.

2.4.2. As one of 14 field test sites for the proposed new A&E access standards, we no longer measure or work to the 4-hour. Removal of a national standard has required significant cross-organisational efforts from almost all staff within the Trust to adjust to the new way of working. Whilst Covid-19 will temporarily disrupt our plans to drive through revised pathways and improved flow, delivering improved performance in the key UECC metrics is a fundamental priority for the organisation, and will remain a key focus throughout 2020/21.

2.4.3. Our RTT performance declined through the year, reflecting the national trend, to the point where we were no longer meeting the standard in the last quarter although our performance remained in the top 25 of all acute, non-specialist trusts in the country. Waiting list sizes have become an ever greater priority through the year, so our failure to meet the waiting list trajectory set for us by the centre for 2019/20 means our overall achievements within elective care did not meet our expectations. Given Covid-19 requirements over non-urgent elective care at the start of 2020/21, this position will worsen fairly dramatically in the first half of the year, and we will then need significant organisational effort and capacity to rebuild.

2.4.4. Cancer performance remained challenged across the 62-day standard in particular, although there were significant improvements in pathway design, effective patient management and the size of the patient tracking list (PTL) with over a 40% reduction in the PTL size since Q1 2019/20. The Covid restrictions had a detrimental effect in the last quarter of the year and the hard won gains from the redesign work of 2019 were all but lost.

Looking forward to 2020/21, the 62-day standard will become our core focus for our cancer teams across the organisation, ensuring we are maximising every stage of the pathway in order to minimise unnecessary delays, and in particular ensuring that our transfers to tertiary centres are delivered within the 38-day time period. In order to deliver a step change improvement in performance against this metric, we hope to use our Cancer Alliance funding
to recruit at least one additional CNS to support our specialty teams and provide further individual patient support throughout the patient journey. We also intend to add further administrative support to ensure delivery of the 28-day Faster Diagnosis Standard as well as reviewing our triage processes internally so that we are managing our referrals as effectively as possible and providing patients with the right care in the right place in the early stages of the pathway.

2.4.5. The Trust has continued to consistently deliver the DM01 standard, and we expect our performance to remain strong in 2020/21, once the Covid restrictions are relaxed and recovery plans are enacted.

2.4.6. The new national standards against which our performance will be compared are still under development and will take some time to emerge. We do, however, know that we are now in a very different position than we were pre Covid-19. It is expected that it will take 18 to 24 months to recover based on the pre Covid-19 position and focus will include developing the necessary recovery plans.

2.4.7. Priority 1: Optimising Flow

2.4.7.1. Effective flow through the Trust has been a challenge for a number of years, and since the start of the field test, we have seen the volume of long waiters significantly increase, mainly due to bed waits. We will need to ensure continued flow through the organisation, in order to manage Covid-19 patients whilst also continuing to provide an urgent care service to non-Covid patients.

2.4.7.2. The focus within this priority will be relatively broad, and include:
- Establishing an effective Same Day Emergency Care service which meets national requirements;
- Developing and implementing effective emergency care pathways from the front door to the back door;
- Increasing rates of early discharge and implementing appropriate front-door streaming and GP OOH services;
- Implement digital patient flow technologies.

2.4.7.3. As a top-level outcome, we would expect to see significant reductions in 12 hour waits in department, reductions in time to see a clinician in UECC and reductions in long ambulance handovers.

2.4.7.4. Whilst the baseline position is understood, the definitive outcome measures and deliverables need clarifying and currently form part of discussions with partners to agree the resulting landscape.

2.4.8. Priority 2: Outpatient Transformation

2.4.8.1. Whilst the Covid-19 pandemic is one of the NHS’s toughest challenges we have necessarily and rapidly taken opportunities to deliver change within the health service, especially around the use of technology to facilitate non face-to-face patient consultation.

2.4.8.2. We need to leverage these developments to accelerate our longer-term aim to significantly reduce the number of outpatient appointments that take place face-to-face, instead encouraging clinicians and patients to make use of readily available technology and conduct consultations by phone or through video chats.
2.4.8.3. Within our five year plan we intended to begin this work in 2021/22, but given the immediate requirements of the health service and likely direction of travel over the coming months, it is pertinent to revise our timescales and bring this work forward into 2020/21.

2.4.8.4. We will undertake a full review of our current interaction methodologies by specialty, and identify which clinics are appropriate to trial.

2.4.8.5. As we test this, we will review and refine the approach, such that by 2021/22 we have agreed a series of local tariffs that incentivise and reward this practice.

2.4.8.6. An outpatient transformation group has been formed which will hold its first meeting in the next week. This group will assist in the definition of the necessary projects, baselines, milestones and outputs through which we will further update Committee.

2.4.9. Priority 6: Estates Moves

2.4.9.1. By Q3 of 2020/21, we will have relocated our Ophthalmology team to the Rotherham Community Health Centre building, turning this service into a paperless service as we do. We will identify the appropriate alternative use for the vacated space at the hospital, and develop plans for the relevant moves in the latter half of the year.

2.4.9.2. In addition, we will vacate the existing Greenoaks building given it is no longer fit for purpose, transferring our ante and post-natal services to Oakwood Community Unit, and relocating cystoscopy services to the same building. Greenoaks will be demolished following this move, and a plan for the empty site drawn up.

2.4.10. Priority 7: Gastroenterology Service

2.4.10.1. Both Barnsley and TRFT have established a productive partnership and have outlined the principles of how to work collaboratively to deliver a more efficient and effective gastroenterology service. The new OOH GI Bleed rota with Barnsley went live on 6 January 2020.

2.4.10.2. Further discussions around the development of a single joint Gastroenterology service with Barnsley were scheduled to take place in March but have now been deferred as a result of the Covid-19 response. The ICS have asked all acute providers to reduce the transfer of patients and suggest we keep patients on acute sites with support from other providers. In order to comply, we have postponed the GI bleed rota with Barnsley and are now dealing with patients on the TRFT site via a local rota. STH have agreed to support TRFT and all local trusts if we have any difficulties. To date we have not needed to transfer any GI patients.

2.4.10.3. We now expect further discussion to reconfirm shared ambition and establish a forward plan to take place in Q2 from which a new roadmap will be developed.
2.5. Objective 3: Workforce

2.5.1. We have struggled to recruit the substantive workforce required to deliver our services and this has meant over reliance on agency and locum clinicians. Creating a dedicated, stable workforce is a necessary condition for ensuring we are a high-performing, effective organisation delivering excellent patient care. We need to support our acute and community staff to deliver the excellent patient care they aim to, putting them at the heart of the organisation and engaging them in the decisions we make and the improvements we seek.

2.5.2. Our focus in this area will fall into three core categories – staff engagement, senior leadership effectiveness and recruitment and retention (the latter which overlaps with the Financial Stewardship objective in which section the core metrics are addressed).

2.5.3. Priority 3: Staff Engagement

2.5.3.1. As part of our key objective around workforce, we will embed a number of programmes to improve our engagement with staff. Some of these will be based on more structured approaches, such as further rollout of the Together We Can programme; some will relate to fundamental cultural change within the organisation, through which we will empower our staff to contribute to the organisation more directly.

2.5.3.2. We will grow and tailor our communications, and make use of all available channels such as smartphone applications and social media.

2.5.3.3. Through an academy approach we will look to inspire all staff in the Trust to be part of service improvement. Working in tandem with Together We Can, the academy will offer support, advice and encouragement through an ambassador, practitioner and teacher system. It will include staff trained in NHS Improvement’s Quality, Service Improvement and Re-design (QSIR) methods giving people a range of skills and tools to help them ‘make service improvement happen’.

2.5.3.4. Indicative high level outcomes and metrics currently being developed include:

- Further rollout of the ‘Together We Can’ Programme of supporting teams who actively engage;
- Increased effectiveness of our communications with our staff, including an increased following on social media platforms;
- Achieve an above average overall score for staff engagement in the 2020 national staff survey (our score 2019 – 6.7 compared to national average of 7.1);
- Improve the 5 worst scores identified in the 2019 national staff survey (Q21a-d and Q4f);
- Implement and embed a systematic staff-led quality improvement framework.
2.5.4. Priority 4: Senior Leadership Effectiveness

2.5.4.1. The arrival of new leadership at any organisation provides an opportunity for senior leaders to collectively review and challenge existing practices and ensure the structures, practices and culture they are endorsing are reflective of the organisation’s overall goals.

2.5.4.2. As a Trust, we recognise that effective leadership starts at the very top, and we need to take time to reflect on our own individual and collective practices to ensure we are role-modelling the leadership behaviours and habits we want to embed across the organisation.

2.5.4.3. Part of this objective will involve redesigning our Executive Team meetings to ensure they are fit for purpose and generate healthy discussion followed by robust decision-making.

2.5.4.4. We will review the terms of reference and membership of our senior management meetings, and ensure all existing forums are impactful and a valuable use of our senior leaders’ time.

2.5.4.5. We will challenge ourselves to ensure we are demonstrating the very behaviours which we want to see from our staff, empowering them to make appropriate decisions and be proactive in implementing them.

2.5.4.6. Indicative high level outcomes and metrics currently being developed include:

- Re-designed Executive Team meetings to ensure they are fit for purpose and generate healthy discussion followed by robust decision-making;
- Launch a new talent management strategy to support all colleagues to maximise their potential;
- Continued compliance with individual appraisal targets (90%);
- Continued compliance with Mandatory training targets (85%);
- Achievement of the Trust’s Operational plan.

2.6. Objective 4: Financial Stewardship

2.6.1. Income and expenditure had a target to break even during the 2019/20 financial year and although the out-turn was £50K favourable of this position, this was mainly as a result of external support due to the SYB ICS being in aggregate balance.

2.6.2. In 2020/21, we will focus our efforts on ensuring effective financial governance, improving transparency and increasing management scrutiny of day-to-day decisions. To do this, we will extend the actions we have recently taken around introducing additional workforce controls within the organisation to better manage our agency spend and establishment position. We will also ensure greater, more frequent scrutiny around our activity performance and workforce (and related financial impact).

2.6.3. We will also make changes to the current business case process, in order to significantly shorten the time taken to make a decision, but also to ensure greater scrutiny is applied to proposed business cases before they are completed. We will support our teams in bringing forward their best ideas, but expect better consideration of the financial proposals (and potential funding sources) as part of this.
2.6.4. As outcome measures, we therefore aim to:

2.6.4.1. Deliver to financial plan;

2.6.4.2. Maintain a financial grip by focussing on:
   - Agency spend
   - Vacancies including medical, nursing and admin & clerical
   - Developing and establishing efficiencies and new ways of working
   - Addressing significant financial variance via performance framework;

2.6.4.3. Manage our capital programme effectively;

2.6.4.4. Strengthen our Cost Improvement Programme by developing more robust governance and executing targeted efficiency improvements;

2.6.4.5. Complete service sustainability reviews.

2.6.5. Additional and specific projects, baselines, milestones and outputs will be determined within the relevant priorities:

2.6.6. Priority 5: Recruitment and Retention

2.6.6.1. Priority 5, in terms of the wider recruitment and retention improvement activity, will be delivered as part of the Workforce objective through the People Committee. However, specific components of the priority are focussed on agency usage and vacancies which themselves have a direct impact on our financial stewardship. These components will therefore be addressed here.

2.6.6.2. A Vacancy Control Panel has already been established and we will look to further develop this new process to reduce the Trust's vacancy rate by 10% from the opening position at 1st April 2020.

2.6.6.3. A Bank and Agency Control Panel has similarly been established and will aim to reduce the Trust's expenditure on temporary staffing by 10% from the outturn position of 2019/20. The highest cost agency for the supply of workers has already been removed from the agency cascade.

3. Conclusion

3.1. It is essential that effective systems and processes are in place to support delivery of the objectives and priorities set out above. We will do this via an agreed framework to oversee progress against key milestones and defined outcome measures for each programme of work. Whilst overall responsibility for delivery will sit with the relevant Clinical or Corporate Division, compliance will be monitored and tracked corporately, and reported to the Board on a monthly basis.

3.2. The framework will build upon the approach taken within 2019/20 with Executive Directors as SRO’s for each programme of work. Implementation will be overseen by multi-disciplinary project teams providing input aligned to their field of expertise.

Neil Stokell
Head of PMO
May 2020
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>185/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Five Year Strategy Refresh</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Michael Wright, Deputy Chief Executive</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B5, B10, B11</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note ☑ Approval ☐ For information ☐</td>
</tr>
</tbody>
</table>

**Executive Summary (including reason for the report, background, key issues and risks)**

The Board’s normal annual cycle includes a refresh of the Five Year Strategy during Quarter 1. However, due to the national pause on all non-essential planning activities at the moment given the Covid-19 pandemic, this work has been postponed until further notice.

The priority for the organisation at this time remains ensuring we are committing our resources appropriately to delivering a response to the Covid-19 pandemic, and as such this request has been de-prioritised accordingly.

In Quarter 2 we will undertake a brief exercise to identify what normal business activities have been put on hold as a consequence of the national dictat, and plan how we will move forward when the longer-term requirements of the Trust become clearer.

**Recommendations**
The Board is asked to note the contents of this report.

**Appendices**
None
## Agenda item
186/20

## Report
People Strategy

## Executive Lead
Steven Ned, Director of Workforce

## Link with the BAF
B3

### Purpose
- **Decision**
- **To note**
- **Approval** ✓
- **For information**

### Executive Summary (including reason for the report, background, key issues and risks)

The People Strategy was discussed at the People Committee on 24th April 2020 and 22nd May 2020. The People Strategy has been the subject of a Board Seminar on 11th March 2020.

The strategy has taken on feedback from colleagues including staff side representatives. Minor amendments to the People strategy (arising from the People Committee) are due to be incorporated as soon as possible. The amendments do not alter the substance of the Strategy.

In publishing this People Strategy, the Board of Directors remains committed to continuing to improve staff engagement and to making sure that all staff members feel valued, recognised and appreciated for their contributions and hard work. Providing people with a great place to work will, in turn, enable us to meet our overall goal of providing outstanding care and treatment for all of our patients and their families.

### Recommendations
It is recommended that the Board of Directors approve the People Strategy.

### Appendices
1. People Strategy.
Our People Strategy
The Rotherham Way
2020/23
On behalf of the Board of Directors, I am pleased to be able to share our People Strategy. As we recover from the challenges of the Covid-19 pandemic, supporting colleagues and their well-being at this challenging time has never been more important. This Strategy sets out our current position and reflects on our achievements so far, as well as outlining our priorities for the next three years (2020-2023) and the improvement actions that will help us to achieve our strategic aim of supporting and developing our people.

In late 2019, members of the Human Resources team held a number of Listening Events with teams from across the organisation. We also got together with leaders and staff representatives.

These conversations helped us to shape the original priorities we outlined in our Trust Strategy – a five-year plan that sets out to transform the culture of our organisation.

You can read more about these priorities, how we approached them and what we achieved on page 4.

We have taken some really positive steps in a relatively short space of time; nevertheless we recognise that there is more work to do to achieve our strategic ambition of being in the top 20% of NHS employers for staff engagement.

In recent years we have struggled to recruit the substantive workforce we need to deliver our services, and this has meant relying too much on agency and locum clinicians, who would normally be expected to be less committed to the Trust given the potential short-term nature of their employment. This is a critical priority for me as the new Chief Executive, as creating a dedicated, stable workforce is a necessary condition for ensuring we are a high-performing, effective organisation delivering excellent patient care. Now more than ever, with these very challenging year(s) ahead for all NHS providers, we need to support our acute and community staff to deliver the excellent patient care they aim to, putting them at the heart of the organisation and engaging them in the decisions we make and the improvements we seek.

In publishing this People Strategy, the Board of Directors remains committed to continuing to improve staff engagement and to making sure that all staff members feel valued, recognised and appreciated for their contributions and hard work. Providing people with a great place to work will, in turn, enable us to meet our overall goal of providing outstanding care and treatment for all of our patients and their families.

I hope you find our People Strategy a good reflection of our progress so far and a real indication of our ambitions and where we want to go from here.

The People Strategy is a team effort. The Board of Directors would like to thank all our staff for their input; and for their willingness to get involved. Contributions from everyone across the Trust are making a real difference to our organisation, our people and our patients and are helping to turn our ambitions into reality.

Dr Richard Jenkins
Chief Executive
Where are we now?

Our strategy reflects on where we are now, looking at the positive steps we’ve taken so far to improve our organisation for everyone who works within it. These are some of the developments that are already making a difference in response to feedback from colleagues around the Trust. The next set of actions in our strategy build on these successes, creating an environment and culture that supports and develops our people.

Together We Can (TWC) – a large-scale staff engagement approach that is designed to support a culture where all team members feel empowered to take their ideas for improving patient care and staff experience and implement them. It’s enabling ‘grass-roots’ staff-led change and together with a new approach to service improvement (see below) colleagues are making a real difference to patient care, services and the places we work in.

Staff-led quality improvement - through an academy approach we’re looking to inspire all staff in the Trust to be part of service improvement. Working in tandem with TWC, the academy will offer support, advice and encouragement through an ambassador, practitioner and teacher system. It will include staff trained in NHS Improvement’s Quality, Service, Improvement and Re-design (QSIR) methods – giving people a range of skills and tools and to help them ‘make service improvement happen’.

Our Talent Strategy 2020-2023 - an overarching approach that will work alongside Our People Strategy in ensuring diverse, capable and evolving professions across all levels. This will ensure succession pipelines are in place, enhance the organisation’s reputation to ensure succession pipelines are in place, enhancing our ‘Safe & Sound’ approach to delivering patient care.

Flexible workforce – with Board support for a ‘think yes rather than no’ approach to flexible working to support work/ life balance and working from home.

Apprenticeships – expansion of apprenticeship opportunities as part of our workforce redesign commitment. These will be available for new people joining our organisation along with existing members of staff.

Recruitment – speeding up the process of recruitment and reducing the need for paperwork with on-line tools and systems including virtual interviewing.

Culture commitments - to help to ensure everyone feels respected and valued we are working with our Staff Networks, Partnership Forums and colleagues across the Trust to meet the recommendations in a host of initiatives such as the national anti-bullying policy ‘Call to Action’, the ‘Dying to Work’ pledge, Freedom to Speak Up, and Safer Working for junior doctor initiatives.

We are creating a culture where staff are thanked for telling us about their concerns, where they know they’ll be heard and taken seriously. We have a real commitment to protect and support our staff through a transparent and open approach.

Health and Wellbeing - we already have a number of health and wellbeing activities and initiatives in place, including flu jabs, health MOTs, mental health champions, weekly yoga sessions, fast-track physio and complimentary therapies. A dedicated COVID page has also been added to The Hub in response to the pandemic offering support and related information. Through our Occupational Health partner all staff have 24/7 access to an employee assistance programme (EAP).

Equality, Diversity and Inclusion - ensuring that everyone has an equal opportunity, and is not discriminated against because of their protected characteristics. Taking people’s different backgrounds and experiences into account while feeling valued. Support and information can be found within our Diversity and Inclusion Steering Group, BAME, Disability, and LGBT+ networks.

MaST & Essential training - creating innovative solutions to deliver essential training that is flexible and adaptable for our wide range of staff groups and their needs.

Encouraging feedback – a focus on everyone having their say through a range of feedback opportunities including Have Your Say, TWC Pulse Check and the National Staff Survey – where we aim to improve our response rate, stretching for 70% response levels by 2023. We want and need to hear your feedback; as it provides us with the opportunity to really improve what matters to our people.

Recognition - giving our staff, our patients and their families the opportunity to show how much they appreciate those who demonstrate our Trust values. The growth of our Shining Star, Star Cards scheme and the PROUD week celebration events is enabling inclusive recognition across the whole organisation.
In defining our People Strategy we’ve reviewed the Trust’s 5 Year Strategy and the key objectives from the recent Operational Plans. We have recognised the progress made in the past few years and the strategic environment and system-wide context we are working in now. We have also listened to our colleagues and taken into consideration national workforce challenges and where you think the focus for our People Strategy should be at this time. We’ve taken these priorities and created four broad themes from them:

Our strategy describes these themes in more detail and sets out the priorities within each of them. We also illustrate how our People Strategy aligns to our Trust’s strategic objective - engaged, accountable colleagues, our ACT values; Ambitious, Caring, Together, and how previous People priorities map across to our refreshed version. We also show how success will be measured through a framework of workstreams. Each theme in our Strategy is underpinned by detailed plans, actions and outcome measures - all overseen by relevant working groups and committees.
What we do

24 hour
Emergency care, Community services, GP and Primary Care services

4,500 staff members

Rotherham CCG fund approximately 87% of the Trust’s activity

21.8% of children in Year 6 are classified as obese, worse than the average for England

100,000 patients attend UECC each year

500 in-patient beds

1,846 Alcohol-related hospital stays per year. Worse than the average for England.

Almost 200 Volunteers

We serve a Rotherham population of around 252,000
Our People Strategy is anchored in the ethos of ‘We Can All Lead the Rotherham Way’, which describes the behaviours we expect everyone at the Trust to adopt and role model, to support outstanding patient and colleague experience. The main purpose of our People Strategy is to describe the key themes and areas of focus designed to help us achieve all of these goals and ambitions.

The Board of Directors is committed to delivering our strategic objective of supporting and developing our staff, to achieve the ambition of being in the top 20% of NHS employers nationally for staff experience (as measured by the national staff survey).

In turn, our People Strategy supports our other strategic objectives and our aim of providing ‘outstanding’ care. The workstreams that will deliver the strategy are aligned to the Trust’s strategic vision and core values (page 8). It also complements our Quality and Clinical Services Strategies (Safe & Sound framework) as by supporting our people, we support the delivery of high-quality patient care and effective services.

**How was the strategy developed?**
The strategy builds on the work undertaken over the past year following publication of our Trust Strategy and priorities. It aims to build on the progress made, further embed new approaches introduced in the last two years and to make improvements in areas where further development is still needed.

**Strategic framework**
This People Strategy supports delivery of the Trust’s strategic plan which is based on our vision, our ACT values and our five strategic objectives (page 8). It aligns to the risks outlined in our Board Assurance Framework (BAF) and fits with the recently published NHS long-term plan, where leadership behaviours, new careers and job roles and entry points into the NHS, along with flexible ways of working are key to future success.

**Mapping the previous colleague priorities to our new People Strategy**
Our People Strategy has evolved over the last few years, as we have achieved some of the workforce priorities previously set and identified new themes of focus through staff feedback and changing priorities.

In addition to the Trust-wide objectives and the themes set out in this document, each of our divisions (clinical service units) and corporate areas have identified their own key ‘people’ priorities. These are supported by the key themes, ambitions and outcomes of this Trust-wide strategy, which are highlighted on page 9. We will continue to review and refresh our strategy to make sure it is able to support other strategic plans within the Trust; can function alongside the national plan for the NHS and importantly that is best-placed to enable achievement of Trust ambitions and goals.
Our Trust Strategy on a page

Our vision and mission
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.

Our core values
The Trust’s values; Ambitious, Caring and Together (ACT) seek to create a culture which will support delivery of our Vision and Mission, guiding the behaviour of colleagues across the organisation.

Our strategic objectives

Patients
Excellence in healthcare

Colleagues
Engaged, accountable colleagues

Governance
Trusted, open governance

Finances
Strong financial foundations

Partners
Securing the future together

Deliver high quality care with patients at the centre of what we do.
Improving the quality of care and services we provide.
Develop and implement new models of care for the future.
Recruit, retain and develop a motivated workforce.
Continuous improvements.
Engage with colleagues.
Develop strong leadership at all levels.
The People Pack - Supporting you, your team, managers and leaders across TRFT during this pandemic and beyond.
Have an effective performance framework.
Be outstanding on the CQC ‘well-led’ framework.
Ensure all teams have regular reviews.
Manage within our budgets.
Improve our efficiency and productivity.
Invest in our estates and facilities.
Use our money and resources wisely.
Work with our partners to provide sustainable health and care services.
Open to new ideas and innovations.
Collaborate on key services to improve service resilience and sustainability.

Our strategic outcomes
### Our People Strategy on a page

#### Areas to focus on

<table>
<thead>
<tr>
<th>Building our workforce</th>
<th>Engaging with our people</th>
<th>Developing our leadership &amp; nurturing talent</th>
<th>Learning opportunities for all</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New roles and workforce development</td>
<td>• Engagement Framework</td>
<td>• Leading the Rotherham Way</td>
<td>• Multi-professional learning and development</td>
</tr>
<tr>
<td>• Attraction, recruitment and retention</td>
<td>• Staff Survey</td>
<td>• Appraisal season</td>
<td>• Essential training</td>
</tr>
<tr>
<td>• Improve our internal bank offer and reduce agency</td>
<td>• Together We Can</td>
<td>• Talent management conversations</td>
<td>• Apprenticeships</td>
</tr>
<tr>
<td>• Using ESR &amp; Workforce intelligence</td>
<td>• Equality, diversity and inclusion</td>
<td>• Coaching ethos</td>
<td>• School, university partnerships</td>
</tr>
<tr>
<td></td>
<td>• Health and Well Being</td>
<td>• Manager Skills Programme</td>
<td>• Access to Leadership Academy</td>
</tr>
<tr>
<td></td>
<td>• Reward and Recognition</td>
<td>• LEAD programme</td>
<td>• Organisational Development initiatives</td>
</tr>
<tr>
<td></td>
<td>• Communications</td>
<td>• Senior Clinical Leadership Programme</td>
<td>• E-Learning access</td>
</tr>
<tr>
<td></td>
<td>• Volunteering</td>
<td></td>
<td>• Links to NHS national support and guidance</td>
</tr>
<tr>
<td></td>
<td>• Our People Pack - Covid-19 recovery</td>
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</tbody>
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New roles and workforce development

Improve our bank offer and reduce agency

Attraction, recruitment and retention

Workforce intelligence

How we will build our workforce

Our ambitions

To work in interprofessional teams, across traditional professional boundaries

To enable our people to work in effective teams, making best use of our resources

To be the employer of choice and a great place to work

To have the right staff, in the right place at the right time

• Teamwork around the patient
• Working with partners
• Sharing best practice and learning
• Listening to our people and our patients
• Career pathways and grow our own
• Inter-professional working

• Flexible workforce
• Best value agency cost
• Focus on hard to fill posts and high agency spend
• Working towards the number of vacancies filled via talent management processes via external recruitment

• Careers events and work experience
• Recruitment roadshows
• Seamless recruitment and keeping in touch
• Welcome to your role and our Trust
• Career pathways and grow our own
• Career counselling

• Workforce data collection and analysis
• Leadership capability to use data
• Joined up systems and processes
How we will build our workforce

**New roles and workforce development**

We will work in inter-professional teams, across traditional professional boundaries

Over the past two years we have made transformational changes to our non-medical and medical workforce, including training programmes and the development of new roles such as Advanced Clinical Practitioners (ACPs), Assistant Practitioners and Nursing Associates. We have a patient centred multi-professional integrated model of care. We have presented at national conferences and have shared with NHS Employers our best practice case studies on innovation.

As an example of this model of care, our Assistant Practitioners and Nursing Associates work alongside our registered nurses to provide high quality patient care and continuity of care. This has resulted in a significant reduction in the use of agency nurses, provided greater stability for teams and enabled a clear career pathway for our support staff.

We will continue to grow these new roles, including developing an advanced practitioner strategy, which will set out clear plans to further develop ACPs and other expanded roles, including enhanced Pharmacists and other therapist roles.

We are also offering increasing support and opportunities for our locally employed doctors to access training to develop their skills.

As part of supporting this approach we will continue to work with our external partners, regional NHS organisations and educational organisations.

Expansion of apprenticeships is part of our workforce development plan to support service redesign.

**Attraction, recruitment and retention**

We will be the employer of choice and a great place to work

We are working hard to make Rotherham a great place to work, and all the themes of our People Strategy support this aim. We recognise the importance of attracting and recruiting the best people to come to work with us at our Trust, and the equal importance of retaining our existing valued team members.

We have four workstreams in place to support attraction, recruitment and retention. Many successful activities have occurred in the last year which have included developing our recruitment branding, enhanced support for successful candidates through ‘keeping in touch’ prior to joining the Trust, providing a supportive learning environment, introducing career clinics and working more closely with schools. We will build on this in the coming years.

Improve our bank and reducing agency. We will enable our people to work in effective teams, making best use of our resources.

We are continuing to work in collaboration with our external providers (NHSP) and our regional partner organisations to grow our staffing bank, provide greater consistency in our workforce and reduce reliance on agencies. We have a well-established nursing bank and a more recently introduced medical bank, and we will explore options to improve bank arrangements for other staff groups.

We have had success in the last two years in reducing temporary workforce expenditure and have plans to continue to see improvement in this area to support greater continuity in teams and patient care.
**Workforce intelligence**

We will have the right staff in the right place at the right time.

We use workforce data from a range of systems to understand our current position and forecast our future workforce needs. As part of the Trust’s Digital Strategy, there are plans to roll-out the Electronic Staff Record (ESR) employee self-service and manager self-service within the time period of this People Strategy. This is the common integrated payroll/HR system across the NHS and would reduce duplication and allow for streamlining of processes when connecting with other organisations.

We make use of the national and regional tools available to support our workforce intelligence, such as the NHS Improvement workforce planning self-assessment toolkit and the ESR national self-audit programme.

**How will we measure our success?**

- Introduction of training programmes and new roles each year, in line with the Trust-wide five year workforce plan
- Achieve a vacancy rate of 10% or less for staff nurses and 15% or less for medical consultants
- Reduce the Trust’s bank and agency expenditure on temporary staffing by 10% each year.
- Successful collaboration on regional banks with achievement of bank growth each year of 5% and nursing bank fill of at least 90%
- Working with colleagues in Finance and IT to support a smooth implementation of ESR self-service functionality.
- Improve staff survey metrics for colleagues wanting to work or recommend as a place to work.
The key components of our Engagement Framework are underpinned by the principles of ‘We can all Lead the Rotherham Way’ (pages 20 and 21) and support staff engagement, involvement and recognition:

- Engaging with ALL our people
- Working in partnership with Trade Unions
- Health and Wellbeing
- Equality, Diversity and Inclusion
- Staff Survey
- Volunteering
- Flexible Working
- Together We Can
- Reward Recognition
Our engagement framework provides key areas of focus:

**Staff surveys**
Feedback from our staff is very important to us and is valued by the Board – we listen to the responses from our surveys to make changes to improve staff and patient experience. Each year we take part in the national staff survey and take steps to ensure all members of staff can have their say, such as providing protected time in working hours to complete the survey.

Each quarter, we will carry out our own Pulse survey which includes the staff Friends and Family Test questions. This will usually focus on a different part of the organisation each quarter for this survey.

Every year there are numerous examples where improvements have been made as a direct result of staff feedback, at both a Trust-wide and local level amongst divisions and corporate areas. We will continue to place this focus on acting upon staff feedback.

**Flexible working**
In 2019 the Board made a commitment to be a more flexible employer, recognising the importance of work/life balance and flexibility in approach to meet different individual and service needs.

There is a working group in place to support this ambition and actions taken in the last 12 months include developing promotional materials and guides for leaders and staff members, challenging some of the existing ‘rules’ and encouraging a ‘think yes rather than no’ approach towards flexible working. These activities will continue as we further embrace a culture of flexible working, particularly as we recover from and move beyond the Covid-19 pandemic.

**Together We Can (TWC)**
Together We Can is our staff engagement approach designed to support a culture where all team members feel empowered to implement their ideas. By adopting the 5 factors to success methodology; PACT, ENACT, INTERACT, ACT and IMPACT to improve patient care and staff experience.

We are committed to the TWC ethos and believe that everyone has the ability to introduce improvements in their working areas, for the benefit of patients and staff. Through multi-disciplinary TWC teams and strong clinical engagement, we continue to see a range of diverse improvement ideas come to fruition across both clinical and non-clinical areas. We celebrate these achievements at events and we are committed to ensuring the TWC ethos is a reality across all parts of the organisation.

**Equality, Diversity and Inclusion**
Our strategic vision for Equality, Diversity and Inclusion is:
To achieve equality and value diversity and for all of our employees to be treated with dignity and respect; and we aim for our workforce to be representative of the population we serve and the wider community from which we recruit.

Each year we summarise our progress, outcomes and next steps in our Equality, Diversity and Inclusion Annual Report. The report presented to the Trust Board in 2019 can be found here. This includes progress against our equality objectives, evaluation of the Workforce Race Equality Standard (WRES) and now includes the Workforce Disability Standard (WDES) which started in 2019/20.

Our strategic vision and our Trust values align to the ethos of Equality, Diversity and Inclusion. Our next steps will be to more clearly define ‘what good looks like’ in our diversity ambitions.
Health and Wellbeing
We already have a strong approach to Health and Wellbeing at the Trust, informed by a wide range of representatives who are passionate about the health and wellbeing of our workforce. This work has resulted in the implementation of a variety of initiatives from a brand new fast-track physiotherapy service to the introduction of the Trust Choir. The Committee also receives excellent support from the Trust’s Charitable Funds Committee, which sees a clear link between the health and wellbeing of our workforce and the provision of high quality patient care.

We will continue to strengthen our links with our staff members to ensure that what we provide on health and wellbeing fits with what is important to our colleagues. There will be a project in 2020/21 to support this work, to review our offer and overall vision and priorities.

Reward and Recognition
Our Star Cards and Shining Star recognition scheme(s) gives thanks to everyone for small acts of kindness and/or larger scale achievements. ‘Recognitions’ are made by colleagues, patients and families and hundreds of us have attended the large celebratory PROUD week events to the more intimate afternoon tea events that are held throughout the year. To develop this further, we will involve our departments to continue to improve recognition ideas, to show we value everyone in #TRFT.

We will continue to review our overall approach to rewarding our staff members, by promoting the national NHS benefits, such as the pension scheme and annual leave, as well as our local benefits such as Long Service Awards, salary sacrifice schemes and wellbeing activities.

Communications
We use a diverse variety of communication tools and methods to engage with #TRFT colleagues across the Trust including social media, apps and daily messages. In the last 12 months, we have introduced our own app for smart phones and tablets. We recognise that there is also a leadership and personal responsibility to share information and communicate messages, and encourage face to face briefings to support these communication methods. We will continue to support a range of communication methods, to suit the differing needs of our teams.

Volunteering
Our volunteers are a key part of our #TRFT family, supporting our staff members and enhancing patient care in areas across the organisation. We have grown our volunteer group to around 115 in the last year and are committed to increasing opportunities for our volunteers. We plan to secure Investing in Volunteers (IiV) status. IiV is the UK quality standard for good practice in volunteer management. Achieving the standard will show our volunteers – and potential volunteers – how much they are valued and will give them confidence in the Trust’s ability to provide an outstanding volunteer experience.

Trade Unions Partnership
Communicating and consulting with our employees and working in partnership with our trade unions and professional bodies is core to our service delivery. In partnership with our union colleagues, we recognise our common interests and are committed to maintaining and improving employment relations and engagement in the Trust; dealing with and resolving any issues at an early stage, as speedily as possible and in line with jointly agreed policies and procedures.
• Staff survey - to be in the top 20% of NHS employers nationally as measured by the national staff survey

• Together We Can – Pulse check improvement to be top quartile amongst comparison group

• Equality, Diversity & Inclusion – WRES/WDES outcomes improvements, measured each year

• Health & Wellbeing – improvements each year in national staff survey question ‘the organisation and management takes an interest in and action on health and wellbeing’ - to be top quartile

• Evaluation of all learning events

• Reward & recognition - annual growth in colleague nominations for the Proud Event Week, Shining Stars, Thank You cards - engagement through the number of recognitions

• Communications - a minimum 10% increase in social media followers and reach across all platforms

• Volunteering – growth in volunteering hours by a minimum of 10% each year,

• Flexible working – improvements each year in national staff survey question on ‘being satisfied with flexible working opportunities’ - to be top quartile
How we will develop our leadership culture and nurture talent

Leading the Rotherham Way
The aim in 2020, is to introduce ‘Leading the Rotherham Way’ – a framework for all leaders, in both clinical and non-clinical roles. It is based on the NHS Healthcare Leadership Model and it sets out the behaviours that the Trust expects from its leaders.

With its nine key principle components ‘Leading the Rotherham Way’ describes what a ‘ACT (values)’ leader looks like and why each of the elements is important. It explains how leaders can effectively demonstrate these behaviours and develop them to improve how they lead day-to-day. As well as providing a leadership structure, the framework is also designed to support individual development through appraisal, career progression and personal development plans.

As part of our People Strategy, we see ‘Leading the Rotherham Way’ shaping people development, compassionate care and quality improvement for years to come. It is an integral part of making our organisation an even better place to work and as a result, improving the high standards of care and service we give to our patients.

We can all lead the Rotherham Way
All team members can adopt and role model the behaviours in this framework – we can all lead the Rotherham Way. By all of us showing our colleagues compassion and care - through listening and offering them our empathy and understanding, we help to create a supportive work place.

We can all be an ambassador for the Trust, by sharing good news and good practice, contributing to debates, having a say and leading an improvement – all ways of influencing what happens to our services in the future.

Our People Strategy is anchored in the ethos of ‘We Can All Lead the Rotherham Way’, which describes the behaviours we expect everyone at the Trust to adopt and role model, to support outstanding patient and staff experience. The infographics on pages 18 and 19 describe its approach.

As part of embedding our leading the Rotherham Way culture across the organisation, we are actively encouraging colleagues to raise any concerns or worries they have about any aspect of working at the Trust, whether it impacts them, or our patients. We will listen, support staff that speak up and take the right action to make sure problems are addressed and resolved.

Appraisal season
We introduced an appraisal season approach designed to ensure all team members have a good quality appraisal discussion and are supported with their development and objectives. Alongside this, we recognise the value of ongoing conversations, one-to-ones and team meetings to provide ongoing support and development.
We deliver a full range of acute services, including 24-hour emergency care, community services and GP and primary care services to the population of Rotherham. We employ around 4,500 staff members, benefit from the support of nearly 200 volunteers and work in partnership with colleagues from a range of other organisations for the benefit of our patients, their families and carers and our community.

We can all lead the Rotherham Way

With its nine principles, Leading the Rotherham Way sets out the behaviours and characteristics we expect from our leaders and that all of us can adopt and role model. By all of us showing our colleagues compassion and care - through listening and offering them our empathy and understandings, we help to create a supportive workplace. We can all be an ambassador for the Trust, by sharing good news and good practice, contributing to debates, having a say and leading an improvement - all ways of influencing what happens to our services in the future.

We can all...

Inspire a shared sense of purpose

Where all of us take pride in what we do, strive to improve the care and services we provide; and understand how our roles contribute to the success of the organisation.

Lead with care

By all of us showing our colleagues compassion and care - through listening and offering them our empathy and understanding - we help to create a supportive workplace.

Use and evaluate information to improve

If we’re all alert to what is happening around us, we can use and evaluate the information we hear, receive or discover to take actions and decisions that improve both patient and staff experience.

Work together to connect services

Every day we all have the opportunity to link up with different colleagues, leaders and partners, building relationships that can help everyone to deliver effective and efficient healthcare.
We can all...

Share the vision

If we communicate in a clear and compelling way it helps colleagues to see how their work matter and why their responsibilities are as important as everyone else’s. The conversations enable all of us to understand the Trust’s ambitions and future vision - and how we all play a part in its success.

Engage with our team

As part of team TRFT we must respect each other, value diversity and make sure that every member of staff feels that their contribution to delivering excellent care and services is appreciated and valued.

Hold ourselves to account

By being clear about what’s expected at work, giving honest feedback and acting quickly to support others who are struggling to meet expectations we can all show fairness and contribute to better standards.

Develop our capability

Everyone has potential and if we all role model and encourage personal development we will develop the skills and knowledge of our workforce to improve services for the future.

Influence what happens

We can all be an ambassador for the trust, by sharing good news and good practice, contributing to debates, having a say and leading an improvement - all ways of influencing what happens to our services in the future.

Leading the Rotherham Way supports the Trust’s objectives and ambitions and as well as providing a framework for leadership behaviours it supports individual development through appraisal, career progression and personal development. You can find Leading The Rotherham Way here.
Quality improvement
Previously we introduced quality improvement methodology (PDSA cycles). In the next 3 years we aim to build on this foundation and introduce Quality Service Improvement and Re-design (QSIR) to the Trust. A nationally recognised and accredited service improvement methodology, QSIR is led by NHS Improvement and provides learning opportunities for staff across the NHS - to enable them to become QSIR practitioners and trainers.

QSIR enhances Together We Can (page 14) and supports the our themes of our People Strategy.

How we will measure our success

• Appraisal season - aim is to complete a minimum of 90%
• Quality appraisal experience - implement and develop and organisational approach based on Best Practice
• Improvements each year in national staff survey question on ‘quality of appraisals’ - to be top quartile
• Improvements each year in national staff survey questions on ‘support from immediate managers’ and ‘recognition and value of staff by managers and the organisation’ - to be top quartile.
A dictionary definition of learning is “the acquisition of knowledge or skills through study, experience, or being taught”; it’s not just about courses! We want to ensure that the learning opportunities available are inclusive of all and the media is as diverse as the subject matter. We will be ensuring that interventions take into account learning styles, offer opportunities both “on” and “off the job”, skills and knowledge development are timely, qualifications will be supported where appropriate, apprenticeships are expanded into all areas, mentoring, coaching whilst being considerate of cost both in terms of finance and staff time.

Opportunities will be offered whether you are new into post or have served the trust for a number of years. Our education and learning mission 2020-2023 states that “working together to create and sustain a first class educational environment, engaging and supporting everyone to reach their full potential to deliver excellent patient care”.

This will be achieved by the following:

1. Embedding a culture of continuous Learning, and Talent Conversations that encourages and motivates colleagues to develop to be the best they can.
2. Effectively and efficiently manage education, training and workforce development tailoring the offerings to meet patient, service and individual needs.
3. Delivering education and training that is continually quality assured and evaluated.
4. Develop leaders and managers with the capability to embed the ethos of learning education, training and development into practice to support patient safety, clinical governance, service and role re-design resulting in a learning culture.
5. Building resilient partnerships and collaborative working maximising the delivery of learning education and training.
What learning interventions are/will be available?
The learning opportunities continue to be diverse and available for both existing staff and those newly recruited.
A new colleague will start with both a corporate and localised induction to ensure they feel part of our Trust from Day 1. We currently offer a variety of development and skills opportunities available in-house including mandatory & statutory training (MaST), management skills including recruitment & selection, management of absence etc, Performance Development Review (PDR) preparation for both managers and staff and our flagship leadership programme (LEAD – Lead, Exploration, and Discovery)
We have excellent relationships with a variety of external training providers, colleges, the NHS Leadership Academy and universities who support with apprenticeships, student placements and provide specific and tailored expertise.
We also offer variety of subjects through the medium of e-learning and we are growing our community of “coaches” and “mentors” to support individuals on a 1-1 basis as well as development and support for all staff to embrace a coaching style which includes active listening.

Learning Quality and Evaluation
We promote a culture that encourages learning from successes and challenges to continuously improve. Safe and Sound is our quality initiative which has 7 different themes including one centred on workforce training and competence.
We are constantly evaluating our learning offer and are always open to new ideas of how staff can become engaged with the learning experience.

Talent Conversations
2020 brings the launch of Our Talent Strategy which is inclusive of all staff.
Talent conversations increases the frequency of interaction between a member of staff and their manager. It enhances the depth of conversation and degree of focus around an individual’s personal needs and development priorities thereby enhancing the relationship between the two.

Talent Conversations produces “A voice for ambition” – Conventional appraisal processes when operating without talent management make it hard for individuals to share their ambitions and when they do it is often difficult for managers to know what to do with this information. The implementation of robust talent management should make it easier for individuals to signal their intent, receive the support they need to make a transition and ultimately to move into another role or the support they need to maintain and/or enhance their performance in their current role.

We review our MaST and essential training programme to ensure it remains relevant for different staff groups, and have increased the delivery methods available to provide greater flexibility and more e-learning options. Over the next year, we will be making changes to our system for recording essential training to see improvements in this area.

Our multi-professional learning and development plan describes ‘what we will do’ and ‘how we will do it’ to achieve our objectives in these three themes.

How we will measure our success
- Number of apprenticeships – growth of 10% year on year
- Essential Training compliance of 90%
- Achievement of objectives in our multi-professional learning and development plan
In Summary

Our People Strategy is a key component of the Trust’s strategic vision and its ACT values (page 8) supports our ambition of becoming a top 20% organisation for the staff experience that is measured by the annual NHS Staff Survey and our own Pulse and Have Your Say surveys. These will contribute to the recovery of our organisation as we move beyond the challenges of Covid-19.

It is also not a stand alone document. With an implementation plan in place it works alongside - and is supported by - a number of other Trust strategies and workstreams; all of which are underpinned by detailed work programmes and improvement action plans. The People Strategy’s components are led by a number of working groups that include representation from staff across the Trust to help deliver the strategy’s goals and objectives. If you would like to know more about these workstreams and how you might be able to get more involved, contact the Learning and Development team.

All strategies in the Trust are overseen by a number of committees. In the case of our People Strategy, scrutiny is provided by the People Committee, a sub-committee of the Board of Directors. The Committee has oversight of all the programmes, plans and actions described above and by assessing them, provides assurance to the Board of Directors in relation to progress, measures of success and achievements, as well as ensuring appropriate action is taken to respond to areas of concern and key areas of risk.

Over the last two years we have put the foundations in place for a People Strategy that delivers large-scale culture change and engagement. We have started to see real progress, with an ambitious programme that is driving a new approach. By sticking to the actions and improvements we pledged to deliver, we are starting to make a real difference to our workplaces - whether they are in our hospital, in our community based services or working with partners in the Rotherham community.

Over the next three years, through everyone bringing Leading the Rotherham Way to life and by supporting and developing our colleagues through the four themes of our People Strategy, we will continue to enhance and build on everything we’ve started to achieve. And in that way we’ll make sure we not only improve staff experience, but that we improve the experience of our patients as a result, supporting our ambition to become an outstanding organisation that provides first-class care and treatment.
### Executive Lead
George Briggs, Chief Operating Officer

### Link with the BAF
B1, B2

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<th>Purpose</th>
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**Executive Summary (including reason for the report, background, key issues and risks)**

2020/21 continues to be an unprecedented year for the NHS. COVID-19 is the first global health pandemic in over ten years, and is the most severe episode in the history of the NHS, with deaths exceeding those from the previous pandemics.

- The Trust initially focussed all of its efforts on preparation for the influx of COVID-19 patients to the acute sector
- Clearing non-essential services
- Manning help and support lines
- Reducing elective services to free up personnel and reduce risks to patients and staff.

The latest guidance from NHSE has asked us to focus on maintaining capacity to deal with COVID-19 patients and to plan to commence urgent elective and diagnostic care. The guidance asks that we plan to increase electives within social distancing directives and within the PPE requirements NHSE have set.

This paper sets out an updated summary of the COVID-19 actions. The ongoing challenge, and our response to such as a Trust.

**Recommendations**

It is recommended that the Committee note the information.

**Appendices**

1. Look back review and next phase
2. Operating framework for phase 2
1. **COVID-19 Update May**

1.1 31 December 2019, a handful of cases of a pneumonia-like virus with an unknown cause was detected in China.

1.2 Overview of The Rotherham Foundation Trust’s response to the pandemic:

The above diagram shows our initial actions and timings regarding the pandemic and more detail is provided in the slide pack attached. Within three months the virus has spread globally to over 200 countries worldwide.

1.3 COVID-19 is currently increasing the levels of deaths in the UK, with hospitals and community facilities continuing to experience high levels of care demand. This is causing severe challenges within the health service given the limited capacity within the system.

1.4 The next few months will see a levelling off of demand and the planning and implementation to increase the diagnostic and elective care our patients need. This is, of course, linked to the likely trend and the impact of the latest social restrictions.

1.5 The new “field hospitals” have been mothballed and equipment and resources have been diverted to acute NHS trusts nationally. The new virus has led to radical redesign within local and national health services, in order to enable the system to quickly ramp up and manage this unique situation our recovery process is aiming to maintain the good practice and ways of working.

2. **The Impact on The Rotherham NHS Foundation Trust**

2.1 The Trust is recording the ongoing information daily and linking into Rotherham Community Services and place. The national need for timely and extensive data has forced us to expand and equip our Incident Room to respond to the national team 7 days a week.
2.2 The critical care facility was opened in record time with full ITU facilities available on Wards A3-A4. We are now looking at how we de-escalate the capacity as the original 56 beds will be required to deliver business as usual.

3. **Our Response to Recovery Planning**

3.1 The presentation attached updates, in significant detail, the governance and the steps we have put in place to deliver essential care and to ensure we can prepare for the challenges of ahead.

3.2 The operating framework sent out by NHS England (NHSE) has been reviewed against our responses to ensure we are picking up the key recovery actions. The majority of actions are well underway with a small number which involve national and local support as below are the red rated actions that the operational teams are focusing on over the next few weeks.

- Enhanced planning and protection for patients who are clinically extremely vulnerable (shielded) from COVID-19, identified from Summary Care Record or by referring Clinician pre-arrival, where possible

- Maintain consistency in staff allocation where possible and reduce movement of staff and the crossover of care pathways where feasible between Planned and Elective care pathways and Urgent and Emergency care pathways.

- For patients who test negative, a further single re-test should be conducted between 5-7 days after admission.

- Asymptomatic: additional available NHS testing capacity should be used to routinely and strategically test asymptomatic frontline staff as part of infection prevention and control measures. Local health systems should work together with their labs and regions to agree the use of available capacity.

**George Briggs**  
Chief Operating Officer  
May 2020
Appendix 1

COVID-19
Look back and moving to the next phase

May 2020
SUMMARY

- TRFT COVID-19 infrastructure and support
- Initial phases were to contain and delay
- Now moving to second phase of responses
- National Level 4 incident remains
- SYLRF – a multiagency major incident was declared at 13:00 on Tuesday 17th March 2020 and continues
COVID-19: THE JOURNEY SO FAR (1)

- Inaugural Coronavirus Webinar
  Professor Keith Willett
  06 Feb

- TRFT Threat and Risk Assessment
  Working Strategy Contain Phase
  Gold & Silver Planning Meetings.
  17 Feb

- Staff swabbing at Woodside commenced
  04 March

- UK Government announces lockdown
  23 March

- South Yorkshire Local Resilience Forum Planning Workshop
  12 Feb

- TRFT Incident Control room opened
  02 March

- COVID assessment pod opened UECC
  13 March

- TRFT staff helpline opens
  24 March
COVID-19 INITIAL PHASE AND INFRASTRUCTURE

- Command and Control structure in place
- Gold and Silver meetings
- Senior nurse support on-site 8am – 4.30pm
- Incident Room support 8am – 8pm
- COVID-19 staff helpline 6am – 7pm
- Infection and prevention support 7 days a week
COVID 19: COMMAND STRUCTURE

**COVID-19 COMMAND STRUCTURE**

- **SILVER Update Email to Gold** - 08:00
  - **EXEC GOLD** - 08:30
    - Chief: CEO
    - Deputy CEO
    - Directors: Nursing, Operations, Finance, HMRC, Therapeutics, Reliability
    - Briefing: Executive Team, Gold in Call
    - Contact: Executive Team, Gold in Call
    - Task: Co-ordinate first strategic response and recovery

- **SILVER Ops Group** - 12:30
  - Chief: COO
  - Directors: Clinical, Nursing, Health, Information, Finance, Facilities, Communications, Human Resources, PCT
  - Briefing: Executive Team, Gold in Call
  - Contact: Executive Team, Gold in Call
  - Task: Manage the tactical level response andeshire the plan, pivotal links between Strategic & Operational command

- **BRONZE**
  - Health Communication
  - Facilities & Facilities
  - UKCC
  - Integration
  - COVID-19
  - Community rocket team
  - Family Health Care team
  - CSS
  - Operations Support
  - HR Support

- **GOLD Briefing** - 09:00
  - Directors: CEO, GM, H/PC, Operations, Estates & Facilities

- **HR Help Line** - 08:30

**Incident Room**

**TACTICAL**

**OPERATIONAL**

**STRATEGIC**

**AMBITION Caring Together**
## COVID-19: TRFT WORKING STRATEGY

### DELAY PHASE

**AIM:** Coordinate Trust command and control to minimise the impact of COVID-19 across the Trust and support recovery to normality as quickly as possible. Objectives as follows:

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<td>Minimise the risk of harm to patients, members of the public and contractors:</td>
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<td>- Provide appropriate segregation throughout the Trust which is proportionate and necessary to inhibit contamination</td>
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<td>Maximise the safety of staff:</td>
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<td>- Provide personal protective equipment for all staff who engage with patients across the Trust</td>
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<td>- Ensure appropriate health and wellbeing services are available for our staff to access</td>
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<td>- Ensure resources are redeployed as necessary to support critical functions</td>
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<td>Maintain all critical functions at pre-determined agreed levels</td>
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<td>Endeavour to treat all time critical cancer and urgent patients</td>
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<td>Deliver a swabbing service to support the return of staff to the workplace who are delivering/supporting critical functions across the Trust and local health partnerships</td>
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<td>Anticipate &amp; Identify current and potential COVID-19 demands in the community to maintain critical functions:</td>
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<td>- Collaborate with Rotherham Place partners to maximise opportunities supporting the maintenance of critical functions</td>
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<td>- Deliver a communication plan to inform both parties and staff, minimising anxiety and providing advice and support</td>
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<td>- Deliver a plan to meet demand exceeding current planning requirements</td>
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<td>8</td>
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<td></td>
<td>- Minimise reputational risk to ensure the Trust’s Vision and Mission are not compromised</td>
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<tr>
<td>9</td>
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<tr>
<td></td>
<td>- In collaboration with the Local Health Resilience-Partnerships prepare to manage additional deaths</td>
</tr>
<tr>
<td>10</td>
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<tr>
<td></td>
<td>- Develop a plan for the promotion of a return to normality and the restoration of any disrupted services at the earliest opportunity</td>
</tr>
</tbody>
</table>
COVID-19 IN NUMBERS

Number of Confirmed Cases (per day)

Cumulative Figures

CV19+  Live DC  Deaths

459  271  145

21/03/20  28/03/20  04/04/20  11/04/20  18/04/20  25/04/20  02/05/20  09/05/20  16/05/20
COVID-19 IN NUMBERS

No. of confirmed pts in any bed @8am

No of Confirmed pts in an ITU bed @8am
MOVING TO THE SECOND PHASE

• Revised infrastructure / support

• Working strategy being revised – second phase of response and recovery

• Gold Command – weekly standard item at Exec Team

• Silver – transition to recovery group and work streams

• Incident room – will remain 7 days per week

• Increasing guidance focused on next phase
GOVERNANCE FRAMEWORK

GOLD: Executive Team

SILVER: Recovery program

- Capacity & Planning KIT
- Workforce
- Outpatients
- Cancer Recovery
- PPE
- Bed Base and Winter Planning
- Community & Pathways

Independent Sector

Data Validation and Training

Testing
GENERATING ELECTIVE CAPACITY

1. PART ONE
   May – June 20
   Individual Divisions plan returns
   Diagnostics re-provide capacity
   - Referrals accept all
   - Cancer services on line but expect increase in demand
   - Add all patients to the waiting list
   - Critical care (60 beds out of the system)

2. PART TWO
   June – July 20
   Intermediate care Winter plan
   Waiting list plans
   - TRFTs Winter Capacity Plans
   - A4/ A3 B6 Winter Plans
   - 24 bed intermediate care unit
   - Closure of Davies Lord Hardy Court (CCG)

3. PART THREE
   Aug – Dec 20
   Winter
   - Winter Acute & Community Capacity
   - Care home usage
   - 60 Beds winter?
   - B6 could be a clean Critical Care rather than A floor
   - Ring fence T&O and surgery beds

Understanding the demand and required capacity
ISSUES NEEDING ESCALATION

• Day to day operational site issues, including COVID-19 related bed capacity – via site meetings – CSM on duty 24/7

• Other COVID-19 related issues which can’t be resolved by divisions – escalate via incident room 8am to 4pm

• COVID-19 planning / recovery issues – via recovery group or relevant work streams – e.g. PPE issues to weekly meeting

• Staff queries and concerns relating to COVID-19 absence – Staff helpline 6am to 7pm

• Out of hours via normal on-call arrangements
INCIDENT ROOM

- 8am to 8pm 7 days a week
- Central contact point for the regional incident management team for the NE&Y
- Ensures receipt and distribution of all information coming into the organisation and submission of all daily SitReps
- Three roles
  - **Tactical Commander** - Senior manager leading the incident room
  - **Manager** - Facilitate the effective management of the incident room, including SitReps, dissemination of guidance etc
  - **Administrator** - Provide comprehensive administration support to the incident control room and infrastructure
- Infrastructure being reviewed and requires a sustainable approach for coming months
- Workload has changed, focus on SitReps and information, less general queries and guidance
AIMS OF THE NEXT PHASE

- Aim in next phase is to maintain the capacity to provide high quality services for patients with COVID-19, whilst increasing other urgent clinical services and important routine diagnostics and planned surgery.

- Need to ensure we align TRFT second phase with the Rotherham Place arrangements/planning for recovery.
<table>
<thead>
<tr>
<th>Planned &amp; Elective Care</th>
<th>Urgent &amp; Emergency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients should only be required to attend hospital where clinically necessary- maximise all opportunities for remote, multi-professional virtual consultations.</strong></td>
<td><strong>On arrival, ensure patients are immediately identified as either i) asymptomatic; ii) symptomatic for COVID-19; iii) COVID+ and apply appropriate Infection Prevention and Control procedures.</strong></td>
</tr>
<tr>
<td><strong>Admission:</strong> only patients who remain asymptomatic having isolated for 14 days prior to admission and, where feasible, tested negative prior to admission (see next page on testing).</td>
<td><strong>Ensure within the Emergency Department and Urgent Access Clinics asymptomatic patients can comply with normal social distancing requirements.</strong></td>
</tr>
<tr>
<td><strong>Outpatients:</strong> only patients who are asymptomatic should attend, ensuring they can comply with normal social distancing requirements.</td>
<td><strong>Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated</strong></td>
</tr>
<tr>
<td>TRFT have rescheduled care based upon clinical needs and redesigned service delivery maximising the use of technology.</td>
<td>TRFT have in place a Front End streaming model by GP/ANP to assess patients on arrival at UECC and stream to appropriate location based upon presenting symptoms.</td>
</tr>
<tr>
<td>As part of recommencing elective work, plans are in place to ensure patients are swabbed and isolated prior to admission. Currently, urgent admissions are being swabbed prior to admission wherever possible and where timeframes allow.</td>
<td>‘Cold’ Waiting and Reception areas configured to comply with social distancing requirements.</td>
</tr>
<tr>
<td>TRFT Outpatient Group is being established to redesign how Outpatient services are developing on an ongoing basis, maximising the use of technology. Supported by PMO with QI approach.</td>
<td>Segregated hot and cold clinical area to enable the isolation of COVID+ or symptomatic patients ward areas and UECC.</td>
</tr>
<tr>
<td>Enhanced planning and protection for patients who are clinically extremely vulnerable (shielded) from COVID-19.</td>
<td>Enhanced planning and protection for patients who are clinically extremely vulnerable (shielded) from COVID-19.</td>
</tr>
<tr>
<td>Further work to be undertaken to identify ‘shielded patients’ What is the Trust doing differently for elective patients who are shielding when they come into hospital? Are we certain we can identify them?</td>
<td>Further work to be undertaken with partners to identify ‘shielded patients’ pre-arrival as a pre-alert and flag on Meditech where possible.</td>
</tr>
<tr>
<td><strong>Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated</strong></td>
<td><strong>Ensure planned activity aligns with other dependencies, inc. testing capacity, medicines supply, consumables and PPE.</strong></td>
</tr>
<tr>
<td>Remodelling of current bed base allows for segregation of COVID+ patient and suspected Covid, isolation is managed through day to day operations.</td>
<td>Modelling activity levels as part of recovery, taking into account PPE and other dependences.</td>
</tr>
<tr>
<td></td>
<td><strong>Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated or managed in a COVID+ cohorted area</strong></td>
</tr>
<tr>
<td>Segregated hot and cold clinical area to enable the isolation of COVID+ or symptomatic patients ward areas and UECC.</td>
<td><strong>Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated or managed in a COVID+ cohorted area</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Maximise opportunities for creating physical and / or visible separation between clinical and non clinical areas used by patients on a Planned &amp; Elective care pathway and those on an Urgent &amp; Emergency care pathway. (Solutions must be flexible and sustainable as demand and activity levels change over the next few months)</strong></td>
</tr>
<tr>
<td></td>
<td>Currently separate elective ward, further work needs to be undertaken in terms of bed capacity to ensure the separation of planned elective from emergency admissions, but this will be challenging to entirely separate them, whilst maintaining flexibility in the bed base. Work is being undertaken with Kinvara private hospital in relation to provision of capacity for elective patients.</td>
</tr>
<tr>
<td></td>
<td><strong>Ensure planned activity aligns with other dependencies, inc. testing capacity, medicines supply, consumables and PPE.</strong></td>
</tr>
<tr>
<td></td>
<td>Modelling activity levels as part of recovery, taking into account PPE and other dependences.</td>
</tr>
<tr>
<td>Patients</td>
<td>Emergency Admissions: all patients should be tested on admission</td>
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<tr>
<td></td>
<td>For patients who test negative, a further single re-test should be conducted between 5-7 days after admission.</td>
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<tr>
<td></td>
<td>Elective Admissions (including day surgery): patients should isolate for 14 days prior to admission along with members of their household. As and when feasible, this should be supplemented with a pre-admission test* (conducted a maximum of 72 hours in advance), allowing patients who test negative to be admitted with IPC and PPE requirements that are appropriate for someone who’s confirmed COVID status is negative.</td>
</tr>
<tr>
<td></td>
<td>The Department of Health and Social Care is leading the rollout of home testing. Pre-admission testing should not require a patient to break isolation requirements.</td>
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<tr>
<td></td>
<td>Inpatients: any inpatient who becomes symptomatic, who has not previously tested positive, should be immediately tested as per current practice.</td>
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<tr>
<td></td>
<td>Other day interventions: testing and isolation to be determined locally, based on patient and procedural risk.</td>
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<tr>
<td></td>
<td>Discharge: all patients being discharged to a care home or a hospice should be tested up to 48 hours prior to discharge.</td>
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<tr>
<td>Staff</td>
<td>Symptomatic: all staff or members of their household who are symptomatic should be tested as per current practice.</td>
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<tr>
<td></td>
<td>Asymptomatic: additional available NHS testing capacity should be used to routinely and strategically test asymptomatic frontline staff as part of infection prevention and control measures. Local health systems should work together with their labs and regions to agree the use of available capacity.</td>
</tr>
<tr>
<td>Serology</td>
<td>Access to antibody testing. as part of the government’s testing programme, will also begin to be made available to NHS staff and patients during this next phase. The results will be used to build our understanding and knowledge of COVID-19 and inform the clinical approach. More details will be set out in due course.</td>
</tr>
<tr>
<td></td>
<td>Follow the national IPC guidance: evidence based, web accessible and printable: associated checklists and compendium of all relevant IPC resources, including training resources, available in one central place (maintained in ‘real time’). And use the IPC Board Assurance Framework to ensure that recommended IPC measures are being reliably implemented within &amp; across the organisation.</td>
</tr>
<tr>
<td><strong>3. Excellence in Infection Prevention and Control</strong></td>
<td><strong>Use the appropriate level of Personal Protective Equipment (PPE), in line with the latest guidance from Public Health England</strong>&lt;br&gt; TRFT is following the National Guidance from PHE for the appropriate use of PPE. The PPE weekly meeting is established, chaired by the DIPC with Staff Side involvement. Utilising PPE Champions. The DCOO and Head of Procurement represent TRFT at the SYB ICS PPE meeting. Green</td>
</tr>
<tr>
<td>Agenda item</td>
<td>189/20</td>
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<tr>
<td>Report</td>
<td>Monthly Integrated Performance Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Michael Wright, Deputy Chief Executive</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1, B2, B10</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note ✓ Approval ☐ For information ☐</td>
</tr>
</tbody>
</table>

**Executive Summary**

**Enclosed is the Integrated Performance Report for the Trust, based on the latest available data (April wherever possible).**

**Given the pause on national contracting arrangements which was initiated in March, activity plans are still being finalised. Given this, activity figures are shown against prior year only.**

**The appendices are not provided this month, as these more detailed performance documents are provided to the appropriate Board assurance committees.**

**Recommendations**

The Board is asked to note the report.

**Appendices**

N/A
C1 A&E % Left without being seen  
Mar-20 5.00% 7.42%

C2 IP Friends & Family Test [% Positive]  
Feb-20 95.0% 97.0%

C3 % LAC assessments reported <30 days  
Apr-20 95% 77.8%

C4 New Complaints per NTE  
Apr-20 7.6 0.8

E1 Ambulance Turnaround Times % > 60 mins  
Apr-20 0.0% 0.2%

E2 Cancelled Operations  
Apr-20 0.8% 0.1%

E3 Delayed Transfer of care  
Apr-20 3.5% 0.1%

E4 Dementia Assessment  
Mar-20 90.0% 60.5%

E5 Hip Fracture Best Practice Compliance  
Jan-20 65.0% 75.0%

E6 Mortality (HSMR Rolling 12 Month)  
Jan-20 100 116.9

E7 % Pre-Neon Discharge  
Apr-20 20.0% 9.3%

R2 Cancer Standards 62 Day  
Mar-20 85.0% 80.0%

R3 Cancer Standards 62 Day Screening  
Mar-20 90.0% 90.9%

R4 Diagnostics (DMMI)  
Apr-20 1.0% 73.6%

R5 18 weeks (RTT Incomplete)  
Apr-20 92.0% 77.1%

R6 e-Referral Slot Issues Rate  
Feb-20 4.0% 10.0%

S1 Access to Antenatal Services within 90 days  
Apr-20 90.0% 92.2%

S2 C. Diff incidence rate per 100,000 bed days  
Apr-20 12.9 27.6

S3 Emergency Caesarean Section Rate  
Apr-20 16.5% 18.5%

S4 Harm Free Care  
Mar-20 95.0% 93.5%

S5 MRSA bacteraeina rate per 100,000 bed days  
Apr-20 0.0% 0.7%

S6 Potential under reporting of incidents  
Apr-20 43.3 47.2

S7 Readmissions (Non Elective 28 day)  
Feb-20 13.3% 12.1%

S8 VTE Assessment Completion %  
Feb-20 95.0% 81.8%

W1 Incident Reporting Culture - % Incidents Severe  
Apr-20 0.35% 0.12%

W2 Variance from Plan  
Apr-20 0.0% 0.01%

W3 Proportion of Temporary Staff  
Apr-20 5.01% 4.87%

W4 Sick leave Rates (In Month)  
Apr-20 3.95% 7.42%

W5 Staff Turnover  
Apr-20 1.26% 0.37%

Integrated Performance Dashboard (April 2020)

Key Achievements

1. Delayed Transfers of Care  
   Following the new discharge requirements coming into force in late March, our DTOC numbers dropped down to 0 and remained at or below 2 for the whole month. Over this period, there were 7 patients with delayed transfers of care in April totalling 14 delayed days.

2. Access to Antenatal Services within 90 days  
   Despite the disruption to most normal services in April, the midwifery team continued to provide patients with excellent access to services, with 272 out of 295 expectant mothers receiving an antenatal appointment within 90 days. The midwifery team have redesigned their services to minimise the risk to patients and their families, with the 28 week scan no longer routinely provided, and consultations provided by video or telephone wherever possible.

3. Staff Turnover  
   Staff turnover in April was positively impacted by the number of new starters in the month, which increased to 85% to over 30 new 3rd year student nurses, who have started work at the Trust as Band 4 support workers in advance of their formal accreditation this summer. There were 29 leavers in the month, including 12 staff with less than 5 years service at the Trust.

Potential Under-reporting of Incidents

This was the 10th consecutive month-of-achievement of this target, which reflects the positive reporting culture at the Trust. There were 2 severe or above incidents reported in April, and just under 100 incidents in total, of which 16 were expected to have led to moderate harm or above. The total number of incidents was significantly lower than previous months (less than 50% of February volumes), but was within the expected range given the reduced levels of activity.

Key Concerns

1. 18 Weeks Referral to Treatment (Incomplete)  
   From late March, given Covid-19, all non-urgent elective surgery and diagnostics were cancelled, meaning patients are still waiting for treatment. Whilst referral volumes were significantly reduced, given the reduction in activity, the waiting list now has over 2,000 long-waiters on it, more than double the number from two months earlier. All specialties bar two are now failing the standard, with ENT and Trauma and Orthopaedics seeing the most significant deterioration in performance.

2. Diagnostics (DMMI)  
   Due to the Covid-19 pandemic, all non-urgent diagnostics were put on hold for April. As we begin the recovery phase, diagnostic capacity is being increased in the Trust, but there is now a very significant backlog to work through, with over 3,600 patients having waited longer than 6 weeks. Over 450 of these patients require an endoscopy, and nearly 2,000 are awaiting urological scans. Patients are being prioritised by clinical need and chronological referral date, with the Trust requesting additional scanning equipment on site as well as access to the Independent Sector diagnostic capacity in Sheffield.

3. Mortality (HSMR Rolling 12 month)  
   There were 12 62-day breaches in March, including 5 within Urology. 4 of the 12 breaches were within wholly-owned pathways, with the other 8 breaches coming from shared pathways with Sheffield Teaching Hospitals NHS FT. Our median IFT day for these breached patients was 54, with 3 of the breaches being fully rectified to TRF due to the delayed transfer. Given Covid-19 led to a delay in almost every outpatient pathway in April, we expect the performance to deteriorate significantly over the next few months.

4. Continued Challenged Performance  
   The HSMR fell slightly to its 2nd highest level in January, with 4 outlying groups attracting significantly higher than expected deaths (Other lower respiratory disease, Pneumonia, COPD and Congestive Heart Failure). Work is being undertaken to further understand this, and make changes to patient pathways or clinical practice where appropriate. The change to the reporting of observation activity was implemented in April, ensuring that the Trust's counting of non-elective activity is in line with our peers and that our mortality metrics are calculated on the same basis.

5. Cancer Standards (62 Day)  
   There were 12 62-day breaches in March, including 5 within Urology. Of the 12 breaches were within wholly-owned pathways, with the other 8 breaches coming from shared pathways with Sheffield Teaching Hospitals NHS FT. Our median IFT day for these breached patients was 54, with 3 of the breaches being fully rectified to TRF due to the delayed transfer. Given Covid-19 led to a delay in almost every outpatient pathway in April, we expect the performance to deteriorate significantly over the next few months.

6. Continued Challenged Performance  
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7. Continued Challenged Performance  
   The HSMR fell slightly to its 2nd highest level in January, with 4 outlying groups attracting significantly higher than expected deaths (Other lower respiratory disease, Pneumonia, COPD and Congestive Heart Failure). Work is being undertaken to further understand this, and make changes to patient pathways or clinical practice where appropriate. The change to the reporting of observation activity was implemented in April, ensuring that the Trust's counting of non-elective activity is in line with our peers and that our mortality metrics are calculated on the same basis.

8. Continued Challenged Performance  
   The HSMR fell slightly to its 2nd highest level in January, with 4 outlying groups attracting significantly higher than expected deaths (Other lower respiratory disease, Pneumonia, COPD and Congestive Heart Failure). Work is being undertaken to further understand this, and make changes to patient pathways or clinical practice where appropriate. The change to the reporting of observation activity was implemented in April, ensuring that the Trust's counting of non-elective activity is in line with our peers and that our mortality metrics are calculated on the same basis.

9. Continued Challenged Performance  
   The HSMR fell slightly to its 2nd highest level in January, with 4 outlying groups attracting significantly higher than expected deaths (Other lower respiratory disease, Pneumonia, COPD and Congestive Heart Failure). Work is being undertaken to further understand this, and make changes to patient pathways or clinical practice where appropriate. The change to the reporting of observation activity was implemented in April, ensuring that the Trust's counting of non-elective activity is in line with our peers and that our mortality metrics are calculated on the same basis.

Data Quality Key

1. Granularity: is there sufficient detail to make this easy to understand?
2. Contemporaneous: is data available, real-time or within 24 hours of clinical event?
3. Completeness: have all required elements been completed?
4. Sign-off: is there a named responsible individual who will authorise the data as accurate and a true reflection?
5. System/Data Source: is there a data capture tool or process that supports the capture of this information accurately and reliably?
6. Auditable Process: is this a process that can be audited and has it been audited recently? i.e least 12 months

84
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>189/20(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Quality Report</td>
</tr>
</tbody>
</table>
| Executive Lead | Angela Wood, Chief Nurse  
Dr Callum Gardner, Medical Director |
| Link with the BAF | BAF: B1, B4, B7  
Corporate Risk Register: 3908, 4733, 4174, 4080 |
| Purpose | Decision [ ]  
To note [✓]  
Approval [✓]  
For information [ ] |

**Executive Summary**  
(including reason for the report, background, key issues and risks)

This report is provided to enable Board Members to summarise a set of quality indicators and to provide assurance to the Board of Directors.

There is an ongoing focus throughout the Trust on management of the pandemic. Systems and processes continue to be utilised as much as possible to maintain and monitor the quality of services. A number of national metrics normally reported to measure quality are currently suspended.

**Recommendations**

The Board is asked to note this report.

The Board is also asked to consider and approve the Quality Improvement Priorities for 2020/21.

**Appendices**

1. Hospital Acquired Infections  
2. Patient Experience response to COVID  
3. Nurse Staffing Data  
4. Quality Improvement Priorities for 2020/21
1.0 Patient Safety

1.1 Harm Free Care – Data collection for all national Patient Safety Thermometers has now permanently ceased. It is anticipated that a replacement national system for monitoring patient safety may be implemented and the Board of Directors will be updated once this information is available.

1.2 Hospital Acquired Infection - There were 35 cases of Clostridium difficile in 2019/20, which breached the trajectory of 11 cases. No links between cases was identified following investigation by the lead IPC nurse at the CCG. There was 1 case of MRSA bacteraemia in 2019/20, which breached the zero trajectory. There were 30 cases of E.coli bacteraemia attributed to TRFT.

COVID19 management is in progress. See appendix 1 for further details.

1.3 Looked After Children (LAC) - The percentage of Initial Health Assessments (IHA) completed within the statutory 20 working day timeframe was 78% for April 2020. During the month, 9 IHAs required completion, of which 7 were within timescale. Both patients who received assessment outside the 20-day timeframe were offered telephone appointments within 20 days but were unfortunately unable to accept these appointments.

1.4 Mortality – The HSMR currently sits at 116. Although this is still statistically significant, it is a slightly improved position. The SHMI sits at 118. This does not reflect recent changes due to the normal 6-month delay. Whilst there is still considerable mortality work happening, in view of COVID-19, the Clinical Teams have been more patient-based. The Trust now receive a detailed mortality report from Dr Foster to provide further insight into the themes and trends affecting our data.

2.0 Patient Experience

2.1 Complaints - The Trust received 57 concerns (87 in March) and 3 formal complaints (25 in March) in the month of April. 30 complaints were closed, of which 6 were local resolutions meetings (it should be noted that these meeting took place before social distancing restrictions were in force). Complaints responded to within the agreed timescale was 79% (87.5% in March). There was 1 complaint re-opened in April, making the total currently being re-investigated 16.

2.2 Friends and Family Test (FFT) – Data collection has been paused and no further data will be provided until further notice.

2.3 Patient Experience Response to COVID – During the current pandemic, visiting to the Trust is severely restricted. To ensure patients are still able to have a positive experience and maintain contact with loved ones, some temporary support roles have been established. See appendix 2 for further details.

3.0 Clinical Effectiveness

3.1 Nurse Staffing – In response to the COVID19 pandemic, significant disruption to nurse staffing has continued. Nurse staffing data has therefore not been included this month due to the frequent reconfiguration of bed bases. Details of actions being taken to ensure safe nurse staffing levels are being maintained are shown in appendix 3.

3.2 CQUIN’s - NHS England and NHS Improvement have confirmed that they will not be seeking the submission of 2019/20 quarter 4 data from providers. In addition, the 2020/21 CQUIN
(Commissioning for quality and innovation) will be suspended for the period from April to July 2020, and there is therefore no requirement to take action to implement the CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. However, the Trust will continue to obtain baseline information and identify any areas for action, where required.

4.0 Quality Governance

4.1 Quality Priorities - The proposed Quality Improvement Priorities for the year are attached at Appendix 4. They have been reviewed and widely consulted on, until the final suite of priorities were agreed. It is anticipated that progress with these will be constrained for at least 6 months, but that progress will be made where possible.

The Board is asked to approve the Priorities for 2020/21.

4.2 Care Quality Commission (CQC) - A range of activities continued throughout April in preparation for the 2020 CQC inspection, focussing on completion of action plans. Confirmation has now been received from the CQC that the current inspection regime is temporarily on hold. Preparations for inspection later in the year will continue where appropriate. It is recognised that some previously completed actions such as mandatory training levels may fall off track due to current pressures.

5.0 Conclusion

5.1 Quality of care delivery remains a priority and measures are being taken to ensure that this continues to be maintained, monitored and reported, as much as possible, despite the continued significant disruption to services.

Angela Wood    Dr Callum Gardner
Chief Nurse     Medical Director
May 2020
Hospital Acquired Infections

- The 2020/21 TRFT trajectory for Clostridium difficile infection has not yet been received, as for 2019/20 will include any case where the person has been an in-patient in the 4 weeks prior to the sample date irrespective of any other hospital admission or GP prescribing. There have been 2 cases to date.

- The 2020/21 TRFT trajectory for MRSA bacteraemia has not yet been received but is anticipated to remain as zero hospital acquired cases. There have been 0 cases to date.

- The 2020/21 TRFT trajectory for E.coli has not yet been received however is anticipated to be issued for all trusts for the first time this year. Previous reduction trajectories have been to CCG’s only. There have been 0 cases to date.

- There have been 0 cases of MSSA bacteraemia to date with no trajectory set.

- Influenza: Numbers of cases have returned to low level, monitoring continues until May

- COVID19: The whole Trust has been rapidly adapted to support the planning, working and management of COVID19 coronavirus. To date there have been 321 in-patients with a positive result of which 233 have been discharged and sadly 129 have died.

Following initial home testing of patients, a drive through facility was made at Woodside. As the testing guidance moved to symptomatic in-patients only the drive through has been used to support staff testing (and immediate household contacts) in order to enable staff to return to work rapidly if negative. Screening is currently being extended into primary care areas with wider essential staff testing via regional models.

Areas within the hospital have been designated between red (positive or respiratory symptoms) Amber (symptomatic and asymptomatic testing in progress) and Green (negative result) to reduce the risk of spread of infection.

The biggest challenge currently is the availability of Personal Protective Equipment (PPE) which is an international situation and is being closely monitored internally on a daily basis to ensure our staff have PPE in line with national guidance. Although procurement has at times been challenging, this has been provided as required across both community and the hospital setting, leaving no staff members without the appropriate PPE by utilising supply chain and Integrated Care System (ICS) partner organisation resources.

Nationally and across the ICS, the re-use of single use items such as masks and gowns is being considered. This has not been required within the Trust to date and will only be undertaken when all supplies and contingencies have been exhausted.

The Trust is now preparing for a return to urgent elective procedures where possible.
**Patient Experience Response to COVID**

**Patient Communication Service**

Due to the Covid-19 pandemic hospital visiting was drastically reduced, with the majority of patients allowed no visitors whatsoever. We have therefore implemented an inpatient communication system. Care Assistant training was underway for the re-deployment of staff, and building on this foundation of knowledge this cohort were asked if they would like to specialise to act as Patient Communication Facilitators. 14 members of staff have been trained to help inpatients contact their loved ones through phone and video calls, updates and messages. The cohort of re-deployed staff have come from Bone Health, Park Rehabilitation, Sterile Services, Diabetes Centre and Doncaster Dentistry and Audiology.

Inpatients can now request for the communication team to help them contact their loved ones. This can be phone calls, video calls, messages/updates and emails. Calls can be pre-arranged with the team at a convenient time or can be done as they go from ward to ward in real time. We can also simulate multiple visitors at one time, with four-way video calls taking place. Many people find themselves in situations where they were not expecting to stay in hospital, so either do not have their mobile phone with them or it has run out of battery, or simply do not own one. The team have been supporting people with visual impairments with video calling so that their family can still see them, and deaf video calls with the nurses on the ward writing on a laminated A3 piece of paper patient and relative dialogue.

Friends and relatives can also email rotherham.patientengagement@nhs.net to send a ‘Rainbow Message’ to their loved one. This is sent with a knitted heart that has been donated to the Rotherham Hospital Charity, by members of the local community.

Reacting in the changing environment has not been without its challenges, and some communication facilitators have been pulled back to other areas as activity increases, despite this, numbers have been increasing rapidly as capacity of the service increases. The emotional and physical demands of this role are high, but staff that have undertaken this role have also expressed that this may change their career trajectory to a more clinical, patient facing role.

**Patient Property Service**

When the communication service was developed, it was predicted that this would generate an increase in inpatients asking their families to send in personal belongings. The Patient Property Service was set up to cope with this demand, reducing the burden on ward staff.

The Patient property service is located at the Moorgate Wing entrance on Level E, the Patient Property Team have been facilitating the entry and exit of essential items for inpatients. Patients, relatives or ward staff contact the team either by email or telephone to arrange an appointment slot. Due to infection control requirements any items brought in must be in a sealed plastic bag. The team also facilitate the exchange of dirty laundry in sealable bags, which dissolves in a washing machine. All wards have received deliveries of the dissolvable bags.

The Patient Property and Communication Team are available between the hours of 9am-4pm, Monday to Friday.

Items brought in often have a direct effect upon patient care, such as:

- false teeth; enabling ease of eating
- hearing aids and spectacles; assisting effective communication
- mobile phones/chargers; helping with communication and mental wellbeing
- snacks and squash; assisting with nutrition and hydration
- photos of loved ones

Nine staff have been redeployed from Cardiac Physiology, Trauma and Orthopedics, Medical Education and Sterile Services.

Staff offer to the person dropping off property, to send a knitted heart to their loved one and keep the matching heart for free (hearts were donated to the The Rotherham Hospital Charity).

The flexibility of re-deployed staff has been astounding, reacting and volunteering to help with the needs of the Trust with professional dedication that deserves recognition and praise.
Appendix 3

Nurse Staffing

There has been an increase in Registered Nurse/Midwife fill rates on both days and on nights when compared to those for March with a reduction in Healthcare Support Worker shift fill rates. The overall vacancy rate has reduced with recruitment plans included during April 2020.

Nurse staffing has been temporarily increased in some wards and departments to safely manage the increase in acuity and patient numbers in those areas. Critical care has temporarily moved location to wards A3 & A4 with an increased number of ventilators in anticipation of increased demand, consequently planned staffing has temporarily increased to support this. Wards have been flexed to care for patients that are Covid positive, negative or awaiting results depending upon requirements.

Care Hours per Patient Day (CHpPD) is a metric introduced following Lord Carter’s review of efficiency in the NHS to record a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. During April the CHpPD for Registered staff was 7.1 and 4.7 for non-registered staff, resulting in an overall increased actual CHpPD of 11.8, driven by the reduced admissions for non covid illness and redeployment of staff.

International nurse recruitment was placed on hold due to the restrictions on travel during the pandemic. The Trust continue to liaise with NHSP International and will resume the recruitment process as soon as possible.

The Staffing Hub was established to manage the movement of staff to support the wards throughout the period of the pandemic. This has enabled a Care Assistant role to be created to provide additional presence in clinical areas and has supported the redeployment of both Registered Nurses and Support Workers to patient facing clinical roles following refresher training.

Forty four 3rd year student nurses have opted-in to move into clinical practice at the Trust and started their extended paid placements during April 2020. Forty two 2nd year adult student nurses have opted-in to undertake a paid placement at the Trust. A rotational placement is currently being explored for these students which will broaden their experience, whilst providing additional support to key teams such as Safeguarding, Infection Prevention and Control and Discharge Co-ordination. Smaller numbers of 2nd and 3rd years students have also opted-in to clinical practice in Children’s and Midwifery services.

Twenty one newly qualified nurses started at the Trust during March 2020. The recruitment process has commenced for nurses due to qualify in September 2020, 39 have accepted a post at TRFT to date.

Rolling adverts are live for nurses wishing to return to practice. Training and support will be provided in-house to enable them to pass the required Objective Structured Clinical Examination (OSCE) to re-register with the Nursing and Midwifery Council (NMC). 12 candidates have been successful from the first cohort. Recruitment are prioritising the pre-employment checks of those on the temporary NMC register. Further interviews are planned to take place on 20 May.

In the Community there were 0 day shifts during April that were not staffed to plan, which is an improved position as compared to last month. There were 16 nights shifts staffed below plan which equates to 26.6% of District Nursing night shifts being below plan, which is a marginally improved position as compared to March 2020.

Senior nurses continue to review rosters on a daily basis to ensure appropriate numbers and experience to manage the current acuity. It has been recognised that additional support for the Health
and Well Being of colleagues is beneficial at this stage and the Trust has successfully secured charitable funding to enable us to participate in the NHS Leadership Support Service: Nightingale Frontline. This service will equip senior nursing and midwifery leaders with the skills to provide emotional well-being support to nurses and midwives during and beyond the crisis.
QUALITY IMPROVEMENT PRIORITIES FOR 2020/21

1. Introduction

1.1 It is a legislative requirement to develop the Quality Improvement Priorities for the Trust, which will be included in the Trusts 2019/20 Quality Account. This report provides an update on the progress of the development of the 2020/21 quality priorities.

2. 2020/21 Quality Priorities

2.1 A three stage process was undertaken to develop the 2020/21 Quality Priorities. This is as follows;

Stage 1 – Review Need for 2019/20 Priorities to Continue
It was recognised that some of the priorities for 2019/20 were new and others had been in place for a number of years. Therefore, some have been suggested for 2020/21 and others are to become business as usual.

Stage 2 – Identification of New Priorities based on Domains
The Chairs of the Patient Safety, Patient Experience and Clinical Effectiveness Groups have held discussions at their respective groups and then ideas were put forward for potential 2020/21 quality priorities. This enabled the proposed 15 to be initially identified.

Stage 3 – Consultation
Consultation then occurred to reduce the 15 to the final 9 (detailed in Appendix 1). This was through the Clinical Governance Committee and Board of Directors seminar session, and will continue through engagement with the Trust stakeholders.

Following approval of the final nine, the information under these, the aim, objectives and measures have been developed and are located at Appendix 2.

3. Conclusion

3.1 In conclusion, the proposed priorities for next year have been developed, which will be included in the 2019/20 Quality Report (Account).

4. Recommendation

4.1 Members of the meeting are asked to approve the priorities for next year.

Anne Rolfe
Quality Governance, Compliance and Risk Manager
May 2020
Appendix A – Proposed Quality Priorities

Patient Safety

- Learning from incidents
- Embed Human Factors & Introduce Schwartz Rounds Within The Organisation
- Roll-Out Medical Examiner Office

Clinical Effectiveness

- Utilisation of Trust Wide Audit to Facilitate Improvement in 3 Key Areas:
  - Sepsis Management
  - Medicines Management (incorporating compliance with anti-coagulation and Insulin Script modules)
  - Completion of Learning from Incidents Action Plans
- Reduce HSMR and improve Learning from Deaths
- Ensure staff have the knowledge and training to give excellent care to Patients with a Learning Disability & Autism, with the implementation of ‘The Learning Disability Improvement Standards’ from NHS Improvement (NHSI).

Patient Experience

- Friends and Family Test (FFT) - embedding of new questions and process and FFT - improved evidence of learning from feedback, you said we did
- Diversity and Inclusion
- Maximising the potential of Volunteering - recognise, recruit, embed and celebrate
### Appendix B – Details of the Proposed Quality Priorities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Learning from Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current position and why is it important?</strong></td>
<td>The Trust is committed to learning and making changes as a result of incidents to improve the safety and quality of health services for service users and the environment for patient’s, colleagues and visitors. When adverse incidents occur, investigations are undertaken resulting in recommendations to prevent future lapses in care. It is important to ensure that any recommendations are acted upon, in a timely manner and shared with colleagues across the trust to ensure trust wide learning.</td>
</tr>
<tr>
<td><strong>The aim and objective(s) (including the measures/metrics)</strong></td>
<td>To ensure that the organisation responds, learns and improves from the outcomes of adverse incidents including Complaints, Inquests, Serious Incidents and Structured Judgement Reviews.</td>
</tr>
</tbody>
</table>
| **The planned activity to achieve this**                                 | • Provide one day training for a range of medical/nursing and therapy staff in undertaking structured judgement reviews.  
• To ensure all investigations are undertaken by appropriate individuals who have received required training to complete the investigation/review.  
• To ensure all investigations/reviews are completed within agreed time scales and make clear recommendations for improvement.  
• To maintain a register of action plans and audit programme to demonstrate completion of actions and ongoing compliance.  
• To ensure a corporate monitoring process is followed to provide assurance of completion of action plans.  
• To utilise a range of methods to disseminate learning and knowledge beyond the immediate team and to the wider Trust, including reviewing emerging themes and trends on a quarterly basis to ensure that any identified areas of concern can be acted upon.  
• Hold regular learning the lessons events across the division, sharing the learning, the good practice and areas for improvement. |
<p>| <strong>How will progress be monitored and reported?</strong>                         | Progress will be reported and monitored by the Patient Safety Group, Clinical Governance Committee and Quality Committee.                                                                                                                                                                                                                                         |</p>
<table>
<thead>
<tr>
<th>Priority</th>
<th>Embed Human Factors &amp; Introduce Schwartz Rounds Within The Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current position and why is it important?</td>
<td>Human factors is the study of interactions between people and the system in which they work. It can be used to improve patient safety both by aiding our understanding of incidents and safe practice and by making changes to the system and the culture that we work in. Historically, there has been limited use of a Human Factors approach within the Trust. However, the uptake of a human factors approach to patient safety is being increasingly advised by bodies such as NHSI(^1) and Health Education England(^2) and has much to offer; as such the Trust has now appointed its first Associate Medical Director for Human Factors. The Quality Priority will focus on two distinct parts: the first which will focus on a number of areas that have the maximum scope for improvement using a human factors approach; and the second which will focus on improving colleagues wellbeing within the organisation.</td>
</tr>
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</table>
| The aim and objective(s) (including the measures/metrics) | • Introduce a human factors approach to incident investigation and action planning.  
  o Metric 1 - Proportion of incident investigations completed by staff with human factors training.  
  o Metric 2 - Proportion of investigation action plans including system change or other higher effectiveness interventions.  
• Wider adoption of in situ simulation for team training in nontechnical skills such as teamwork, leadership and communication. Simultaneous use of in situ simulation as a governance and quality improvement methodology to detect latent errors (hidden safety hazards) and lead improvements in work environment.  
  o Metric 1 - Number of in situ simulations completed.  
  o Metric 2 - Number of simulation reports leading to safety actions.  
• Re-introduction of Schwartz Rounds to the Trust.  
  o Metric 1 - Appoint Clinical Lead and link with POF Q1.  
  o Metric 2 - Rounds arranged/communication plan in-situ Q2.  
  o Metric 3 - At least 4 Schwartz Rounds within Trust by end Q4. |
| The planned activity to achieve this | • Human factors training (1 day workshops) for staff involved in incident investigation and all Divisional Directors, Heads of Nursing and Managers, and relevant Safe & Sound Quality Directorate staff.  
• In situ simulation programme to be increased in size. To be rolled out into new areas of the Trust beyond the current programmes in UECC and Obstetrics. Reporting from each session to divisional Governance structure and use of Datix (incidents from simulation) where required.  
• Re-introduction of Schwartz Rounds to the Trust. |
| How will progress be monitored and reported? | • Number of colleagues completing human factors training.  
• Analysis of SI reports quarterly for human factors authorship, content and actions.  
• Number of in situ simulation reports completed quarterly. Number of safety actions resulting.  
• Staff Survey results (to be published Dec 2020). Questions 4j, 6c, 13b and 13c relate to staff interactions and questions 17a, 17c and 18c relate to the organisational response to incidents and the staff involved. |
• Number of, and attendance at, Trust Schwartz Rounds.
• Audit feedback on use of Schwartz rounds
• Monthly reporting of above matrices to Clinical Governance Committee and Quality Committee.

1 NHS Safety Strategy. Safer culture, safer systems, safer patients. NHSI 2019
2 In Safe Hands: Prioritising Patient Safety across the NHS, HEE, 2020
<table>
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<tr>
<th>Priority</th>
<th>Roll-Out Medical Examiner Office</th>
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</table>
| **Current position and why is it important?** | The Trust is currently strengthening the mortality process such that all deaths are reviewed in a timely manner and that issues in the quality of care are highlighted and escalated quickly to ensure learning from deaths across all divisions.  
The implementation of the Medical Examiner Office will allow all deaths to be reviewed, supporting bereaved families to ask questions or raise concerns about the quality and safety of care of their loved one to ensure a full picture of the episode of care has been considered. A full Structured Judgement Review will be undertaken to review the quality and safety of the care provided by a multi-disciplinary team will identify areas where quality of care could be improved, taking into account the family and concerns they have highlighted.  
Whilst the Medical Examiner’s office is non statutory at present, it will become statutory in the near future. It is therefore important that the Trust has an adequately resourced Medical Examiner Office in order for it to carry out the necessary duties. |
| **The aim and objective(s) (including the measures/metrics)** | The aim is to ensure all deaths have scrutiny and that family members and carers have the opportunity to comment on the quality of care their loved ones received so that learning, both positive and negative, can be disseminated across the organisation.  
At least 98% of all deaths within the Trust will have either a first-stage within 1 month of the death or both a 1st and second-stage review (SJR) within 2 months of the death within each division.  
A dashboard of the timely reviews and the outcomes of these reviews will be discussed monthly at Corporate level with performance monitored through the Trust Mortality and Morbidity Meetings.  
Any death scoring 1 or 2 in any phase of care (significant quality of care issues) will be escalated within 1 month to the Trust mortality meeting and will be reviewed by the Serious Untoward Incident panel.  
All deaths involving learning disability patients and all deaths resulting in either a Coroner’s investigation and/or inquest will undergo a stage-two mortality review (SJR) and report into the divisional Mortality and Morbidity meeting and Trust wider Mortality meeting and Trust Board. |
| **The planned activity to achieve this** | There is currently 1 lead ME with plans to appoint 2 more MEs. The Medical Examiner’s office will have a band 6 Medical Examiner Officer, 2 Band 5 Medical Examiner Officers and a band 2 administrator. The other arm of the Medical Examiner will be to have learning from deaths nurse in post to coordinate the outcomes of the reviews and ensure learning from these deaths.  
Each division will implement robust, multi-disciplinary SJR reviews, which will be timetabled within the Division. |
| How will progress be monitored and reported? | Progress will be reported monthly by the Trust Mortality Group, Patient Safety Group, Clinical Governance Committee, Quality Committee and the Board, including through the introduction of a new monthly dashboard with Executive oversight by the Medical Director. |
## Utilisation of Trust Wide Audit to Facilitate Improvement in 3 Key Areas:

- Sepsis Management
- Medicines Management (incorporating compliance with anti-coagulation and Insulin Script modules)
- Completion of Learning from Incidents Action Plans

### Current position and why is it important?

Audit is a powerful tool but is often considered to be useful for assurance purposes only. The Clinical Effectiveness department, and the Safe & Sound Quality Directorate as a whole, wishes to show that audit is a powerful quality improvement tool by using audit to identify gaps in standards in areas of Trust-wide significance and to use audit as a launch for Trust-wide improvement projects. National audits are often criticized at the local level as by the time results are reported changes to local systems and services have occurred, thereby reducing the value of results. By undertaking local audits, results can be more readily available and reported in a timely and useful way. It is important to focus on areas that staff believe is an area of local/Trust importance to encourage engagement if a Trust-wide systems approach is to be employed.

The first key area chosen for Trust-wide audit remains an ongoing area of challenge; the 2nd key area chosen is to give the Trust further assurance of sustained learning from incidents by auditing key action plans for significant actions and/or themes that are determined through the learning from incidents.

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

The aim will be to undertake an audit and use the results to identify areas where other quality improvement techniques can be used to improve the service/patient outcomes. Measures and metrics will be confirmed once the area of focus has been agreed.

**Medicines Management** – compliance with anti-coagulation and Insulin Script modules mandatory training for identified medical staff and relevant non-medical prescribers

- Q1 – identification of those in scope which are then added to ESR and communicated to those staff
- Q2 - 50% compliance with those two mandatory training modules by end of the quarter
- Q3 - 70% compliance with those two mandatory training modules by end of the quarter
- Q4 – 85% compliance with those two mandatory training modules by end of the quarter

**Completion of Learning from Incidents Action Plans**

- Q1 - set up meeting for the monitoring of learning from complaints, claims and incidents and process for monitoring action plan compliance.
- Q2 - 30% of actions implemented and learning embedded
- Q4 – achieve 75% for the re-audit of actions which were not implemented and embedded in Q2
| The planned activity to achieve this | • Agreement and refinement of areas of focus for first 2 key areas in Quarter 1, including compliance with sepsis bundle  
• Audit of standards pertaining to topic agreed  
• Analysis of results and Root Cause analysis of non-compliant areas  
• Implement recommendations – ongoing measurement of outcomes (use of Plan, Do, Study, Act (PDSA) and Statistical Process Control (SPC))  
• Re-audit at post 6 months’ implementation (for first 2 key areas)  
• For the 3rd key area, spot audits of ongoing compliance and/or sustained learning from completed action plans relating to significant actions and/or themes will be added to the Trust’s Forward Audit Plan. |
<p>| How will progress be monitored and reported? | Progress will be reported and monitored by the Clinical Effectiveness and Research group and Clinical Governance Committee, with highlight reporting to the Quality Committee. |</p>
<table>
<thead>
<tr>
<th>Priority</th>
<th>Reduce HSMR and improve Learning from Deaths</th>
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| Current position and why is it important?   | The Trust’s HSMR and SHMI are both currently high at 116 and 118 respectively (December 2019 data).  
It is vitally important that the Trust learns from deaths and implements change where necessary within a timely fashion so that care can quickly be altered to improve patient safety and outcomes, focussing on the ‘3 C’s’ (quality of Care; Case mix; Coding). |
| The aim and objective(s) (including the measures/metrics) | The Trust will improve its HSMR and SHMI to within the accepted normal range, aiming for a target of 108 or less.  
The Trust will improve the Learning from Deaths by ensuring and evidencing that the learning from the Trust’s external mortality review is shared and disseminated at local/specialty level and that this informs positive changes in practice.  
The Trust will focus on 3 key areas to improve quality of care, identified through recurrent mortality alerts:  
  - **Sepsis**  
    - Early and improved recognition of Sepsis – baseline and measure TBC  
    - Timely application of Sepsis 6 tool and compliance with the tool – baseline and measure TBC  
  - **Community-acquired Pneumonia (CAP)**  
    - Reintroduce the Trust’s CAP care bundle and improve achieve utilisation in 50% of all cases by end of Q3 and 90% of all cases by end of Q4  
    - Ensure that the CAP risk-stratification CURB65 tool is routinely documented and improve achieve utilisation in 70% of all cases by end of Q3 and 90% of all cases by end of Q4  
    - Agree coding parameters, such that clinical coders can code severity of pneumonia based on CURB65 and/or where “severe” pneumonia is documented.  
  - **Improve End of Life Recognition and proactive implantation of appropriate ceilings of care**  
    - Introduce palliative care training/End of Life training to all relevant medical staff with compliance of 25% by end of Q3 and 50% by end of Q4  
    - Work with Rotherham Place partners to consider the introduction of either ReSEPCT or the Gold Standard Framework (GSF) Hospitals Programme  
| The planned activity to achieve this | The Trust will also improve its assurance around the Learning from Deaths by monitoring the dissemination of learning from Structured Judgement Reviews (SJRs), inquests and Serious Incidents resulting in death within CSUs and Divisions, with reporting of relevant governance meeting minutes to the Clinical Governance Committee.  
The Trust will ensure that regular, timetabled SJRs are taking place in each division, with appropriate monitoring of compliance via the Trust’s new mortality dashboard. |
All SJR's will be timetabled for the presentation at the divisional M&M meetings, with agreement of any problems in care as outlined within the SOP.

The Trust will ensure that there are monthly, quorate Mortality Group meetings within each Division and that the Trust Mortality Group is represented by all Divisions.

<table>
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<tr>
<th>How will progress be monitored and reported?</th>
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<tr>
<td>Priority</td>
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<tr>
<td>Current position and why is it important?</td>
</tr>
<tr>
<td>The aim and objective(s) (including the measures/metrics)</td>
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</table>
| The planned activity to achieve this | • Identify which staff groups and Trust areas would most benefit from the training, by identifying where people are most often admitted from the flagging of PLD  
• Audit the staff groups level of knowledge with a questionnaire to obtain benchmark and identify areas for concentrated effort.  
• Look at flexible training sessions for staff groups, ward meetings, face to face training sessions, information on wards, Tuesday lunchtime lecture at PGME  
• Involvement from experts by experience to deliver some training sessions (outreaching to advocacy groups within Rotherham for people with LD and Autism)  
• Provide access point to staff with LD to discuss issues on urgent basis if necessary.  
• Identify those staff who might need more support than others and have plan how to do so effectively.  
• Create culture of confidentiality and trust with the LD staff.  
• LD can be one manifestation of complex conditions, therefore address these complexity if it is arise by providing the right resources.  
• Review the care of PLD within 3 days of admission, ensuring reasonable adjustments are being made for PLD & Autism across our care pathways  
• Test that our flagging systems working and identify a person at point of admission |
- Ensure that patient passports are requested, read and care is implemented based upon content
- Engage PLD & Autism, families and carers
- Monitoring any restrictions in place, application of Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DOLs), working in a person’s best interests
- Appointment of learning disability champions on each unit/division

| How will progress be monitored and reported? | To re audit with a questionnaire the level of knowledge of the staff groups that attended the training sessions, to see if this level of knowledge has improved.  
To monitor complaints to see if there is a reduction  
Monitored through Clinical Governance Committee and Quality Committee. |
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<tr>
<td>Priority</td>
<td>The Friends and Family Test (FFT) – the embedding of new questions and processes and FFT - improved evidence of learning from patient feedback, - adopting ‘You said - we did’</td>
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</table>
| Current position and why is it important? | The NHS FFT is designed to be a quick and simple mechanism for patients and other service users of the NHS to give their feedback, which can then be used to identify what is working well, address what did not go as expected and thereby to improve the quality of any aspect of a patient’s experience.  

The national change and required revisions to the FFT will now be made up of a single mandatory question, which is then to be followed by at least one open question to enable a free text response, so that users can provide their feedback in the detail they want and in their own words. Within the Trust and in collaboration with stakeholders the following questions have been agreed.  

1. Overall, how was your experience of our service (mandatory question)  
2. What worked well?  
3. What could we do better? |
| The aim and objective(s) (including the measures/metrics) | The aim and objective of this change is that anyone using any service should be able to give quick and easy feedback to the provider of that service. The FFT is designed to be a quick and simple mechanism for patients and users of NHS services to give their feedback, which will be in a format that enables the Trust as the provider, to hear what is working well and to focus upon all areas for attention that will improve the quality of an aspect of the patient’s experience.  

In the three settings for which we have previously published Trust level response rates (general and acute inpatient, UECC and the second maternity touch point – Labour and Birth), this will no longer be possible because there is now no limit upon how often a patient or service user can give their feedback. We will therefore no longer calculate or publish a ‘response rate’. We will however continue to collect and submit the same data items and will continue to publish the number of responses received in the context of the size of the service concerned so that an under representation of users can be identified from the feedback received. It is intended that this will provide Trust teams with an indication on how well FFT is being promoted and taken up, and for Commissioners and Regulators it will give a sense of how effectively the FFT is being implemented by each provider.  

From the inception of the FFT there has been a target of a 40% participation rate to be achieved, therefore Trust Boards and Commissioners have been previously focused on the number of responses collected and from this the percentage of positive or negative responses received. However, for the future this will change as it does not align with the revised guidance which commences on the 1 April 2020. Henceforth, NHS England and NHS Improvement, stress that the most important element of the FFT, is encouraging the free text feedback, what responsive actions have occurred from this, and how Trusts are also identifying good practice and all opportunities to improve their services.  

The numerical data from the 1st April 2020 will not therefore be comparable between NHS organisations; this was also a factor in the ending of national reporting on the percentage response rate achieved. Therefore, NHS England and NHSI are now considering producing an example of what a Board or Commissioner report on the FFT results might look like for |
the future. This will give each Trust a clear indication of the expectations of how the data is used and may provide a
template for a standard Board or Commissioner report, to also help to steer their conversations away from focusing solely upon the ‘numbers’ and towards making the most use of the free text feedback received.

| The planned activity to achieve this | Individual comments collected through the FFT process can make a significant difference to understanding a patient’s lived experience as a service user and in turn lead to actions that improve the quality of care for all patients in a given service. Taken collectively, feedback can also identify themes and issues that need to be investigated. This can be triangulated with other data, resulting in significant insights and changes in how care is provided. Often it is the small improvements that make the biggest difference to patients, such as quieter wards at night, better food, or shorter fasting times before an operation. Therefore:

- Divisions will have robust mechanisms in place to ensure that the feedback received is reviewed promptly, acted upon and that any action plans required are developed and closely monitored to meet the expectations of their patients’ feedback.
- The Trust will provide visible evidence in public places to show that FFT feedback is valued and to demonstrate what actions have taken place as a result of this.
- The Trust will use feedback from the FFT alongside other measures of patient experience and quality and as a valuable insight into the patient journey.
- Staff will work within professional and clinical networks to share examples of good practice across the Trust which can be replicated by others.
- The Trust will support staff to promote the FFT to their patients to encourage them to engage and to give their feedback.

Using clear communication is also vital to tell patients how you are responding to their feedback so they can see it is important to you, such as “you said, we did” as a key statement on notice boards or posters, using Trust website updates, or sharing changes made via local news stories. |

| How will progress be monitored and reported? | The FFT numerical data will no longer be comparable across NHS organisations, but it can be used internally to continuously measure user engagement with the process, monitor quality and to inform service or care change decisions. This will include the analysis of time series data such as the FFT generates, to show improvement or a decline in patient experience.

The numerical data has two key uses:

- We can use The Trust’s own data as an informal ‘temperature check’ on satisfaction and engagement, and to look at change over time – e.g. looking at trends and anomalies. |
And

- Commissioners and Regulators can use FFT data alongside other information to get a richer picture of how engaged the provider is with their patients.

The Assistant Chief Nurse for Patient Experience will monitor and report this progress by liaising with the Divisions, to ensure that there is visible evidence in public places to demonstrate what actions have taken place because of feedback (i.e. standardised Quality Boards with ‘you said, we did’ displayed) and that actions are taken and plans are developed, delivered and monitored to address all feedback received in a timely manner. This will be reported to the Clinical Governance Group and Quality Committee within the quarterly Patient Experience Report.
<table>
<thead>
<tr>
<th>Priority</th>
<th>Diversity and Inclusion</th>
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<tr>
<td>Current position and why is it important?</td>
<td>Diversity and Inclusion is central to the successful delivery of high quality services that are responsive to the needs of patients from diverse backgrounds. Services are generally well-designed to meet the needs of those with protected characteristics within the local community and the FFT feedback obtained is very positive. Numbers of complaints are below the national average. Feedback obtained via the national Friends and Family survey methodology is also positive with consistently good satisfaction scores. However, it is important that we do not become complacent about Diversity and Inclusion and we need to ensure that all service users feel they are receiving a fair and equitable service, taking into consideration their views and ensuring assessments are made to ensure no discriminatory practice occurs.</td>
</tr>
</tbody>
</table>

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

- To create a fully inclusive environment and to support the development of services that reflect the diversity within our local communities.  
- For all staff to have a full understanding of the privileges and disadvantages experienced by different groups, the concept of intersectionality and the impact of micro-aggressions on individuals and to practice inclusively.  
- For the Trust to comply with agreed targets for Diversity and Inclusion training.  
- For all proposed service changes / developments to include an equality impact assessment  
- Quarterly Patient Experience Report to report incidences of Diversity and Inclusion themed complaints and concerns with an aim for these to be zero.  

The planned activity to achieve this |

- Implementation of the Engagement and Inclusion role to deliver the Diversity and Inclusion activities identified in the Patient and Public Involvement Strategy.  
- Monthly monitoring of compliance with Diversity and Inclusion training at Divisional and Corporate level.  
- Development of community initiatives to assess service need – First initiative to be with the deaf community.  
- Development of listening events to support individuals and groups with protected characteristics to ensure their views are being heard and needs being met.  

How will progress be monitored and reported? |

Via Diversity and Inclusion Group, Patient Experience Group and Quality Committee.
## Current position and why is it important?

Volunteers are widely recognised as an enabler to promote healthy communities, as well as the improvement of healthcare services. Currently the Trust is passionate about maximising the potential of volunteers within the Trust, making sure that we make the most of their talents, offer of their time and that this is borne of a true commitment to help their local community and hospital. As a Trust we are doing all that we can to bring this generous offer of volunteering into our organisation.

We want to see more volunteers being placed across a wider range of wards and departments within our hospital and the community services and to have the appropriate volunteer service infrastructure to support this. We want to become an inspirational Trust for NHS volunteering and for our patients and staff to recognise that wherever there are volunteers we are then able to provide an enhanced service.

We make a firm commitment to new and existing volunteers and as to what we will do to enhance and grow the volunteering opportunities. We aim to:

- Promote interesting and diverse volunteering opportunities
- To engage and retain our volunteers
- Ensure that there are clear standards of best practice and consistency in supporting volunteers
- Respond to emerging trends and issues in the volunteer sector
- Recognise and celebrate all volunteer contributions to this Trust

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

We want to see more volunteers across a wider range of services within our hospital and community services. We want to, have the necessary infrastructure to enable and support the volunteers to realise their potential here and enjoy every placement they accept within this Trust. We want to become an inspiration for NHS volunteering and for our patients and the staff to know that wherever there are volunteers placed then we are providing an enhanced service with their input.

The volunteer service has been awarded ‘Kitemark Plus Award’ status, after ‘Voluntary Action Rotherham’ praised and championed the way the Trust’s service is co-ordinated and managed, especially by ensuring that all volunteers have a rewarding experience here.

Many of our volunteers have been with the Trust for over 5 years, with several in excess of 15 years’ service and they work from 4 to 12 hours each per week, often accepting 2 or 3 placements across our hospital sites; including Breathing Space, Park Rehabilitation Centre and the Community Hospital.
New volunteering opportunities are regularly being developed within our services. These are to support patients and staff in a variety of settings across the Trust, performing a range of roles including within Pharmacy, the Patient’s Library, for ward support, in Chaplaincy and in Gardening. The vision for volunteers at our hospital and within the community is to have:

- An inclusive, comprehensive and flexible system of volunteering that encourages, enables and supports individuals, groups and other organisations to contribute to volunteer activity in the Trust.
- A fully integrated team of volunteers who contribute to the services we provide, who are drawn from the diverse population that we serve, who feel valued, recognised and find their volunteer experience to be personally rewarding.
- To further develop and champion a voluntary service that offers a wide range of benefits to patients, their families and friends, to staff and of course to our volunteers themselves.

The volunteers complement and enhance the services provided by Trust staff and can thereby improve the experience of all patients. Through our approach to volunteering we will increase the wider involvement of and contribution to our local communities.

A monthly report of volunteering activity features within the Quarterly Patient Experience Report. The following quality indicators will be developed in 2020/21 and tracked:

We will adapt or design a Friends & Family Volunteer Survey to understand the experience of our volunteers and we will aim for:

- 90% volunteers feeling that they are valued by this Trust
- 90% volunteers are feeling prepared and confident to fulfil their roles
- 90% achieving their goals and personal satisfaction through volunteering
- 90% would recommend volunteering at TRFT to their peers
- Case studies and volunteer stories will be collated to demonstrate their contribution to the patient’s experience, to staff support and the impact to the volunteers themselves through volunteering.
- Increases to volunteer numbers, roles and hours will be tracked.
- Demographic information on who is being attracted to join the Trust’s Volunteer programme e.g. by age, experience, gender, disability, faith and ethnicity
- How frequently and for what duration per week and over time people volunteer
- The type of work that volunteers are offered and what they best engage with

<table>
<thead>
<tr>
<th>The planned activity to achieve this</th>
<th>We now have 115 volunteers placed across the Trust, offering their time once or twice per week in the hospital and community and some individuals offer much more time. A number of the Trust’s volunteers also dedicate their time to fundraising and have raised thousands for the Rotherham Hospital and Community Charity. As the service continues to grow, the role of the Voluntary Services team has expanded and now includes an administration assistant role, which has been supported by the Patient Experience Group (PEG). This role will be an integral support to assist in key event preparation and at times of data collection and reporting.</th>
</tr>
</thead>
</table>
Identify targeted audiences to promote volunteering, to ensure that our volunteers reflect the diverse local population and a representative patient demographic.

Champion an organisational culture that welcomes and celebrates volunteers as an integral part of our Trust teams.

Increase the number and diversity of our volunteers through targeted recruitment and being proactive in engaging across all sectors and ages in the local communities and within any marginalised groups.

Discover and apply innovative forms of volunteering to increase the flexibility and accessibility of our volunteering placements.

Deliver a high quality volunteer experience that maximises the reciprocal benefits for the Trust and the volunteers.

Prepare, develop and empower volunteers to achieve their roles safely and effectively.

Recognise and celebrate the value and impact of volunteering through dedicated evaluations.

Maintain clear policies and procedures to enable safe, legal and accessible hospital volunteering, ensuring training around safeguarding arrangements for children and vulnerable adults in particular, and compliance with relevant Trust policies and procedures e.g. the uniform policy etc.

Following the appointment of the current Voluntary Services Co-ordinator 16 months ago who is, a lone worker at times and a part time employee, the service has grown significantly and continues to do so in line with the Voluntary Service strategy in place, therefore to continue to maximise the potential of volunteering, additional support will be required.

**Inpatient Volunteers:** In 2020/21 this will be the major focus and priority for new volunteer recruitment and for their role development. We will prioritise the recruitment, training and placement of volunteers in existing and new roles that will have the greatest direct and tangible impact upon the quality of patient experience for inpatients on our wards.

To deliver this we will:

- Increase coverage of the volunteer dining companions and ward support within the Trust
- Develop the ‘Dementia friend’ volunteer provision to support the implementation of the Trust’s Dementia Strategy
- Explore volunteer-led activities for priority patient groups e.g. offering arts & crafts, singing & music and games etc.

**Outpatient Volunteers:** Building on the success of existing outpatient volunteer roles, there is a proven need to increase existing volunteering capacity of the ‘Meet & Greet’ role, supporting patients, assisting them to check in on arrival and directing and
escorting them to their appointments. The majority of ‘Meet and Greet’ volunteers will be also be trained to push wheelchairs and we will:

- Develop, test and evaluate new ways of involving volunteers to support patients and their families in the UECC
- Introduce Befrienders: They will be sited in clinics/outpatient departments. Sitting and chatting with patients and relatives, supporting patients who may live alone or have no immediate family to accompany them to their appointment.

This Voluntary Services Strategy will also allow for flexibility in introducing and adapting to new and innovative projects and schemes to improve the overall patient experience.

<p>| How will progress be monitored and reported? | This will be monitored on a continuous basis and reported via the quarterly Patient Experience Report by the Head of Patient Experience and annually. |</p>
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>189/20(b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Operational Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>George Briggs, Chief Operating Officer</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1, B2</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note [✓] Approval [ ] For information [ ]</td>
</tr>
</tbody>
</table>

This report summarises operational performance at TRFT for the month of April 2020. It highlights some of the key issues and actions going forward to improve performance.

It includes a summary of latest positions against:

- **Urgent and Emergency care standards**
  - Initial Assessment (Local agreed standard 15 minutes) 11 minutes last period slightly better than previously
  - Time to be seen by a Clinician (Local agreed standard 60 minutes) 42 minutes last period
  - Improved performance against 12 hour waits - 0 patients in the last month

- **18 week RTT incomplete pathway** – validated position for April 2020 is at 77.1% (86.4% March)

- **77.1% overall performance for incompletes**
- **2 x 52-week breaches for Oral Surgery and ENT**
- **Total incomplete PTL size 12727 (14591 March)**

Diagnostics (DMO1) – the validated position for DMO1 for April 2020 is 73.6%. 3636 breaches as can be seen this is across all specialties. Detail attached in Appendix

- **National Cancer Standards un-validated Quarter 4**
  - 62 days 77.4% – against 85% target
  - 2 week waits – 93.5% against 93% target
  - 31 days 1st treatment is 97.3% against the 96% target
  - Faster diagnosis standard 75.7% target not agreed but we believe 70%

**Recommendations**

It is recommended that the Board note the information

**Appendices**

1. Operational Report
Appendix 1

1.0 Introduction

1.1 This paper covers key operational indicators, an overview of performance in April 2020, summarising headline progress and actions being taken to address areas of concern and deliver improvements forecasting expected delivery improvements as required.

1.2 The healthcare landscape in the UK continues to operate in a very abnormal environment at the moment, with significantly different operational requirements to those we are used to. There have still been no official relaxations of the national constitutional standards, although the expectation amongst the national, regional and Clinical Governance Group teams is obviously that our performance will deteriorate significantly across all elective care standards given the response that we have had to provide to Covid-19 patients.

1.3 The expectation is that it will take months, if not years, to work through the backlog we now have, given the readjustments we have had to make to the new way of providing care. Our Phase 2 response to Covid-19 is being developed with a particular focus around our recovery plans at the moment.

2.0 Operational Performance

2.1 The initial graphs show attendances across the north and changes in activity TRFT vs North vs England.

Accident & Emergency attendance for North - all Trusts

2.2 The reduction in attendances and release of capacity throughout the hospital has led to good flow out of the Emergency Department on a daily basis. In the latter half of the month, the Trust increased streaming through to the combined Assessment Area (located in the existing Acute Surgical Unit) and this has had a positive impact, and the intention will be to ensure we can continue this best practice beyond the Covid-19 period.
2.3 In addition, there were only 3 ambulance handover delays over 60 minutes in April, which is a significant reduction on the 25 we had in April 2019, and evidences the impact of the reduced demand and better ways of working to ensure appropriate flow.

3. **Urgent and Emergency Care Standards**

3.1 The Trust is showing a marked improvement in the standards we are being asked to report on, the national team have asked us to continue during the pandemic period.

May 2020

<table>
<thead>
<tr>
<th>Rolling</th>
<th>12hrs in Department</th>
<th>Mean Total Wait (Mins)</th>
<th>Time to be seen by a Clinician (Mins)</th>
<th>Time to Initial Assessment (Mins)</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wed</td>
<td>0</td>
<td>134</td>
<td>48</td>
<td>12</td>
<td>13/05/2020</td>
</tr>
<tr>
<td>Thu</td>
<td>0</td>
<td>122</td>
<td>45</td>
<td>9</td>
<td>14/05/2020</td>
</tr>
<tr>
<td>Fri</td>
<td>0</td>
<td>119</td>
<td>39</td>
<td>12</td>
<td>15/05/2020</td>
</tr>
<tr>
<td>Sat</td>
<td>0</td>
<td>118</td>
<td>34</td>
<td>9</td>
<td>16/05/2020</td>
</tr>
<tr>
<td>Sun</td>
<td>0</td>
<td>131</td>
<td>30</td>
<td>10</td>
<td>17/05/2020</td>
</tr>
<tr>
<td>Mon</td>
<td>0</td>
<td>123</td>
<td>37</td>
<td>11</td>
<td>18/05/2020</td>
</tr>
<tr>
<td>Tue</td>
<td>0</td>
<td>142</td>
<td>53</td>
<td>14</td>
<td>19/05/2020</td>
</tr>
<tr>
<td><strong>Rolling 7 Days</strong></td>
<td><strong>0 (0 per day)</strong></td>
<td><strong>126</strong></td>
<td><strong>42</strong></td>
<td><strong>11</strong></td>
<td><strong>11/05/2020</strong></td>
</tr>
</tbody>
</table>

3.2 Initial assessment is showing improvement compared to previous reports and improvement in overall wait times in this period. The figures are considerably different than pre pandemic.

3.3 Attendances have started to rise again as have ambulances and ambulance admissions.

4. **Waiting List 18 Week Referral to Treatment (RTT) Incomplete**

4.1 We are no longer able to maintain the RTT standard of 92% and are tracking a reduction in treatments as expected. With all but 2 services breaching 18 weeks.

4.2 Please find attached the RTT Submission:

- 77.1% overall performance for incompletes
- 2 x 52-week breaches for Oral Surgery and ENT
- Total incomplete PTL size 12727

<table>
<thead>
<tr>
<th>Trust Total Incomplete</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>% &lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>1152</td>
<td>340</td>
<td>77.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>480</td>
<td>111</td>
<td>81.2%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>982</td>
<td>444</td>
<td>68.9%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>800</td>
<td>432</td>
<td>64.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1358</td>
<td>390</td>
<td>77.7%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>40</td>
<td>25</td>
<td>61.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>116</td>
<td>0</td>
<td>-</td>
</tr>
</tbody>
</table>
General Medicine | 106 | 30 | 77.9%
Gastroenterology | 310 | 48 | 86.6%
Cardiology | 534 | 119 | 81.8%
Dermatology | 471 | 40 | 92.2%
Thoracic Medicine | 540 | 165 | 76.6%
Neurology | 0 | 0 | -
Rheumatology | 335 | 16 | 95.4%
Geriatric Medicine | 140 | 17 | 89.2%
Gynaecology | 1114 | 323 | 77.5%
Other | 1446 | 420 | 77.5%
Total | 9808 | 2920 | 77.1%

5. **Cancelled Operations**

5.1 No elective operations were cancelled in April, we only planned Urgent and Emergency Care patients.

6. **Diagnostics**

6.1 The validated position for DMO1 for April 2020 is 73.6%. 3636 breaches this is across all specialties.

7. **Cancer Update**

7.1 As predicted as with all national standards we are seeing a reduction in performance as below the effects of the changes in elective care and the fragility of our teams will have a lasting effect on our ability to recover. The performance for 2019/20 deteriorated again in Quarter 4 final validation will be complete on 6 June 2020 - I do not expect any major changes.
### 8.0 Cancer Waiting Times

#### 8.1 Weekly update – Q1 2020/21 weekly update

<table>
<thead>
<tr>
<th>Target</th>
<th>APR 2020 Unvalidated</th>
<th>MAY 2020 Unvalidated</th>
<th>Q1 2020/21 to date</th>
<th>Operational standard (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
</tr>
<tr>
<td>Data capture 20% complete (estimate)</td>
<td>65.8</td>
<td>100</td>
<td>68.2</td>
<td>93</td>
</tr>
<tr>
<td>2ww Breast Symptoms</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>93</td>
</tr>
<tr>
<td>62 Day from GP</td>
<td>81.3</td>
<td>81.3</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>31 Day First Treatment</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster Diagnosis Standard - 28 days</td>
<td>49.5</td>
<td></td>
<td></td>
<td>49.5</td>
</tr>
</tbody>
</table>

8.2 We have clinically prioritised all of our Cancer patients in order to identify which patients we need to treat urgently and which patients do not require diagnostics or treatment in the short-term. This process has now been implemented for all new referrals, who will receive a telephone triage appointment with a consultant following receipt of their referral, in order for them to be appropriately prioritised. Our Cancer Support Workers have started doing welfare calls for all of our non-urgent cancer patients, in order to provide these patients with a level of reassurance that we are continuing to review their care and know that they are awaiting investigations or treatment.
8.3 Given the focus on restarting activity and ensuring we are minimising the indirect impacts of Covid-19 through delayed investigations and treatment, we are now restarting non-urgent diagnostics for patients.

8.4 Currently there are over 200 cancer patients waiting for endoscopy procedures (which were cancelled following national guidance). These will start being carried out from early June (patients are required to self-isolate for 2 weeks before the procedure), with activity planned to increase gradually throughout the month.

8.5 Given the 62-day cancer standard relates to when patients are treated (as opposed to the Referral to Treatment standard which is based on patients waiting), the impact of the delays will likely be seen later in the year, when these patients do receive treatment.

9. Discharge Information

9.1 Covid-19 has led us to replace our ward work on the SAFER bundle with a critical daily focus on early discharge, driven by a home-first approach. This has removed most of the delays in discharge as funding is sorted outside of the acute hospital. Patients are therefore no longer waiting in the hospital for Social Care package agreement; instead they are transferred out to our community services to have assessments and home planning done there. This re-focus using a home-first approach has had impressive results in a very short space of time. By 2nd April we had 0 Delayed Transfers of Care (DTOCs), and they remained at 2 or below for the month of April. In addition, we are moving to twice-daily medical reviews of all patients, and focussing our work on discharge actions and “the right to reside”. Same day discharge is therefore happening more frequently, with fewer patients discharged the day after a discharge decision is made. We intend to make this the ‘new normal’ after Covid-19, which will involve close working with our place partners and agreements around interim funding.

9.2 Status update for 13th May 2020

<table>
<thead>
<tr>
<th>Total Number of patients</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Internal Patients</td>
<td>9</td>
</tr>
<tr>
<td>Number of External Patients (OOA)</td>
<td>1</td>
</tr>
<tr>
<td>DTOC</td>
<td>0</td>
</tr>
<tr>
<td>Health</td>
<td>0</td>
</tr>
<tr>
<td>LA Roth</td>
<td>0</td>
</tr>
<tr>
<td>OOA</td>
<td>0</td>
</tr>
<tr>
<td>Byron</td>
<td>8</td>
</tr>
<tr>
<td>Athonrope</td>
<td>13</td>
</tr>
<tr>
<td>Ackroyd</td>
<td>9</td>
</tr>
<tr>
<td>IMC</td>
<td>24</td>
</tr>
<tr>
<td>Clifton</td>
<td>13</td>
</tr>
<tr>
<td>Number of Definite Discharges</td>
<td>3</td>
</tr>
<tr>
<td>Number of Potential Discharges</td>
<td>5</td>
</tr>
</tbody>
</table>

9.3 We are no longer seeing DTOCs and medically fit patients have reduced from 50-80 pre pandemic to under single figures.
10. **Summary**

10.1 It is very likely that our position across all elective care metrics will continue to deteriorate in the next few months, with cancer performance likely to be more severely affected in the next 6 months as we work through the backlog of patients. We expect our non-elective (UECC) performance to be significantly improved given the levels of reduction in activity, and will ensure we retain all of the good practice that has been established during this period as demand does increase again.

10.2 As a Trust, our focus now is on defining and implementing our ‘recovery’ plans, which need to involve an increase in our elective activity, to ensure we minimise the indirect impact of Covid on our patients and population. The primary issue to resolve is how we are able to treat more of our routine patients whilst working to all of the necessary guidelines and requirements, which will require changes to our physical capacity as well as our processes and ways of working. Each specialty has developed a plan for how they intend to manage this, and these plans are now being scrutinised to ensure they are deliverable and appropriate.

George Briggs  
Chief Operating Officer  
May 2020
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>189/20(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Workforce Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Steven Ned, Director of Workforce</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B3, B4 and B5</td>
</tr>
</tbody>
</table>

### Purpose

- Turnover during April 2020 was 0.37% (99.63% retention) which is a 0.33% reduction against April 2019.
- The month of April 2020 saw a decrease in leavers (29.08 WTE) compared to previous month and a decrease of 0.62 WTE compared to April 2019.
- The Trust’s sickness absence for April 2020 was 4.13% (excluding COVID 19 absence) which is a 0.63% improvement compared to March 2020.
- Sickness rate including COVID-19 is 7.42% April 2020, an increase of 1.38% compared to previous month.
- The Trust’s core MaST compliance for April 2020 remains at 91%.
- The 12 month rolling Personal Development Review (PDR) compliance is currently 80.40% against a 90% target.
- The redeployment service has been established to support front line colleagues that need to work in other areas.
- Work continues to support colleagues across a number of health and wellbeing initiatives e.g. PAM Assist, Mindfulness, Covid-19 helpline etc.

### Recommendations

It is recommended that the Board of Directors note the contents of the Workforce Report.

### Appendices

1. Workforce Report
1.0 **Recruitment and Retention**

1.1. Turnover during April 2020 was 0.37% (99.63% retention) which is a 0.33% reduction against April 2019.

1.2. There was a decrease in leavers (29.08 WTE) compared to previous month - further analysis shows of the 19 leavers who left voluntarily in April, 6 (4.32 WTE) left because of 'Relocation' followed by 'Retirement' 5 (3.66 WTE).

1.3. Time to clear through the recruitment process increased in April to 36 days, above the target of 34 days for the first time in 6 months. This is because of an increase of 52 2nd/3rd year students and 12 return to practice being processed in April as well as the workarounds in place for Covid.

1.4. As part of the Bring Back Staff (BBS) national initiative launched in March, TRFT have received 22 people that have the potential of transferring to the Trust with 15 currently now employed.

<table>
<thead>
<tr>
<th>BBS – Staff Group</th>
<th>Number Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>6</td>
</tr>
<tr>
<td>Medical</td>
<td>1</td>
</tr>
<tr>
<td>AHP</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

2.0 **Sickness Absence**

2.1. The Trust's sickness absence for April 2020 was 4.13% (excluding COVID 19 absence) which is a 0.63% improvement compared to March 2020.

2.2. Sickness rate including COVID-19 is 7.42% April 2020, an increase of 1.38% compared to previous month. The Medicine Division has seen the largest increase in sickness absence relating to COVID-19 (3.08%), followed by Surgery Division (2.92%), compared to previous month. Cleansing of the COVID 19 absence data has now commenced with Divisions and this can be attributed to some of the increases.
2.3 Absence rate improved by 0.63% to 4.13% and remains above target by 0.18%. Clinical Support Services and Corporate Divisions have fallen below the sickness absence target of 3.95%. COVID-19 related sickness absence has been separated out in the above graph to allow comparable analysis to previous months’ data.

2.4 12 month rolling sickness absence for March 2020 was 4.80% and represents a 0.18% improvement from the previous month (4.98%).

3.0 Mandatory and Statutory Training (MaST)

3.1 The Trust’s overall core MaST compliance for April 2020 remains at 91%; the Medical & Dental staff group compliance is currently at 78%. The table below highlights the Trust’s compliance by Division.

<table>
<thead>
<tr>
<th>Division</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>94%</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>91%</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>90%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>91%</td>
</tr>
<tr>
<td>Family Health</td>
<td>93%</td>
</tr>
<tr>
<td>Medicine</td>
<td>89%</td>
</tr>
<tr>
<td>Surgery</td>
<td>88%</td>
</tr>
</tbody>
</table>

4.0 Personal Development Review

4.1 The 12 month rolling Personal Development Review (PDR) compliance is currently 80.40% against a 90% target. The data below is the position at 10 May 2020.

<table>
<thead>
<tr>
<th>Division</th>
<th>Assignment Count</th>
<th>Reviews Completed</th>
<th>Reviews Completed %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Support Services</td>
<td>881</td>
<td>718</td>
<td>81%</td>
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<td>Corporate Operations</td>
<td>498</td>
<td>380</td>
<td>76%</td>
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<td>Corporate Services</td>
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<td>193</td>
<td>73%</td>
</tr>
<tr>
<td>Emergency</td>
<td>163</td>
<td>138</td>
<td>85%</td>
</tr>
<tr>
<td>Family Health</td>
<td>603</td>
<td>479</td>
<td>79%</td>
</tr>
<tr>
<td>Medicine</td>
<td>792</td>
<td>629</td>
<td>79%</td>
</tr>
<tr>
<td>Surgery</td>
<td>722</td>
<td>617</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3,923</strong></td>
<td><strong>3,154</strong></td>
<td><strong>80%</strong></td>
</tr>
</tbody>
</table>

4.2 The 2020 PDR season is in progress with consideration being taken into account for the Covid-19 situation: training is available virtually, support accessed remotely, the season extended and new guidance has been issued in accordance with social distancing rules.
5.0 **Leadership, Culture and Engagement**

5.1 A final draft of Our People Strategy was shared with the People Committee; following any final comments or feedback the document will then be shared and made available across the organisation.

5.2 The team is developing a wellbeing and recovery support pack - Our People Pack, which will align to Our People Strategy and forms part of the Rotherham Way, is a response created to support you, your team, managers and leaders across TRFT during this pandemic and beyond. It contains tools and guidance for self, managers and teams whilst also signposting to NHS links and has been designed in collaboration with key stakeholders and staff side colleagues.

5.3 The L&D team have embraced new ways of working during the pandemic which includes a continuous updating of the Hub, ensuring training (management skills, induction) content can be accessed remotely and exploring delivery alternatives using Teams, email and phone to support delegates. This has allowed for a greater degree of flexibility in terms of timings and the delivery becoming much more bespoke than before.

5.4 Work experience placements have been postponed, with a message on the Trust’s website stating that this is the case. Work is underway to modernise work experience across the region, with virtual and funded placements being considered to complement the limited offerings currently being made by organisations. TRFT is playing a key role in shaping the approach being led by the ICS.

5.5 The Trust’s dedicated staff helpline operates 06.00 – 19.00, 7 days a week provides support to colleagues with Covid symptoms, concerns and identifies colleagues prioritised for swabbing. The helpline has taken in excess of 10,000 calls since it’s inception. A Covid-19 absence staffing profile is shared each day with Exec team, divisions and staff side colleagues.

5.6 There is proactive partnership working in place with staff side colleagues, ensuring they are involved in the appropriate Trust decision making forums e.g. PPE forum, receiving daily Covid-19 sitrep’s plus a weekly local/regional reps Teams meeting; as well as involvement with the People Strategy and People Pack development.

5.7 Due to the Covid-19 outbreak a number of planned apprenticeship starts for April/May have had to be postponed. The programmes affected were Operations Management (15), Team Leading (15) and Assistant Practitioner (3). Over the next few months we will introduce apprenticeships in Clinical Coding, Advanced Clinical Practitioner, Physiotherapy and Occupational Therapy.

5.8 As a Trust we have supported Rotherham Hospice and Connect Healthcare Rotherham by transferring some of our apprenticeship levy in order for them to invest in their own TNA’s, without our support they would not have been able to do this.

5.9 The Trust is following national guidance around risk assessment for BAME staff and closely following any developments in this area. BAME staff have also been given the opportunity to raise any concerns outside of their normal line management route, if they wish to do so.
6.0 Equality, Diversity & Inclusion

6.1 All 3 of the Trust's staff networks (BAME, Disability and LGBT+) are currently operating virtually via Microsoft Teams.

6.2 During Q4 of 2019-20, the Trust carried out a reassessment against EDS2. This has been used to inform the drafting of new equality objectives for the Trust for 2020-23.

6.3 The Trust's Rainbow Badge launch had been planned for April 2020 with accompanying LGBT+ awareness training for staff. Unfortunately, this has had to be postponed due to the pandemic.

6.4 Following a rigorous application process, the Trust has been successfully selected by NHS Employers as one of their Diversity and Inclusion Partners for 2021. This programme will commence in June 2021. The partners programme supports participating health and social care organisations to progress and develop their equality performance and build an inclusive culture in the workplace over a period of 12 months. It is closely aligned to the Equality Delivery System (EDS2), NHS Long Term Plan and Interim People Plan.

6.5 As the Covid-19 pandemic continues, there is emerging evidence of a disproportionate impact on people from a Black and Minority Ethnic background. As a result, the Trust has added BAME staff to the list of vulnerable workers and introduced a revised risk assessment process to support all staff to remain well and at work where appropriate.

7.0 Bank & Agency / NHS Professionals

7.1 NHSP has a rapid recruitment process in place that will allow workers to be recruited with on-boarding within 24 hours.

7.2 Demand for both registered and unregistered staff groups has reduced in April; this is a culmination of usual trend plus the Covid-19 impact; i.e. repurposing the hospital and increasing normal staffing capacity which resulted in a reduction of costs for Bank and Agency workers.

7.3 The removal of Ambition agency in April has resulted in a decrease in the average hourly cost of agency workers. At its highest in March it was £34.57 per hour; in April this dropped to £30.77.

8.0 Systems

8.1 The team are working with Divisions to improve and support the organisation in using roster effectively and efficiently. Following discussion at the Board seminar session earlier in the month an E-roster oversight monthly meeting has been arranged and will commence on 02 June 2020.

8.2 The e-roster team are working with internal audit to agree a suitable approach in order to undertake the audit given the current restrictions in relation to Covid-19. Aim is to complete the roster audit in July.
8.3 The Trust implemented the move to electronic payslips in April as planned which proved successful with just over 80% of the Trust accessing their Employee Self Service profile within the last two months. TRFT will be mentioned in the next edition of ESR news (national newsletter) regarding the success of the project.

9.0 Occupational Health / People Asset Management

9.1 The monitoring of the Occupational Health performance continues each month; there has been ongoing communication in relation to Covid related wellbeing support and extended service offerings.

9.2 A key priority for TRFT is to ensure there are optimal referral pathways into PAM to ensure managers/employees access services in the most cost effective manner. The team review all late cancellations/DNAs of appointments and are working with divisions to eliminate this problem which has averaged around £4k - £5k cost each month. During April a reduction of £1,500 was achieved from the previous month.

Steven Ned
Director of Workforce
May 2020
## Agenda item

189/20(d)

## Report

Finance Report

## Executive Lead

Steve Hackett, Interim Director of Finance

## Link with the BAF

B8 and B9:
This report provides assurance regarding development of the four months' emergency financial plan covering the period 1st April to 31st July 2020 together with the out-turn results for the month ending 30th April 2020 against the Trust’s requirement to deliver a break-even position in line with national guidance.

## Purpose

<table>
<thead>
<tr>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
</tr>
</thead>
</table>

The report provides details of:

- **Section 1 – Emergency Financial Plan 2020/21**

  A summary of the emergency financial plan for 2020/21 and how this has been constructed in line with national guidance issued for the period 1st April to 31st July 2020 in light of the COVID-19 pandemic. During this period the Trust is expected to deliver a break-even position, excluding any additional COVID-19 related expenditure/loss of income, without further central resources being made available. Normal planning rules and requirements for 2020/21 have been suspended and therefore, the Trust only has a definitive financial plan in place for this initial four months’ period.

- **Sections 2 to 5 – Financial Performance 2020/21**

  This includes details of financial results for the month of April 2020 in terms of:

  - Income and expenditure account;
    - Break-even position as at 30th April 2020;
    - After accounting for £2,819K COVID-19 expenditure; and
    - Additional Top-Up income of £3,547K.
  - Capital expenditure;
£1,074K incurred during April 2020;  
Which includes £366K of COVID-19 related expenditure, which the Trust expects to be reimbursed for nationally.  
A financial plan has yet to be agreed via the South Yorkshire & Bassetlaw Integrated Care System under rules which have been introduced from 1st April 2020.

Cash
- A closing cash position at 30th April 2020 of £19,576K as a consequence of the revised arrangements to compliment the emergency financial planning framework.

**Recommendations**
It is recommended that the Board of Directors **note** the out-turn position for the financial year 2019/20.

**Appendices**
- 1 – Income & Expenditure Account Summary for Month 1 2020/21 (April 2020)
- 2 - COVID-19 Expenditure Summary for Month 1 2020/21 (April 2020)
- 3 - Capital Expenditure Summary for Month 1 2020/21 (April 2020)
1. **Emergency Financial Plan 2020/21**

1.1 With the onset of COVID-19 during March 2020, interim guidance was issued jointly by NHSE/I in their letter dated 17th March 2020. This was designed to help:

(a) Free-up the maximum possible inpatient and critical care capacity;
(b) Prepare for, and respond to, large numbers of inpatients requiring respiratory support;
(c) Support NHS staff, and maximise staff availability;
(d) Support the wider population measures newly announced by Government;
(e) Stress-test individual organisations’ operational readiness; and
(f) Remove routine burdens.

1.2. Included in this joint letter was guidance related to financial planning for an initial period covering 1st April to 31st July 2020.

(a) The normal operational planning process for 2020/21 is suspended to be replaced by a guaranteed minimum level of income for all providers reflecting the current cost base. In practice this means that providers will:

- Have a Block Contract with current contracted commissioners;
- Receive a national Top-Up payment to reflect the difference between actual costs and income guaranteed where the expected cost base is higher;
- Claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19; and
- Submit claims on a monthly basis, alongside regular monthly financial reports.

(b) This should provide sufficient funds for providers to deliver a break-even position through the period and will provide the basis against which financial performance will be monitored.

(c) Any remaining contract sanctions for all NHS provider groups are suspended.

1.3 It is now expected that these interim arrangements will be extended to at least 31st October 2020.

1.4 The Trust has reconciled and validated the figures that have been used to arrive at the Block Contract and Top-Up values. This has then enabled the Trust to set detailed income and expenditure budgets at cost centre level across all of its services in line with its normal business planning processes in order to maintain strong financial governance, control and accountability throughout this initial emergency plan period.

1.5 The emergency financial plan for the first four months of the 2020/21 financial year is therefore, a break-even position, before accounting for additional COVID-19 related expenditure.

2. **Key Financial Headlines**

2.1 The key financial metrics for the Trust are shown in the table below. These are:

- Performance against the monthly income and expenditure plan;
- Capital expenditure;
- Cash.
3. **Income & Expenditure Account**

3.1 As per Section 1 above, the Trust has set itself a break-even plan for the first four months of the financial year 2020/21, in accordance with national guidance.

3.2 For the first month ending 1st April 2020 The Trust has delivered a break-even position in line with this plan, which is after taking account of COVID-19 related expenditure of £2,819K. This has been offset by additional Top-Up value payments of £1,418K above the value assumed in the Trust’s emergency financial plan. The Trust will expect that this level of Top-Up payments will be fully reimbursed by NHSE/I.

3.3 A summary of April 2020 financial position is shown in Appendix 1, which shows that:

(a) NHS clinical income is above plan as the Trust is requesting £1,418K additional Top-Up payments to help fund the additional costs of COVID-19. This is made up of £817K not initially required as part of the Trust’s initial emergency financial plan (excluding COVID-19) together with a further £601K to enable the Trust to break-even in accordance with national requirements and expectations.

(b) These Top-Up values are being offset by £272K of identified income risks brought into account from 2019/20, together with under-performance in other areas, but primarily linked to road traffic accidents and other insurance reclaimable amounts (£54K).

(c) Other operating income is primarily related to a loss of car parking income, which is directly related to COVID-19. Patients and visitors have not been charged for parking since mid-March 2020, with staff charges being waived part way through April 2020, initially until the end of May 2020.

(d) Pay costs are over-spending, but this is related to the additional costs of COVID-19. Whilst services in the Trust have been significantly curtailed, additional staff costs have been necessarily incurred in anticipation of the increased safety and quality issues that need to be addressed in dealing with this cohort of patients.

(e) Equally, non-pay costs are also over-spending as the Trust has incurred significant costs on personal protective equipment and other medical equipment which offsets under-spends on other non-pay costs due to the significantly reduced levels of normal activity.

(f) Non-operating costs relates mainly to lower than planned depreciation and amortisation of fixed asset values.

3.4 Details of COVID-19 related is summarised in Appendix 2. This shows that:
(a) COVID-19 related expenditure has been incurred and recorded in accordance with the latest guidance issued by NHSE/I.

(b) These figures reported here are consistent with the analysis submitted to NHSE/I included within the monthly monitoring return summarising financial performance.

(c) Costs are identified and recorded against each separate part of the organisation. These are incremental costs above existing budgets/costs with the exception of £788K related to staff sickness costs calculated in relation staff who are self-isolating, shielding, etc.

(d) Non-pay costs include c. £1,041K related to central procurement of personal protective equipment and other non-capital equipment, some of which will have been distributed to other organisations under national procurement initiatives.

4. **Capital Expenditure**

4.1 Details of capital expenditure incurred in April 2020 is shown in Appendix 4 – a total of £1,074K.

4.2 Plans have yet to be determined and need to be agreed by the South Yorkshire & Bassetlaw Integrated Care System. This follows new guidance issued recently from NHSE/I effective from 1st April 2020.

4.3 Internal calculations indicate a total capital programme of between £6,500K and £7,100K is affordable for the Trust.

4.4 In terms of expenditure incurred:

   (a) Air conditioning relates to the refurbishment of X-Ray Room 4 which commenced in 2019/20.

   (b) Medical equipment relates to mammography equipment of £295K for which funding was received in 2019/20.

   (c) COVID-19 related expenditure is expected to be refunded nationally via additional PDC in year. A return has already been submitted to NHSE/I seeking reimbursement for these costs.

5. **Cash**

5.1 At the same time as new financial planning guidance was issued nationally in March 2020 (see Section 1 above), accompanying guidance was also issued regarding cash management. This was on the basis that provider organisations should have certainty regarding cash inflows during the first four months’ emergency financial plan phase.

5.2 To facilitate this, commissioners and NHSE/I central have been required to make payments to providers upfront in April 2020 and monthly thereafter, effectively paying a month in advance on both Block Contract and Top-Up payments.

5.3 Additional Top-Up payments for additional costs (COVID-19 related together with reasonable business as usual costs) incurred above these monthly income levels will be payable two months in arrears i.e. payable in June 2020 for April 2020, etc.
5.4 At the same time the Trust is to endeavour to pay its suppliers within 7 working days, which is still subject to internal authorisation processes. However, against this background the Trust had a closing cash balance at 30th April 2020 of £19,576K.

Steve Hackett  
Interim Director of Finance  
28th May 2020
## Appendix 1 – Income & Expenditure Account Summary for Month 1 2020/21 (April 2020)

### Summary Income and Expenditure Position

<table>
<thead>
<tr>
<th>Category</th>
<th>Monthly Position (April - Month 1)</th>
<th>Year to Date Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
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<tr>
<td>Elective Inpatient</td>
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<td>0</td>
</tr>
<tr>
<td>Elective Day case</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non Elective Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outpatients</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Critical Care Services</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Community Services Income</td>
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<td>721</td>
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<tr>
<td>Excluded Drugs</td>
<td>0</td>
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<tr>
<td>Other Clinical Income</td>
<td>21,817</td>
<td>22,909</td>
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<tr>
<td><strong>Total NHS Clinical Income</strong></td>
<td>22,538</td>
<td>23,630</td>
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<tr>
<td>Other Operating Income</td>
<td>1,653</td>
<td>1,534</td>
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<td>Provider Sustainability Fund (PSF)</td>
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<tr>
<td><strong>Total Income</strong></td>
<td>24,191</td>
<td>25,163</td>
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### EXPENDITURE

<table>
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<tr>
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<th>Year to Date Position</th>
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<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
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<tr>
<td>Pay Costs - Agency</td>
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<td><strong>Total Pay Costs</strong></td>
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<td>Total Non-Pay Costs</td>
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<td>Total Operating Costs</td>
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<td>EBITDA</td>
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<tr>
<td>Non-Operating Costs</td>
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<td>RETAINED SURPLUS / (DEFICIT)</td>
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## Appendix 2 – COVID-19 Expenditure Summary for Month 1 2020/21 (April 2020)

### Summary Income and Expenditure Position

<table>
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<tr>
<th>Item</th>
<th>Monthly Position (April - Month 1)</th>
<th>Year to Date Position</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Plan £000s</td>
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<td>Elective Day case</td>
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<td>Outpatients</td>
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<td>Critical Care Services</td>
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<tr>
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</tr>
<tr>
<td>Other Clinical Income</td>
<td>0</td>
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</tr>
<tr>
<td><strong>Total NHS Clinical Income</strong></td>
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<tr>
<td>Other Operating Income</td>
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<td>0</td>
</tr>
<tr>
<td>Provider Sustainability Fund (PSF)</td>
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</tr>
<tr>
<td><strong>Total Income</strong></td>
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<td>0</td>
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### Expenditure

<table>
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<tr>
<th>Item</th>
<th>Monthly Position (April - Month 1)</th>
<th>Year to Date Position</th>
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<tbody>
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<td>Plan £000s</td>
<td>Actual £000s</td>
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<td><strong>EXPENDITURE</strong></td>
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### Appendix 3 – Capital Expenditure Summary for Month 1 2020/21 (April 2020)

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<th>(Above) Below Plan</th>
<th>Description</th>
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<td>(0)</td>
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<td>(0)</td>
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<td>6</td>
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<td>Substation Upgrade</td>
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<td>0</td>
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<td>End User Device Refresh</td>
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### Agenda item

**190/20**

### Report

**Digital Strategy Report including Engagement and Data Quality**

### Executive Lead

Michael Wright, Interim Deputy Chief Executive

### Link with the BAF

B1, B7, B8

### Purpose

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<th>To note</th>
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### Executive Summary

**Summary of Key Points:**

- Our focus since early March, has been to support the organisation and our own informatics staff to adapt to systematic changes as a result of COVID19.
- The Trust is now participating in the national Digital Aspirant programme, an injection of funding up to £6m over 3 years and national support to further accelerate our digital ambitions.
- Over 10,000 patients from across Rotherham have signed up to the Rotherham Health App and the 3rd party supplier continues to work to integrate with TRFT.

### Recommendations

The Board is asked to note the content of this paper.

### Appendices

None
1.0 Introduction

1.1 In April 2017, the Trust board approved the 5 year, 9 point #Digitalbydefault strategy Trust, which emphasized a “cloud-first” approach along with optimisation of existing Electronic Patient Record systems that are complemented by the award winning Rotherham Health Record system (SEPIA).

1.2 This paper usually provides a summary update with respect to progress along each of these 6 dimensions, with Feb 2020 position shown graphically below.

1.3 The majority of our efforts over the last 3 months, has been focused on supporting the organisation and our staff in a rapidly changing environment, in response to the COVID-19 pandemic.

1.4 In addition, during February and March of this year, we were proud to be approached by NHSx to participate, along with RDaSH, in the national Digital Aspirant programme and access £1.7m of a potential £6m, to commence our much needed Data Network and wifi refresh programme and bring forward investment in Windows 10 upgrades.
2.0 Clinical Backbone

2.1 Functionality within MediTech and SystmOne has been harnessed across the organisation to support our response to COVID-19 including:
- COVID-19 Special Indicators to enable tracking of patients
- Custom order sets, to enable clinicians to easily request relevant tests
- COVID-19 status and surveillance boards
- Community ePrescribing in SystmOne with electronic links to community pharmacists
- Reconfigured EPR to support changes to ASU and other inpatient areas
- Deployed Inpatient admission summary documentation sets to Surgery and now deploying across Medicine divisions
- MediTech integration with national child protection information systems is now live
- New noting functionality for COVID-19 telephone and video triage

2.2 Led by our Chief Clinical Information Officer, we rapidly deployed new ways of working to support safe and effective clinical care using technology, with specific innovations such as:
- 10 iPad across ITU / HDU, and webcams into every theatre, with Microsoft Teams so doctors could maintain communication channels and access MediTech/SEPIA
- Created and deployed COVID-19 Assessment templates
- Scanners across Theatres and Medical records, allows paper, such as paper charts, to be instantly scanned into MediTech and reduce the need to be taken out of RED areas
- Move critical care documentation to be electronic
- Trained other clinicians how to carry out virtual ward rounds utilising electronic progress noting
- Deployed large touch screens in the Ravenfield Critical Care command centre
- Worked with our Telehealth lead to test and train other clinicians on the AccurX and ‘Attend Anywhere’ video consultation platforms.

Message from Anil Hormis consultant anaesthetist – 30.3.30

Hi Richard - got access to the VDI set up - works flawlessly from home Mac and iPad … amazing in fact. The IT solution (iPad etc) on the unit works great - we did a WR yesterday from the AR Seminar room - and had a video chat with the nurses - saw ABGs and vent settings etc. The scanned Anaesthetic charts are great on Meditech too …Thanks so much for all yours and IT support. It really has been a game changer for us in this time… please thank everyone in IT. … See you soon . Anil

2.3 In addition to our historical utilization of Microsoft Teams for patient video consultation, we rapidly adopted both AccurX and the national ‘Attend Anywhere’ platforms, which offer much simpler methods for establishing video consultations with patients or other carers from any device. From 1st of April to 27th May 2020 nearly 5500 video calls have been initiated, predominantly across community, therapy and inpatient areas. So far there has been little uptake with ‘traditional’ outpatient consultant led areas (except for Dermatology).

2.4 Strategically, there has been a very positive adoption of existing electronic tools across the organisation in response to COVID-19, and we are now seeing areas which have been traditionally the hardest to engage coming forward wanting to adopt and change their process.
2.5 By the end of the Summer and in preparation for Winter, it is highly likely we will be paper free across all our inpatient wards and we will have large portions of our patient interactions carried out electronically in outpatient and community settings.

3.0 Rotherham Health Record

3.1 We are now live and operational with an Internet first Rotherham Health Record https://rhr.care allowing other care provider organisations, e.g. RMBC Social Services and Integrated Discharge Teams, to access information within the Rotherham Health Record.

3.2 In response to COVID-19, the Rotherham Health Record development team very quickly adapted the system to present COVID-19 status information across the organisation. This included customized dashboards and functionality for our community teams, to show patients who had recently been discharged.

3.3 Rotherham CCG continue their deployment of the Rotherham Health App, which has been endorsed as an approach by NHSE, and now has over 10000 registered patients. We had planned to integrate the app with MediTech appointments by the end of December 2019, however this is still on plan for Q1 20/21.

3.4 Full integration between Yorkshire Ambulance Service and MediTech was due to be enabled on the 19th of May 2020, however this had been delayed into June due to further software changes to be made by Meditech US.

4.0 Information Management – Analytics, Data Quality and Coding

4.1 I am pleased to welcome Lisa Fox, our new Associate Director of Information to Rotherham. Lisa joined us towards the end of February 2020 and has led the ‘Information’ response to COVID-19 across the organisation and with our partners at RMBC and Rotherham CCG.

4.2 The Trust has been utilising a daily COVID-19 dashboard, designed and implemented by our Information team, updated and distributed every 24 hours, 7 days a week since the end of March, pulling information for IPC, HR, procurement, MediTech and other data sources.

4.3 Whilst a number of nationally mandated information reports have ceased during this crisis, the demand for ‘other’ information to support local and national teams has helped to fill this void. A significant amount of effort has been and will continue to be, focused around providing and maintaining lists of shielded patients. During April, provider organisations were issued guidance on how to apply national algorithms to determine which patients should be shielded. Working closely with the Medical Director, and Rotherham CCG, the Trust has met national targets to upload our lists by following internal systematic clinical review to determine which patients we need to communicate directly with.
4.4 A revised Integrated Performance Report has been developed with the Director of Strategy and Performance. The contents, format and approach have been adapted to be suited to the 2020/21 performance needs of the Trust.

CODING

4.5 Significant changes have occurred within the Clinical Coding Department due to the COVID-19 situation. The team has initiated a process of coding patient episodes from home and only from paper notes when necessary. There is a team rota in place to ensure social distancing when on site.

4.6 To mitigate against any potential quality issues related to coding purely from the electronic patient record (EPR), the Clinical Coding team have been utilising the reuse of previously coded co-morbidities. This means that any patients known to us from previous spells of care who have had co-morbidities recorded that are not recorded on the existing EPR notes may have these co-morbidities reused. A policy to support this has been written by the Clinical Coding Team manager and signed off by the Medical Director and the approach is also approved by audit standards.

4.7 The reuse of co-morbidities has meant that we have managed to sustain our depth of coding over this period and maintained 99.72% of March discharges coded by Freeze data, with April on track to sustain the same level.

4.8 National guidance for the coding of COVID-19 patient spells has been changing on a near weekly basis, requiring all COVID-19 spells to be revisited and the clinical coding amended on a regular basis, which has caused significant time delays for the team.

Data Quality

4.9 The Trust has key datasets evaluated by NHS Digital, via the Data Quality Maturity Index (DQMI) tool that compares how the Trust is performing against other Trusts nationally. February 2020 data submissions highlighted that the Trust had a DQMI score of 61.5 against a national average of 83.4. This score is lower than what the Trust had seen previously and this is primarily due to:
Recent changes and long-term sickness within the Business Engagement Team resulting in the Community Services Dataset (CSDS) not being submitted for a short period of time. From March 2020 this has now been fully reinstated. Ordinarily a DQMI score of 96.2 had been attained for this indicator, which is above the national average for this dataset. This data has been included from March 2020 onwards the DQMI will reflect positively in our overall DQMI.

The Diagnostic Imaging Dataset (DID) is compiled outside of the timeframe needed to be included within the DQMI, therefore this has always attained a score of zero. The service is working on getting these submissions out in a timelier manner, which will also improve our overall DQMI.

Our other submissions achieve individual DQMI scores that compare well within the Yorkshire and Humber area and are above the national average.

A&E and the MSDS Submissions are also anticipated to improve in April 2020 due changes being implemented to capture more meaningful date items in some key fields.

4.10 As noted above, the Integrated Performance Report is being reviewed for the year ahead and as such a full data quality review of all Trust Board performance indicators (including constitutional KPIs) is required based on the new IPR format.

- Data Quality Assurance statements are required to be performed, written and signed off by Executive owners for each indicator for this financial year.
- Due to working restrictions there is a proposal that the Trust utilise the ‘our light’ version, which is promoted by NHS Digital as a product for Trusts in England to utilise. This product is known as STAR-Lite DQA, it still focuses on the six core data quality dimensions as per our original existing product but has been developed to enable self-assessment by Indicator Owners, thus avoiding the need for face to face assessments.
- The Assurance Mark (KITE) has changed in format but is still based on the traffic light system and is as easy to follow and will still seem familiar to the board.
- The process supports the Data Protection and Security Toolkit assertion 1.7.3.
- Each indicator will still have an Executive Director lead and an operational lead.

4.11 Finally, we have received final dissertations from our work with UCL and the Microsoft funded IXN i.e.:
- Improve access to policies using chatbot technology.
- Assessing FFT and patient satisfaction using machine learning and sentiment analysis.
- Predicting Emergency department peak activities using AI.
5.0 Infrastructure

5.1 In March, the Trust utilised Digital Aspirant and other sources of funding to raise orders to commence the much needed replacement of our data and wifi networks, including replacement firewalls and new UPS systems and Air Conditioning systems in our data centres. We plan to commence with a 14-month programme in July/August 2020.

5.2 From the end of March and during April, there was an unprecedented demand on our IT support services and infrastructure as hundreds of our staff very quickly moved to working from home.

5.3 From 16th March 2020, the team have deployed over 400 additional laptops, 50+ iPad/tablet devices, a Virtual Desktop system that can support up to 200 people. The Internet pipe has been upgraded from 100MB to 1GB and the team has supported multiple ward and community physical reconfigurations. On most days, there are now between 1000 and 1200 devices remotely accessing systems and services.

5.4 To support this seismic shift, and adhere to national and internal guidelines, the majority of IT support call handlers continue to work from home and the majority of our processes have shifted to being electronic only.

5.5 As an organisation, we are utilising Microsoft Teams in various parts of the business, COVID-19 also necessitated the deployment of this technology and we now have over 5500 people configured and various training video and user guides. The chart below, shows that in the last 90 days nearly ¼ million messages have been sent on Microsoft Teams, with over 10,000 1:1 calls and over 4,500 meetings organised, assisting the organisation in maintaining communication and collaboration within clinical settings, with people working from home (and across the globe), care homes and our other partners.

6.0 People

6.1 As previously reported Lisa Fox, a very experienced Informatician joined us from Calderdale and Huddersfield Foundation Trust in Feb 2020.

6.2 To support adoption and deployment of patient teleconferencing systems (AccurX and Attend Anywhere), Rebekah Davies has been seconded to the team from Speech and
Language Services. She has been instrumental in driving Microsoft Teams patient consultations in SLT.

6.3 Interviews took place on 26th May 2020 for a jointly funded Digital Midwife and once appointed this will mean we have dedicated clinical informatics people in the following areas, under the leadership of our Chief Clinical Information Officer (CCIO):

Consultants from:
- Emergency Care
- Critical Care
- Anaesthesia
- Maternity and Family Health
- ENT

Also:
- Clinical Safety and Clinical Analytics
- Nursing Practice Development Team
- Therapy Services
- Midwifery
- Community Nursing

6.4 Two coding apprentices have been successfully recruited.

7.0 Digital Aspirant Programme

7.1 In March 2020, the Trust was named as one of 24 trusts to be a pilot site for the new Digital Aspirant programme, run by NHSX. These Trusts benefited from nearly £28m of funding in March 2020 to assist with digital transformation projects so they can provide safe, high quality and efficient care. This was the first tranche of funding for them, over three years of support under the programme.

7.2 The programme aims to accelerate procurement, deployment and most importantly, uptake of the technology that is needed to underpin digital transformation. It will aim to raise the bar across the NHS by making sure organisations have a core set of digital capabilities in place and will also build on the work of the current Global Digital Exemplar (GDE) programme by using their blueprints and shared learning. Shared learning is a key component of all future digital investment. As well as using the existing blueprints, we expect the digital aspirants to also create blueprints to enable others to progress more efficiently.

7.3 Uniquely and demonstrating the strength of partnership working, RDaSH are also participants of the Wave 1 programme and along with other system partners, we are attempting to develop a place based approach to digitization, co-ordinated by Rotherham CCG.

7.4 £1.7m of 19/20 funding was utilized to purchase the much needed infrastructure upgrades and we would look to utilise the remaining 20/21 and 21/22 funding (circa £4m-£6m 80:20 capital / revenue split), to support our digital transformation strategy in areas such as:
- Outpatient and clinic transformation, including remote consultations and end to end digital interactions
- Patient flow and command centres support by AI
- Real-time site wide location aware with integrated clinical messaging and Chatbots
- Conclude move to paper free clinical services across the organisation
- Accelerate movement of systems and services to the cloud
- Jointly establish Rotherham Office of Data Analytics
- Enhancing Rotherham Health Record and Rotherham Health App

7.5 NHSx will require outline proposals for Year 2 and Year 3 by June 2020, however some complications still exist on additional capital, which will place pressure on the I&E position and how benefits and liabilities could/should be shared across the place will need to be considered.

8.0 Recommendations

8.1 The Board is asked to note the contents of this report

James Rawlinson
Director of Health Informatics
25 May 2020
Board of Directors’ Meeting  
2 June 2020

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<td>Executive Lead</td>
<td>Anna Milanec, Director of Corporate Affairs (non-voting) / Company Secretary</td>
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**Executive Summary**  
(including reason for the report, background, key issues and risks)

- The ‘Emergency Support Framework’ from the CQC has been published and outlines circumstances where inspections may continue in healthcare organisations;
- The Government’s plan to move into the second phase of the COVID-19 pandemic, and what it means for employers in protecting their employees;
- NHS Improvement has introduced new rules relating to COVID-19 spending, which see some bids having to be approved by regional Directors of Finance prior to submission;
- Details of the Accounting Policies used as part of the preparation of the annual audited accounts, are provided;
- The 2020/21 Assurance Map has been produced and details which of the board committees will seek assurance against progress with the objectives approved by the board;
- Four new Integrated Care Systems (ICS) have been approved by NHSI.

**Recommendations**

The Board is asked **to note** the content of this report.  
Board members are asked to **approve** the allocations as provided in section 6 to the report.

**Appendices**

- Appendix A: Accounting Policies 2019/20 & Accounting Guidance update 2019/20, report to Audit Committee February ‘20
- Appendix B: 2020/21 Assurance Map
1.0 Introduction

1.1 This report provides an update since the last board meeting on 5 May 2020.

2.0 ‘Emergency Support Framework’ from the CQC

2.1 The CQC announced its new ‘Emergency Support Framework’ (ESF) on 1 May, which it stated, would be effective immediately during the COVID-19 pandemic and for a period afterwards.

2.2 The regulator was keen to stress that the ESF was not an inspection regime although their website advised that “the ESF is part of our regulatory approach during the COVID-19 pandemic.”

2.3 The framework will utilise a number of elements;

a) using and sharing information to target support where it’s needed most:
Using information from usual collection sources and increased encouragement for patients and public to provide feedback, the CQC will monitor data to recognise trends or areas where additional support may be required. Highlighting any issues with NHSE and the Department of Health and Social Care may mean that action may be taken to provide additional support.

b) having open and honest conversations;
The regulator will make contact with providers to have conversations (via Microsoft Teams) regarding challenges that organisations face in managing COVID-19, and to seek information regarding innovative methods of working so that these can be shared. Using existing knowledge, services that are considered a higher risk will be prioritised and contacted more often. Calls will focus on: 1) safe care and treatment, 2) staffing arrangements, 3) protection from abuse, and 4) assurance processes, monitoring and risk management.

c) taking action to keep people safe and to protect people’s human rights;
Information gathered from the calls (above) will be added to the regulator’s existing records relating to the provider, and will be used to support regulatory planning during and after the pandemic. In exceptional cases, the CQC may request providers to ‘share’ their screen during the calls (above) should they require evidence about specific risks. Should information be received during the conversation, or from any external sources, about actual or avoidable harm, abuse, etc., the regulator may decide to inspect following existing procedures. Enforcement powers may still be used.

d) capturing and sharing what we do:
The CQC will not publish records of findings onto their website. However, if an inspection takes place following their findings, an inspection report will be published and information shared on a national level about the decisions taken.

2.4. Whilst routine inspections have been paused, the new framework allows for inspections to take place within a short time frame, where concerns exist.

3.0 Our plan to rebuild: The UK Government’s COVID-19 recovery strategy

3.1 On 11 May, the Government published its recovery strategy document, which contained
an outline plan for a three stage phased reopening of the country, and explained that we are entering stage two of that plan, and that businesses not required to close by law should be open and that people unable to work from home should be encouraged to return to work.

3.2 Employers, who have a statutory duty to exercise all reasonably practicable steps to ensure the health, safety and wellbeing of their employees, must now ensure that workplace health and safety arrangements include arrangements that minimise the transmission of coronavirus. Failure to do so will be in breach of the statutory duty, which is a criminal offence.

3.3 The Government published guidelines to assist employers in this task. The guidelines were set out in a series of eight separate documents, each corresponding to a different workplace environment.

3.4 There was no specific guidance provided for health and care providers, although there are some aspects that may now be covered by this guideline. For example, all hospitals have a significant number of office areas, operate labs and use vehicles daily. However, the main thrust of the Government’s approach was to maintain social distancing in the workplace universally. That will apply equally to healthcare staff when they are outside of the clinical environment.

4.0 New COVID-19 spending rules

4.1 On 19 May 2020, NHS Improvement updated its COVID-19 financial reporting and approval processes; changes to revenue expenditure outlined within the guidance took place effective 1 May 2020, and changes to capital expenditure guidance became effective on 19 May.

4.2 In anticipation of a decline for a need in urgent capital expenditure, all COVID-19 cases requiring national funding will require national pre-approval (rather than retrospective approval), which may take up to 7 days to facilitate.

4.3 Capital bids for investment in infrastructure to respond to second phase COVID-19 requirements, will need to take into account the agreed capacity plans at regional level and will require the prior agreement of the regional director of finance before they can be submitted for national consideration.

5.0 Accounting Policies 2019/20

5.1 Attached at appendix A is the paper presented to the Audit Committee in February 2020 confirming that no new accounting standards were implemented in 2019/20 since the previous year.

5.2 The Audit Committee confirmed their acceptance of the accounting policies, and had indicated their recommendation to the Board of Directors for approval.

5.3 Work on the Annual Report and Accounts 2019/20 has now been completed and they are included on the board agenda for approval. Approval of the accounts by the Board will imply approval of the accounting policies.
6.0 Assuurance Map 2020/21

6.1 On an annual basis, work is undertaken to assign the Board approved objectives to its assurance committees, thus providing assurance as to progress being made and also an early warning if timelines are being delayed.

6.2 The details for 2020/21 are provided on Appendix B, which has been developed with input from the Executives.

6.3 The 2020/21 Transformation Plan Report, appearing earlier on the agenda, provides more details of the approved objectives.

6.4 The board members are asked to approve the proposed committee allocations.

7.0 Newly established Integrated Care Systems (ICS)

7.1 The number of ICS’ increased by four over the last month. The new formations are:
   - Humber, Coast and Vale Health and Care Partnership
   - The Hertfordshire and West Essex ICS
   - South West London Health and Care Partnership
   - Sussex ICS

7.2 This now brings the total number of ICS’s to eighteen.

7.3 It is anticipated that the remaining STP’s will all become ICS’ by the end of the current financial year.

Anna Milanec
Director of Corporate Affairs / Company Secretary,
May 2020
APPENDIX A

Audit Committee Meeting
25 February 2020

Agenda item | 11/20
---|---
Executive Lead | Simon Sheppard, Director of Finance
Link with the BAF | B9 & B13
Purpose | Decision ✓ To note ☐ Approval ☐ For information ☐

**Purpose of this paper:**

The purpose of this report is to brief the Committee on changes required to the trust’s Accounting Policies, which form Note 1 to its Accounts, and on changes to the Accounting requirements in 2019/20.

The paper outlines the amendments made to the 2018/19 Accounting policies for inclusion in the 2019/20 Annual Report and Accounts incorporating changes resulting from the publication of the NHS Improvement’s template Accounting policies for Foundation Trust’s within the DHSC Government Accounting Manual 2019/20 (GAM) and the FT Annual Reporting Manual (ARM) 2019/20.

The required amendments to the Accounting policies are outlined in more detail in Appendix 1, and all changes are presented in their entirety in the attached tracked version of the Policies at Annex A. Please note that in conversion from Excel, and in applying commentary and tracked changes, this version of the policies presents inconsistent formatting. Please be assured that the formatting will be consistent once the approved text is transferred into the master Accounts document.

**Summary of Key Points:**

**Accounting Policies**

For the purposes of confirming the Accounting Policy text for inclusion in Rotherham NHS FT’s Annual Accounts 2019/20, the Rotherham NHS FT Accounting Policy text from 2018/19 has been adopted and adjusted for material changes outlined in the 2019/20 GAM where required. This continues the approach from last year.

The Trust consider that the additions and amendments made to the 2019/20 Accounting policies in respect of:
• inclusion of accounting policy text relating to Service Concession arrangements, not previously required (Appendix 1 Para 3)
• changes to outline Accounting Standards issued but not yet adopted (Appendix 1 Para 5),
• date changes (2018/19 to 2019/20)
• changes to wording where appropriate to reflect updates in the 2019/20 FT ARM and GAM, and Her Majesty’s Treasury Financial Reporting Manual (HMT FReM)

are appropriate as they have been determined in accordance with the Foundation Trust Annual Reporting Manual 2019/20, the DH Government Accounting Manual (GAM) 2019/20 and HMTs FReM, and through the application of approved IFRS based accounting policies.

Joint Arrangements Policy text in the Accounting Policies (Appendix 1 Para 4)
In previous years the Joint Pathology Partnership with Barnsley FT has not been treated as a joint arrangement per IFRS 11 Joint Arrangements. However, a review is currently underway to ascertain if more detailed disclosures are required in this respect. If so, additional text will be added to the Accounting Policies in that regard for the April Audit committee and Draft Accounts submission.

NHS Pension ‘text’ for the Accounting Policies (Appendix 1 Para 6)
Final changes in respect of mandated wording on the NHS Pension Scheme will be included in the Accounting policies if the Department of Health issue any further changes to this section, as has been the case in previous years in April; therefore, this section will be considered to remain at draft stage until that time. The final version will be presented to the Audit Committee in April 2020 as part of the Draft Accounts, prior to submission to NHSI and Audit.

Changes to the DH GAM and FT ARM in 2019/20 will be applied in the wider Annual report preparation process to ensure the trust’s Annual Report and Accounts continue to follow up-to-date guidance on layout, form and content.

Full details of the changes made are in Appendix 1, with the draft Accounting policies text produced in full (with tracked changes) at Annex A.

Looking forward
Members are also asked to note that the Accounting standard IFRS16 Leases is due for implementation on 1st April 2020 and as such impacts the planning process, in which accounting treatment for all leases will change. In particular, where a lease is recognised, the accounting will be on-Statement of Financial Position. This will result in a move from rental costs to increased depreciation and finance costs. Further information will be provided in Annual Plan reports and through 2020/21 as implementation progresses.
1.0 Introduction

1.1 The accounting policies adopted in the preparation of the 2019/20 annual accounts are broadly consistent with those adopted in 2018/19. The main changes are:-

2.0 Accounting Standards implemented in 2019/20:

2.1 No new accounting standards were implemented in 2019/20.

3.0 Potential Disclosure changes – PFI / Service Concession Arrangements

3.1 In 2019/20 the Trust embarked on a project with the Carbon Energy Fund.

3.2 This arrangement is initially deemed to meet the IFRIC12 definition of a service concession*. As such, the accounting policies for IFRIC 12 Service Concessions have been added to the Trust’s Accounting Policy Note. In previous year’s disclosure of our policy on these transactions was not required, as we didn’t previously have arrangements of this type. To summarise, the disclosure outlines that the annual unitary payment is separated into three component parts; payment for the fair value of the services received, repayment of the finance lease liability including finance costs, and payment for the replacement of components of the asset during the contract lifecycle replacement. See Note 1.14

3.3 This arrangement will result in increased disclosures in the 2019/20 accounts for this element.

4.0 Potential Disclosure changes – Joint Arrangements/Ventures

* work ongoing to review the contract arrangements to confirm accounting treatment.
4.1 Rotherham and Barnsley operate a joint Pathology Service. Whilst not historically reported as a Joint Arrangement in the trust’s Accounts, there is a potential need to include additional disclosures in respect of this arrangement per IFRS11. An assessment is underway. If so, there will also be additional Accounting Policy text, added as a result.

4.2 The additional text is not added at this stage, and if required, will be added to the Annual accounts at Draft submission stage.

5.0 Accounting Standards that have been issued but not yet adopted

5.1 This section of the Accounting policies is updated for new year Accounting Standards that have been issued but have not yet been adopted. Amended text italicised and in red is below.

“The DH GAM does not require the following Standards and Interpretations to be applied in 2019/20. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020/21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – The standard is effective 1st April 2020 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1st January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

5.2 The Trust has considered the above new standards, interpretation and amendments to published standards that are not yet effective and concluded that, with the exception of IFRS 16 that is dealt with below, they are currently either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures. This conforms with the FT ARM 2019/20, which requires that any amendments to standards are applied in accordance with the applicable timetable, with early adoption not permitted.

5.3 It is anticipated that IFRS16 Leases will impact the Trust accounts presentationally to the extent that existing operating leases that are for over 1 year will be reclassified, on implementation, to on-SoFP (on-balance sheet) leases, with all new leases, that meet the definition, being accounted for on-SoFP. Current rental costs will be replaced in the Accounts with finance costs (interest) and depreciation costs. The Trust's Non-Current Asset value will also increase as these assets are taken onto the Statement of Financial Position, with an equal and opposite liability. (Refer to Paragraph 1.14). Additionally, there will be uneven I&E profiling over the life of the lease, due to the higher finance costs (and lower principal repayments) incurred in the early years of the lease.”

6.0 Other amendments

6.1 A number of other minor amendments have been made to the accounting policies to remove out of date references to 2017/18 transactions and to update date references to 2018/19.

7.0 Next Steps

7.1 Should any other changes be required, for example, on NHS Pensions which is usually issued as a late update, these will be highlighted to Audit Committee when the draft Accounts are presented in April.

* work ongoing to review the contract arrangements to confirm accounting treatment.
7.2 The full Accounting Policies are to be disclosed in Note 1 in the 2019/20 annual accounts.

Louise Lowry, Head of Financial Services. February 2020
## APPENDIX B: Assurance Map 2020/21

<table>
<thead>
<tr>
<th>Covid-19 objectives</th>
<th>Audit Committee</th>
<th>Quality Committee</th>
<th>People Committee</th>
<th>Finance and Performance Committee</th>
<th>Executive Team and/or board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every patient is able to access the clinically appropriate level of care.</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with urgent life-threatening non-Covid illness will receive the care they need</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff will be protected against the risk of acquiring Covid-19 in the workplace through the use of nationally specified PPE</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff will be supported with the psychological consequences of working through the pandemic</td>
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</tr>
<tr>
<td>We will make timely decisions, support each other and where appropriate, embrace new ways of working that may have value beyond the pandemic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>We will support our local health and social care partners in their responses</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

154
## Wider objectives

<table>
<thead>
<tr>
<th>Item</th>
<th>Audit Committee</th>
<th>Quality Committee</th>
<th>People Committee</th>
<th>Finance and Performance Committee</th>
<th>Executive Team and / or board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality:</strong> ensure TRFT mortality rates are being counted and reported correctly</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Operational Performance:</strong> Comply with national requirements around operational standards</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Workforce:</strong> Increase the substantive establishment of our staff, including through improving our staff engagement</td>
<td></td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Stewardship and Governance:</strong> Deliver our financial plan based on revised Cidiv-19 expectations; ensure improvement financial stewardship across the organisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>

155
<table>
<thead>
<tr>
<th>Item</th>
<th>Audit Committee</th>
<th>Quality Committee</th>
<th>People Committee</th>
<th>Finance and Performance Committee</th>
<th>Executive Team and/or board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priorities for 2020/21</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimise flow through the hospital by developing resilient emergency pathways, shoring up Same Day Emergency Care provision, increasing early discharge and implementing appropriate streaming and on-site GP OOH services</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Deliver a step change reduction in the number of face to face appointments, lowering the overall number and utilising technology solutions where appropriate</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Improve staff engagement and morale by driving a fundamental change in the volume and impact of staff engagement activity in the Trust</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximise the effectiveness of the senior leadership within the organisation, empowering staff to work collectively to make informed decisions</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of our workforce who are substantively employed by the Trust and in doing so, reduce the vacancy rate and ensure a minimum 10% in-year reduction in agency cost</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Ophthalmology move to RCHC and relocate existing Greenoaks services (ante and post-natal care) and hysteroscopy services to the Oakwood Unit</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Implement joint Gastroenterology service with Barnsley Hospital NHS Foundation Trust, including a joint GI bleed rota and joint ward cover</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

156
**Board of Directors’ Meeting**  
**2 June 2020**

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>192/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td><strong>Board Assurance Framework</strong></td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Anna Milanec, Director of Corporate Affairs (non-voting) / Company Secretary</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>n/a</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision ☐ To note ☐ Approval ✓ For information ☐</td>
</tr>
</tbody>
</table>

### Executive Summary  
(including reason for the report, background, key issues and risks)

This is the regular quarterly report to the Board of Directors relating to the Board Assurance Framework and containing the proposed quarter 4 risk scores for all 11 BAF items as recommended by the Finance & Performance Committee, People Committee, Quality Committee and Audit Committee.

Following the recommendation of the Trust’s Internal Auditors, during Q4 the recommendations from each of the Board Assurance Committees in relation to the BAF items they are responsible for, were reviewed by the Audit Committee at its meeting on 20 May 2020.

The key points arising are:
- The full BAF\(^1\) was presented to the Audit Committee on 20 May 2020 for the second time during 2019/20, as recommended by the Trust’s Internal Auditors
- The People Committee assumed oversight of BAF items B3, B4 and B5
- The Audit Committee assumed oversight of BAF item B10 for Q4
- The Finance & Performance Committee assumed oversight of BAF item B11 for Q4

### Recommendations

The Board is asked to note the content of this report, and **to APPROVE** the scores determined by the assurance committees for Q4.

### Appendices

- Appendix 1: Q4 review of the BAF in simple view

---

\(^1\) The ‘full’ BAF refers to the summary sheet together with all of the detailed sheets received and challenged by the Board Assurance Committees on a quarterly basis.
1.0 Introduction

1.1 As part of the oversight of the Board Assurance Framework for 2019/20 this update for Q4 is presented to the Board of Directors for consideration.

1.2 Following the cessation of the Strategy & Business Planning Committee, BAF item B10 was overseen by the Audit Committee for Q4 and B11 was overseen by the Finance and Performance Committee for Q4.

1.3 Following the creation of the People Committee in April 2020 it assumed oversight of BAF items B3, B4 and B5.

1.4 The full BAF was presented to the Audit Committee at its meeting on 20 May 2020 for approval of the current risk scores for BAF items B7 and B10 and overview of the current risk scores for the other nine BAF items, which had been previously reviewed by the Finance & Performance Committee, People Committee and Quality Committee during their April 2020 meetings.

1.5 To support the Audit Committee’s overview of the other BAF items, the rationale behind the proposed current risk score for each of the BAF items was included in the report to that Committee.

2.0 Q4 Outcome

2.1 The full details of B3, B4 and B5 were presented to the People Committee meeting on 24 April 2020.

After consideration, the Committee proposed no changes to the scoring, which remain the same as at the end of Q3.

2.2 The full details of B8, B9 and B11 were presented to the Finance & Performance Committee at its meeting on 29 April 2020.

After consideration, the Committee increased the current risk scores for B8 and B9 from 4(L) x 5(C) = 20 to 5(L) x 5(C) = 25 on the basis that the Cost Improvement Programme was not achieved in full (B8) and because the year-end financial position was a significant deficit that was not planned (B9).

The Committee proposed no changes to the scoring for B11, which remains the same as at the end of Q3.

2.3 The full details of B1, B2 and B6 were presented to the Quality Committee at its meeting on 29 April 2020.

After consideration, the Committee proposed no changes to the scoring, which remain the same as at the end of Q3.

2.4 The full details of all BAF items were presented to the Audit Committee at its meeting on 20 May 2020.

In relation to BAF item B7 the Committee considered the proposed reduction in current risk score from 3(L) x 5(C) = 15 in Q3 to 2(L) x 5(C) = 10 on the basis of improvements to the effectiveness of the controls and reporting mechanisms; the addition of five new
positive externally-provided assurances during the quarter and actions to close the remaining gaps in control being on track.

However, the Committee agreed that as a result of the Trust’s financial position deteriorating during quarter 4, the current risk score for B7 should be increased from 3(L) x 5(C) = 15 to 4(L) x 5(C) = 20.

After consideration, the Committee proposed no changes to the scoring for B10, which remains the same as at the end of Q3.

For the other nine BAF items considered by the Audit Committee the Committee accepted the recommendations made by the Quality Committee, Finance & Performance Committee and People Committee.

2.5 The current scoring position of the BAF is shown in appendix 1, with full information being provided to Board members separately.

Anna Milanec
Director of Corporate Affairs / Company Secretary
May 2020
<table>
<thead>
<tr>
<th>ID</th>
<th>Risk title</th>
<th>Risk Owner</th>
<th>Oversight Committee</th>
<th>Date on which oversight Committee reviewed Q4 BAF scores</th>
<th>Q1 2019/20 current risk score</th>
<th>Q2 2019/20 current risk score</th>
<th>Q3 2019/20 current risk score</th>
<th>Q4 2019/20 current risk score</th>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Standards and quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements</td>
<td>CN / MD</td>
<td>QAC</td>
<td>29 Apr 2020</td>
<td>4x5</td>
<td>4x5</td>
<td>4x5</td>
<td>4x5</td>
<td>1x5</td>
</tr>
<tr>
<td>B2</td>
<td>Demand for care exceeds the resources available, leading to failure to achieve recognised healthcare standards</td>
<td>COO</td>
<td>QAC</td>
<td>29 Apr 2020</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>3x4</td>
</tr>
<tr>
<td>B3</td>
<td>Insufficient workforce capability and / or capacity impedes the ability to deliver the Trust’s Plan</td>
<td>DoW</td>
<td>FPC PC</td>
<td>24 Apr 2020</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>2x4</td>
</tr>
<tr>
<td>B4</td>
<td>Workforce costs cannot be reduced nor workforce productivity improved (efficiency)</td>
<td>DoW</td>
<td>FPC PC</td>
<td>24 Apr 2020</td>
<td>5x4</td>
<td>5x4</td>
<td>5x4</td>
<td>5x4</td>
<td>3x4</td>
</tr>
<tr>
<td>B5</td>
<td>Lack of effective staff engagement and the inability of the Trust to implement new regional / national workforce models / structures / initiatives at pace may impact on the recruitment, retention and culture changes needed to achieve the Trust’s Plan</td>
<td>DoW</td>
<td>FPC PC</td>
<td>24 Apr 2020</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>4x4</td>
<td>3x4</td>
</tr>
<tr>
<td>B6</td>
<td>Insufficiently robust Trust-wide quality governance arrangements impede the delivery of a number of Trust plans / objectives</td>
<td>CN</td>
<td>QAC</td>
<td>29 Apr 2020</td>
<td>3x4</td>
<td>3x5</td>
<td>3x5</td>
<td>3x5</td>
<td>1x5</td>
</tr>
<tr>
<td>B7</td>
<td>Insufficiently robust Trust-wide corporate governance arrangements impede the delivery of a number of Trust plans / objectives</td>
<td>DCE DoF Co Sec</td>
<td>Audit</td>
<td>20 May 2020</td>
<td>3x5</td>
<td>3x5</td>
<td>3x5</td>
<td>4x5</td>
<td>2x5</td>
</tr>
<tr>
<td>B8</td>
<td>Planned efficiencies are not delivered</td>
<td>DoF</td>
<td>FPC</td>
<td>29 Apr 2020</td>
<td>4x5</td>
<td>4x5</td>
<td>4x5</td>
<td>5x5</td>
<td>1x5</td>
</tr>
<tr>
<td>B9</td>
<td>The financial plan is not delivered</td>
<td>DoF</td>
<td>FPC</td>
<td>29 Apr 2020</td>
<td>4x5</td>
<td>4x5</td>
<td>4x5</td>
<td>5x5</td>
<td>1x5</td>
</tr>
<tr>
<td>B10</td>
<td>Misaligned governance and decision-making may arise from divergent Trust, Place and ICS interests and objectives</td>
<td>DCE</td>
<td>SBPC Audit</td>
<td>20 May 2020</td>
<td>3x4</td>
<td>3x4</td>
<td>3x4</td>
<td>3x4</td>
<td>2x4</td>
</tr>
<tr>
<td>B11</td>
<td>Ineffective relationships with key stakeholders may adversely impact Trust services</td>
<td>DCE</td>
<td>SBPC FPC</td>
<td>29 Apr 2020</td>
<td>3x4</td>
<td>3x4</td>
<td>3x4</td>
<td>3x4</td>
<td>2x4</td>
</tr>
<tr>
<td>Agenda item</td>
<td>193/20</td>
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<tr>
<td>Report</td>
<td>Risk Management Report - Including the Risk Register (with risks scoring 15 and above)</td>
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</tr>
<tr>
<td>Executive Lead</td>
<td>Angela Wood, Chief Nurse</td>
<td></td>
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</tr>
<tr>
<td>Link with the BAF</td>
<td>B1-12</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision</td>
<td>To note</td>
<td>Approval</td>
<td>For information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>To present the Risk Register. The report is based on the risk register from Datix as at 15 May 2020</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The key points arising from the report are:</td>
<td>• There are 19 approved risks (scoring 15 or above) on the risk register.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>The Risk Register is noted.</td>
<td></td>
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<td></td>
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<tr>
<td>Appendices</td>
<td>1. 15 and above Risk Register</td>
<td></td>
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<tr>
<td></td>
<td>2. TRFT Risk Appetite</td>
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</tr>
</tbody>
</table>
1. Introduction

1.1 This report provides an update to the Board of Directors for the purpose of providing assurance with regards to Risk Management.

1.2 Since the previous report in February 2020 the monthly Risk Analysis Group and Risk Management Committee have continued, and they have reviewed the risks scoring 15 or above along with management information in relation to all risks.

2. Review of Risk Management Arrangements

2.1 A review has been undertaken by Internal Auditors of Risk Management within the Trust and the actions from this will be presented to a future meeting.

3. Risk Register

3.1 There are 19 approved risks scoring 15 or above which are detailed in Appendix 1.

4. Conclusion

4.1 A detailed review has been undertaken of risk management and the actions have been delivered

Anne Rolfe, Quality Governance, Compliance and Risk Manager
May 2020
## Appendix 1 – 15 and above Risk Register

There are 19 approved risks scoring 15 or above and are detailed below.

<table>
<thead>
<tr>
<th>ID</th>
<th>Responsible Executive Director</th>
<th>Responsible Manager</th>
<th>Division</th>
<th>Title</th>
<th>Risk Type</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Date Reviewed</th>
<th>Review date</th>
<th>Assurance Committee</th>
<th>Change in Current Risk Score from previous report.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3813</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Surgery</td>
<td>Continual breakdown of Automatic Endoscope Reprocessors affecting equipment disinfection and patient lists</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>Moderate 6</td>
<td>30/04/2020</td>
<td>30/06/2020</td>
<td>Finance and Performance Committee</td>
<td>↔ Due to COVID the replacement scheme has been delayed, therefore there is no change to the risk.</td>
<td></td>
</tr>
<tr>
<td>3997</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Integrated Medicine</td>
<td>Ability to Deliver the TB Service in line with National Guidance (NICE)</td>
<td>Staffing and Competence</td>
<td>Extreme Risk 16</td>
<td>Moderate 6</td>
<td>04/05/2020</td>
<td>04/06/2020</td>
<td>Quality Committee</td>
<td>↔ A business case has been produced to increase staffing in the service. The risk will remain the same until the business case has been approved.</td>
<td></td>
</tr>
<tr>
<td>4174</td>
<td>Medical Director</td>
<td>Medical Director</td>
<td>Corporate Services</td>
<td>Clinicians do not always recognise the deteriorating patient</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>Moderate 5</td>
<td>08/03/2020</td>
<td>08/06/2020</td>
<td>Quality Committee</td>
<td>↔ Although clinicians identify and treat deteriorating patients there are still times when these incidents are escalated to Serous Incident Panel and more robust actions need to be taken with evidence of improvement before the risk can be reduced.</td>
<td></td>
</tr>
<tr>
<td>4363</td>
<td>Director of Finance</td>
<td>Deputy Director of Finance</td>
<td>Corporate Services</td>
<td>Increased cost of bank and agency resulting in over spend against budgets</td>
<td>Financial Risk</td>
<td>Extreme Risk 16</td>
<td>Significant 15</td>
<td>27/08/2019</td>
<td>27/08/2020</td>
<td>Finance and Performance Committee</td>
<td>↑ Risk score increased from 15 to 16, as likelihood decreased from 5 to 4 and consequence increased from 3 to 4.</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>Responsible Executive Director</td>
<td>Responsible Manager</td>
<td>Division</td>
<td>Title</td>
<td>Risk Type</td>
<td>Risk level (current)</td>
<td>Risk level (Target)</td>
<td>Date Reviewed</td>
<td>Review date</td>
<td>Assurance Committee</td>
<td>Change in Current Risk Score from previous report</td>
<td>Notes</td>
</tr>
<tr>
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<td>-------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>4630</td>
<td>Deputy Chief Executive Director</td>
<td>Director of Health Informatics</td>
<td>Corporate Services</td>
<td>Reliability of Infrastructure</td>
<td>IT</td>
<td>Significant 15</td>
<td>High Risk 10</td>
<td>09/04/2020</td>
<td>01/07/2020</td>
<td>Finance and Performance Committee</td>
<td>¬</td>
<td>Further work to be undertaken by the Finance Department to explain this change and review the current score.</td>
</tr>
<tr>
<td>4959</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Integrated Medicine</td>
<td>Reliability of Infrastructure</td>
<td>IT</td>
<td>Extreme Risk 20</td>
<td>Moderate 4</td>
<td>07/05/2020</td>
<td>07/06/2020</td>
<td>Quality Committee</td>
<td>¬</td>
<td>There is no change to the infrastructure therefore the risk remains the same.</td>
</tr>
<tr>
<td>5100</td>
<td>Chief Operating Officer</td>
<td>Deputy Chief Operating Officer</td>
<td>Corporate Services</td>
<td>Risk of inappropriate care and safety for patients within available resources due to operational challenges</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>High Risk 9</td>
<td>15/05/2020</td>
<td>01/12/2020</td>
<td>Quality Committee</td>
<td>¬</td>
<td>Reviewed following Risk Management Committee with a potential recommendation of reduction to 12.</td>
</tr>
<tr>
<td>5154</td>
<td>Director of Finance</td>
<td>Deputy Director of Finance</td>
<td>Corporate Services</td>
<td>Insufficient cash to pay goods and services in a timely manner</td>
<td>Financial Risk</td>
<td>Significant 15</td>
<td>Significant 12</td>
<td>27/08/2019</td>
<td>27/08/2020</td>
<td>Finance and Performance Committee</td>
<td>¬</td>
<td>Further work to be undertaken by the Finance Department to review the risk score with expectation that this would be reduced.</td>
</tr>
<tr>
<td>5169</td>
<td>Medical Director</td>
<td>Medical Examiner</td>
<td>Corporate Services</td>
<td>Significantly raised HSMR and SHMI meaning higher mortality rates than expected</td>
<td>Clinical Patient Safety and Quality</td>
<td>Extreme Risk 20</td>
<td>High Risk 9</td>
<td>15/05/2020</td>
<td>15/06/2020</td>
<td>Quality Committee</td>
<td>New</td>
<td>New risk.</td>
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<td>Responsible Manager</td>
<td>Division</td>
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<td>Risk level (Target)</td>
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<td>Review date</td>
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<td>Change in Current Risk Score from previous report</td>
<td>Notes</td>
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<td>5238</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Emergency Care</td>
<td>insufficient provision of medical cover within the UECC</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 12</td>
<td>High Risk 9</td>
<td>15/04/2020</td>
<td>15/06/2020</td>
<td>Quality Committee</td>
<td>↓</td>
<td>Reduced from 16 to 12. Presented to Risk Management Committee for approval however it was not approved due to challenge that the staffing vacancies in UECC still remain significant. Service agreed to review the risk.</td>
</tr>
<tr>
<td>5442</td>
<td>Chief Nurse</td>
<td>Deputy Chief Nurse</td>
<td>Corporate Services</td>
<td>Inability to fill high number of registered nurse vacancies leading to potentially a reduction in patient experience and safety.</td>
<td>Staffing and Competence</td>
<td>Extreme Risk 20</td>
<td>High Risk 8</td>
<td>05/05/2020</td>
<td>11/07/2020</td>
<td>People Committee</td>
<td>↑</td>
<td>Risk score increased from 16 to 20 as likelihood increased from 4 to 5 due to current staffing issues.</td>
</tr>
<tr>
<td>5599</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Integrated Medicine</td>
<td>Cardiac Team capacity resulting in possible clinical risk for heart failure patients</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>Moderate 4</td>
<td>04/05/2020</td>
<td>04/06/2020</td>
<td>People Committee</td>
<td>↔</td>
<td>Risk currently remains the same until review of capacity and staffing has been completed, with update to be provided to the next Risk Management Committee.</td>
</tr>
<tr>
<td>5715</td>
<td>Chief Operating Officer</td>
<td>Lead Advanced Clinical Practitioner – Hospital at Night (H@N) Team</td>
<td>Corporate Services</td>
<td>Ability to treat deteriorating patients in a timely manner due to lack of capacity within the Hospital at night team.</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>Moderate 4</td>
<td>15/05/2020</td>
<td>15/07/2020</td>
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<td>New</td>
<td>New risk.</td>
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<td>5779</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Integrated Medicine</td>
<td>Opening additional capacity on AMU above funded bed base (44)</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>High Risk 9</td>
<td>06/05/2020</td>
<td>06/06/2020</td>
<td>Quality Committee</td>
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<td>New risk.</td>
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<td>Assurance Committee</td>
<td>Change in Current Risk Score from previous report</td>
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<tr>
<td>5907</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Clinical Support</td>
<td>Loose filing of patient records across the Trust</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>Moderate 6</td>
<td>04/05/2020</td>
<td>06/07/2020</td>
<td>Quality Committee</td>
<td>↔</td>
<td>Although significant work has been undertaken to resolve this, backlog still remains and current workforce capacity is an issue.</td>
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<tr>
<td>5967</td>
<td>Chief Operating Officer</td>
<td>Divisional General Manager</td>
<td>Division of Emergency Care</td>
<td>Bank and Agency Costs</td>
<td>Financial Risk</td>
<td>Extreme Risk 20</td>
<td>High Risk 9</td>
<td>04/05/2020</td>
<td>07/09/2020</td>
<td>Finance and Performance Committee</td>
<td>↔</td>
<td>Bank and agency costs remain high although nursing agency costs have reduced in the last month, the risk will not be reduced until this sustained.</td>
</tr>
<tr>
<td>6075</td>
<td>Medical Director</td>
<td>UECC Divisional Director</td>
<td>No Specific Division</td>
<td>Increased 30 day mortality due to delayed boarding</td>
<td>Clinical Patient Safety and Quality</td>
<td>Significant 15</td>
<td>Significant 12</td>
<td>31/01/2020</td>
<td>09/06/2020</td>
<td>Quality Committee</td>
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<td>New risk.</td>
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<tr>
<td>6095</td>
<td>Chief Nurse</td>
<td>Deputy Chief Nurse</td>
<td>Corporate Services</td>
<td>Risk of patient harm as a result of lack of governance and oversight of Point of Care Testing (POCT) usage across the Trust</td>
<td>Clinical Patient Safety and Quality</td>
<td>Extreme Risk 16</td>
<td>Moderate 4</td>
<td>15/05/2020</td>
<td>15/07/2020</td>
<td>Quality Committee</td>
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<td>New risk.</td>
</tr>
<tr>
<td>6127</td>
<td>Chief Nurse</td>
<td>Deputy Chief Nurse</td>
<td>Corporate Services</td>
<td>Inability to deliver planned and emergency services due to national pandemic</td>
<td>Clinical Patient Safety and Quality</td>
<td>Extreme Risk 25</td>
<td>Moderate 5</td>
<td>15/05/2020</td>
<td>15/06/2020</td>
<td>Quality Committee</td>
<td>New</td>
<td>New risk.</td>
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Since the previous report in February 2020, the following has been undertaken:
- The addition of seven risks to the register of risks scoring 15 or above (reference 4379, 5169, 5715, 5779, 6075, 6095 and 6127)
- The removal of 10 risks from the register of risks scoring 15 or above (see table below)
<table>
<thead>
<tr>
<th>ID</th>
<th>Division</th>
<th>Title</th>
<th>Risk level (current)</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>4379</td>
<td>Corporate Services</td>
<td>Late payments to suppliers resulting in delays or stopping of goods or services.</td>
<td>Moderate 6</td>
<td>In the short-term (April to July 2020) the Trust should not experience have any cash flow problems under temporary financial arrangements introduced nationally in response to COVID-19. All NHS organisations are now being encouraged to pay suppliers within 7 working days as they are being provided with the cash to be able to do so. However, payments can still only be made once confirmation of goods and services and/or invoices have been approved by budget holders. Risk score reduced to 6.</td>
</tr>
<tr>
<td>4514</td>
<td>Division of Integrated Medicine</td>
<td>The Division’s ability to deliver the full range of Gastroenterology Services due to substantive Consultant workforce challenges</td>
<td>Significant 12</td>
<td>3x Trust locums have been appointed but are still going through the recruitment process. Risk score reduced to 12.</td>
</tr>
<tr>
<td>5422</td>
<td>Division of Clinical Support</td>
<td>There is a risk of loss of Pathology capacity due to the age of equipment affecting turnaround times and supporting diagnosis</td>
<td>Significant 12</td>
<td>Risk score reduced to 12 due to lack of incidents and Business Continuity Plan in place.</td>
</tr>
<tr>
<td>5536</td>
<td>Division of Integrated Medicine</td>
<td>Divisions ability to deliver Substantive Consultant led services within the Division of Medicine</td>
<td>Significant 12</td>
<td>Risk excluded Gastroenterology (4514) and Acute Medical Unit (New risk added) 28 WTE Consultant funded posts in the Division of Medicine, currently 3.7 WTE Vacancies, 2 covered by Locum Consultants and 1.7 WTE absorbed within the establishment. Controls/Mitigation; On-going recruitment Long Term Agency Locums in place Identifying Lead Clinician engagement Risk Score reduced to 12</td>
</tr>
<tr>
<td>5796</td>
<td>Division of Integrated Medicine</td>
<td>Mortality Reviews Not Taking Place Within All Medical Specialties within the Division of Integrated Medicine</td>
<td>Significant 12</td>
<td>Significant progress has been made against backlog of mortality reviews to be undertaken. Aiming to work towards a 4 week review plan. Focus to be on learning from deaths Discussed at Divisional Governance 13.02.20</td>
</tr>
<tr>
<td>5812</td>
<td>Corporate Services</td>
<td>Insufficient bed capacity leading to patients being seen/treated in inappropriate areas affecting patient safety</td>
<td>Significant 12</td>
<td>Currently reduced issues with bed capacity and patients therefore being seen in appropriate areas and patients therefore being seen in appropriate areas. Reduced to 12.</td>
</tr>
<tr>
<td>5921</td>
<td>Corporate Services</td>
<td>UECC not assessing and treating patients in a timely manner affecting patient safety and achievement of the new metrics</td>
<td>Significant 12</td>
<td>Risk reviewed and reduced to 12 in light of the reduced activity through UECC during the COVID crisis. This will be reviewed monthly at the Divisional governance meeting.</td>
</tr>
<tr>
<td>5942</td>
<td>Division of Clinical Support</td>
<td>Clinical Support Services - Financial year end risks</td>
<td>Extreme Risk 20</td>
<td>Risk has been closed. Now into new financial year of 2020/21. This risk was correctly assessed and the end of year deficit was realised. A new assessment of risk for the new financial year will be completed in June 2020 following the end of the financial year (2020/21) month 2 to allow for an assessment of forecast outcome.</td>
</tr>
<tr>
<td>ID</td>
<td>Division</td>
<td>Title</td>
<td>Risk level (current)</td>
<td>Comments</td>
</tr>
<tr>
<td>-----</td>
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<td>----------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5947</td>
<td>Corporate Services</td>
<td>Inappropriate use of Urinalysis Point of Care Test (PoCT) devices within the Trust</td>
<td>Significant 15</td>
<td>Closed as replaced by risk 6095</td>
</tr>
<tr>
<td>5950</td>
<td>Division of Emergency Care</td>
<td>Lack of consistent triage through a single service overnight</td>
<td>Significant 12</td>
<td>This risk was discussed at the risk analysis group and as we are currently maintaining triage and keeping the times within the targets the risk has been reduced but will be assessed monthly until activity returns. Risk score reduced to 12.</td>
</tr>
</tbody>
</table>
Appendix 2 – TRFT Risk Appetite

Risk Appetite Statement

The Rotherham NHS Foundation Trust recognises that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its service users, carers, staff, public and partners. As such, The Rotherham NHS Foundation Trust will not accept risks that materially provide a negative impact on quality.

However TRFT has a greater appetite to take considered risks in terms of their impact on organisational issues. TRFT has a greatest appetite to peruse Commercial gain, partnerships, clinical innovation, Financial/Value for Money and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within constraints of regulatory environment.

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Appetite</th>
<th>Risk Appetite Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Innovation</td>
<td>TRFT has a <strong>MODERATE</strong> risk appetite for Clinical Innovation that does not compromise quality of care.</td>
<td>12-16</td>
</tr>
<tr>
<td>Commercial</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Commercial gain whilst ensuring quality and sustainability for our services</td>
<td>6-10</td>
</tr>
<tr>
<td>Compliance/Regulatory</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.</td>
<td>6-10</td>
</tr>
<tr>
<td>Financial/Value for money (VFM)</td>
<td>TRFT has a <strong>MODERATE</strong> risk appetite for financial/VfM which may grow the size of the organisation whilst ensuring we minimising the possibility of financial loss and comply with statutory requirements.</td>
<td>12-16</td>
</tr>
<tr>
<td>Partnerships</td>
<td>TRFT has a <strong>MODERATE</strong> risk appetite for partnerships which may support and benefit the people we serve.</td>
<td>12-16</td>
</tr>
<tr>
<td>Reputation</td>
<td>TRFT has a <strong>MODERATE</strong> risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.</td>
<td>12-16</td>
</tr>
<tr>
<td>Category</td>
<td>Risk Appetite</td>
<td>Risk Appetite Score</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Quality – Clinical Effectiveness</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for risk that may compromise the delivery of outcomes for our service users.</td>
<td>6-10</td>
</tr>
<tr>
<td>Quality – Patient Experience (including complaints and claims)</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for risks that may affect the experience of our service users.</td>
<td>6-10</td>
</tr>
<tr>
<td>Quality – Patient Safety (including complaints and claims)</td>
<td>TRFT has a <strong>VERY LOW</strong> risk appetite for risks that may compromise safety.</td>
<td>1-5</td>
</tr>
<tr>
<td>Workforce</td>
<td>TRFT has a <strong>MODERATE</strong> risk appetite for actions and decisions taken in relation to workforce that does not compromise quality of care.</td>
<td>12-16</td>
</tr>
<tr>
<td>Environment</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Environment that does not compromise quality of care.</td>
<td>6-10</td>
</tr>
<tr>
<td>Plant and Equipment</td>
<td>TRFT has a <strong>MODERATE</strong> risk appetite for Plant and Equipment ensuring that it does not compromise quality of care.</td>
<td>12-16</td>
</tr>
<tr>
<td>Information Governance / IT</td>
<td>TRFT has a <strong>MODERATE</strong> risk appetite for actions and decisions taken in relation to Information Governance/IT.</td>
<td>12-16</td>
</tr>
<tr>
<td>Fire Safety / General Security</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Fire Safety/General Security</td>
<td>6-10</td>
</tr>
<tr>
<td>Business / Service Interruption</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Business/Service Interruption.</td>
<td>6-10</td>
</tr>
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### Agenda item
194/20

### Report
Disciplinary Policy

### Executive Lead
Steven Ned, Director of Workforce

### Link with the BAF
B3

### Purpose
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<th>To note</th>
<th>Approval</th>
<th>For information</th>
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### Executive Summary
(including reason for the report, background, key issues and risks)

This policy meets the duties imposed by legislation set out in the Employment Rights Act 1996 and the Employment Act 2010 and also reflects good practice included in the ACAS (Advisory, Conciliation and Arbitration Service) - Code of practice on disciplinary and grievance procedures.

The policy has been through the Trusts ratification process with staff side colleagues supporting the policy. The policy will be available on the Intranet for all employees to access. Hard copies can be provided upon request by the Employee Relations Department for employees who cannot gain access.

The Trust’s Disciplinary Policy will ensure that all staff are aware of:
- The standards of conduct and behaviour required
- How they will be helped to achieve improvements in their conduct and behaviour if necessary.
- How they can be supported during both the informal and formal stages of the disciplinary procedure.
- This Disciplinary Policy and the Disciplinary Management Guide which provides a clear framework for managers to use.

### Recommendations
It is recommended that the Board of Directors approve the policy.

### Appendices
1. Disciplinary Policy.
DISCIPLINARY POLICY

SECTION 1 PROCEDURAL INFORMATION

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<td>Date ratified:</td>
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<td>Title of originator/author:</td>
<td>Senior Human Resources Advisor</td>
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<tr>
<td>Title of responsible committee/individual:</td>
<td>Executive Director of Workforce</td>
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<tr>
<td>Date issued:</td>
<td>May 2020</td>
</tr>
<tr>
<td>Review date:</td>
<td>12 May 2023</td>
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<td>Target audience:</td>
<td>All Staff excluding Medical &amp; Dental</td>
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## Document History Summary

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<td>Jane Saunders</td>
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## Section 1 Contents

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<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Purpose &amp; Scope</td>
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<tr>
<td>4.2</td>
<td>Formal Disciplinary process</td>
<td>9</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Informal or formal process?</td>
<td>9</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Decision Making – Autonomous authority</td>
<td>9</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Support available for employees</td>
<td>10</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Investigatory disciplinary meeting</td>
<td>10</td>
</tr>
<tr>
<td>4.2.5</td>
<td>Allegations of fraud</td>
<td>11</td>
</tr>
<tr>
<td>4.2.6</td>
<td>Suspension</td>
<td>11</td>
</tr>
<tr>
<td>4.2.7</td>
<td>Formal Investigation</td>
<td>16</td>
</tr>
<tr>
<td>4.3</td>
<td>Disciplinary Hearings</td>
<td>18</td>
</tr>
<tr>
<td>4.3.1</td>
<td>The Hearing procedure</td>
<td>18</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Disciplinary Sanctions</td>
<td>20</td>
</tr>
<tr>
<td>4.3.3</td>
<td>Sanctions and Pay Progression</td>
<td>22</td>
</tr>
<tr>
<td>4.4</td>
<td>Live Warnings</td>
<td>22</td>
</tr>
<tr>
<td>4.5</td>
<td>Right to representation</td>
<td>22</td>
</tr>
<tr>
<td>4.6</td>
<td>Reasonable adjustments</td>
<td>22</td>
</tr>
<tr>
<td>4.7</td>
<td>Confidentiality</td>
<td>23</td>
</tr>
<tr>
<td>4.8</td>
<td>Safeguarding</td>
<td>23</td>
</tr>
<tr>
<td>4.9.1</td>
<td>Failure to renew Professional Registration/keep training and/or</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>qualifications up to date</td>
<td></td>
</tr>
<tr>
<td>4.10</td>
<td>Alleged or Actual Criminal Convictions</td>
<td>24</td>
</tr>
</tbody>
</table>
4.11 Unauthorised Absence 24
4.12 Freedom to Speak Up 25
4.13 Disciplinary Records 25
4.14 Action in the Event of Resignation 25
4.15 Appeal Procedure 26
4.16 Board Monitoring 27
5 Definitions and Abbreviations 27
5.1 Definitions 27
5.2 Abbreviations 28
6 References 29
7 Associated Documentation 29

Section 1 Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Time limits for sanctions</td>
<td>30</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Levels of Disciplinary Authority</td>
<td>31</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Disciplinary Rules</td>
<td>32-33</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Guidance On Writing A Statement For A Disciplinary Investigation</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>The Disciplinary Hearing process</td>
<td>35-36</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>The Disciplinary Appeal Hearing process</td>
<td>37-38</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Trust Core Values</td>
<td>39</td>
</tr>
</tbody>
</table>

Section 2 Contents – Documentation, Development, Communication, Implementation and Monitoring

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Consultation and Communication with Stakeholders</td>
<td>41</td>
</tr>
</tbody>
</table>

Please check the intranet to ensure you have the latest version
<table>
<thead>
<tr>
<th></th>
<th>Section 2 Appendices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appendix</strong></td>
<td><strong>Title</strong></td>
</tr>
<tr>
<td><strong>Appendix 1</strong></td>
<td>Completed Equality Impact Assessment</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Document Approval</td>
<td>41</td>
</tr>
<tr>
<td>10.</td>
<td>Document Ratification</td>
<td>41</td>
</tr>
<tr>
<td>11.</td>
<td>Equality Impact Assessment</td>
<td>41</td>
</tr>
<tr>
<td>12.</td>
<td>Review and Revision Arrangements</td>
<td>41</td>
</tr>
<tr>
<td>13.</td>
<td>Dissemination and Communication Plan</td>
<td>42</td>
</tr>
<tr>
<td>14.</td>
<td>Implementation and Training Plan</td>
<td>42</td>
</tr>
<tr>
<td>15.</td>
<td>Plan to monitor the Compliance with, and Effectiveness of, the Trust Document</td>
<td>43</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

The Rotherham NHS Foundation Trust recognises the need for managers to manage their staff in a supportive, consistent and fair manner so that they adhere to acceptable and expected standards of conduct and behaviour. Any alleged misconduct or unacceptable behaviour must be dealt with sensitively and firmly.

This policy meets the duties imposed by legislation set out in the Employment Rights Act 1996 and the Employment Act 2010 and also reflects good practice included in the ACAS (Advisory, Conciliation and Arbitration Service) “Code of practice on disciplinary and grievance procedures” and other non-statutory ACAS guidance, the GMC (General Medical Council) “Principles of a good investigation”, the NMC (Nursing Midwifery Council) “Best practice guidance on local investigations”, “A fair experience for all” by NHS England and NHS Improvement, and the recommendations of an advisory group commissioned by NHS England and NHS Improvement in 2019.

This policy will be available on the Intranet for all employees to access. Hard copies can be provided upon request by the Employee Relations Department for employees who cannot gain access.

2. PURPOSE & SCOPE

2.1 Purpose

The Trust’s Disciplinary Policy will ensure that all staff are aware of:

- The standards of conduct and behaviour required
- How they will be helped to achieve improvements in their conduct and behaviour if necessary.
- How they can be supported during both the informal and formal stages of the disciplinary procedure.
- This Disciplinary Policy and the Disciplinary Management Guide which provides a clear framework for managers to use.

Informal approaches will be utilised whenever appropriate.

Informal approaches will be inappropriate when staff have failed to resolve unacceptable conduct and/or behaviour.

Formal approaches may also be necessary because of the seriousness of the situation.

2.2 Scope

2.2.1 When this policy applies

This policy and procedure applies to all staff employed by the Rotherham NHS Foundation Trust with the exception of Medical and Dental staff who must follow the processes defined in Maintaining High Professional Standards (MHPS).
Concerns relating to performance/capability and sickness absence are not within the scope of this policy and must be treated in accordance with the Capability Policy and the Managing Attendance Policy. However, there may be instances where performance/capability and sickness absence concerns become conduct issues if the principles of the relevant policies are not followed by an employee and therefore the Disciplinary procedure may be invoked in accordance with this policy. This will be communicated to the employee at the earliest opportunity.

2.2.2 Overlapping disciplinary and grievance cases

A disciplinary investigation will not normally be delayed by the presentation of a grievance or claim of bullying and harassment. However, in certain circumstances the disciplinary procedure may be temporarily suspended to deal with the grievance. This will be decided by the Case Manager. Where the disciplinary and grievance issues are related it may be appropriate to deal with both issues at the same time.

2.2.3 Professional Codes of Conduct

Various professional bodies have professional standards of conduct. The Trust requires employees in those professions to adhere to the standards of conduct set by their professional body. The Chief Nurse (CN)/Medical Director with support from the Employee Relations department, is responsible for notifying the relevant professional body such as the NMC or The Health and Care Professions Council (HCPC) which may take action independently of the Trust.

3 ROLES AND RESPONSIBILITIES

These are defined within the informal and formal Disciplinary processes.

3.1 Expected behaviours

The Trust core values encompass the behaviour expected from staff (available on the Trust intranet - Appendix 7)

Trust employees are expected to familiarise themselves with and follow relevant Trust Policies and Procedures, local guidance and Standard Operating Procedures (SOP) (available on the Intranet) and to adhere to relevant professional codes and legislation and follow reasonable management instructions.

Examples of misconduct and gross misconduct are detailed in Disciplinary Rules - Appendix 3 (These lists are non-exhaustive.)

New employees will be advised to check key Trust policies at their Corporate Induction. Line managers must ensure sufficient time is allowed for this.

The Trust seeks to encourage employees to be accountable for their actions in an open and honest environment. Involvement in an incident will not necessarily lead to disciplinary action. Before a decision is taken, an initial fact finding investigation will be carried out to determine the appropriate course of action to be followed.

No formal disciplinary action will take place until the case has been formally and fully
investigated, and all parties have been given the opportunity to state their case, except in exceptional circumstances where all the facts have been fully established e.g. an employee has admitted to theft.

4. PROCEDURAL INFORMATION

4.1. When to use the informal disciplinary process

The Trust has a responsibility to help and encourage all employees to achieve and maintain standards of conduct and behaviour. When employees conduct/behaviour fall below expected standards, the Line Manager will contact the Employee Relations Department to discuss whether it is appropriate to deal with the matter informally or formally. However, in some circumstances the Line Manager may be able to deal with straightforward concerns about conduct/behaviour informally without requiring support from Employee Relations.

Responses alternative to invoking the formal disciplinary procedure must always be given careful consideration. On occasions it will not be appropriate for managers to address conduct issues informally. This is dependent on the nature of the allegation and the level of seriousness. If the Line Manager considers that formal disciplinary action may be warranted they will, with support from Employee Relations, consider the Decision Tree (see the Management Guide – Disciplinary Policy) and if it is decided that formal action may be appropriate, the case will be referred to a Case Manager.

4.1.1 Informal counselling for minor breaches

Where, considering all the circumstances, use of the formal disciplinary procedure would not be appropriate, the Line Manager must invite the employee to an informal counselling meeting during which there must be an open discussion between the Line Manager and employee so that all relevant issues are addressed. This must be followed up by a written confirmation of the expected behaviour and/or conduct and any required actions or training within a reasonable specified time period (see the Management Guide – Disciplinary Policy). A copy of this will be signed by the Line Manager and the employee and kept on the employee’s personal file. It may be referred to must there be an incident of a similar nature. The relevance and timeliness of the counselling record must be justified: any counselling record that has been on file for more than 12 months will not normally be referred to.

The employee must be given a copy of the record and must also be given an opportunity to record any comments in writing that they may wish to make in relation to the matter which will also be retained on their personal file.

In most cases this informal approach will resolve concerns without recourse to the formal disciplinary procedure. If the breach is more serious or there is a failure to maintain the improvement, the formal disciplinary procedure may be implemented.
4.2 THE FORMAL DISCIPLINARY PROCESS

4.2.1 Informal or formal process

If the Line Manager believes that it would be inappropriate to deal with the alleged concerns/incidents informally, the Employee Relations Department must be contacted without unreasonable delay and as soon as that decision has been made in order to allocate a Case Manager.

The Employee Relations Department will assign a Case Manager who will, within 10 calendar days of appointment, consider the available facts and assess the seriousness of the issue to decide whether it would be a proportionate and justifiable response to invoke the formal disciplinary procedure.

The Case Manager must not automatically attribute an incident wholly to the acts or failings of an individual alone and must consider if there have been any organisational or systems failures. The Case Manager may also consult with others before making the decision. For example, the Case Manager may seek professional advice if the alleged misconduct relates to matters of a professional nature.

In making the decision to proceed to the formal disciplinary procedure the Case Manager must complete and sign the Case Screening Form (see the Management Guide – Disciplinary Policy). If a concern/concerns are identified on the Case Screening Form, the Case Manager must then follow the Decision Tree (see the Management Guide – Disciplinary Policy) when deciding if to invoke the formal disciplinary procedure.

**Decision to proceed to a formal disciplinary investigation**

If the Case Manager decides that the matter must proceed to a formal disciplinary investigation, the Case Manager must meet with the employee as soon as possible to advise on the details of the allegation/s, the procedure to be followed and to identify any appropriate support that the employee may require.

The Case Manager must also, with the support of Employee Relations, appoint an Investigating Officer to carry out a disciplinary investigation by following the “Investigation flow chart” (see the Management Guide – Disciplinary Policy).

**Decision to deal with the concern informally**

If the Case Manager decides that the matter must be dealt with informally, they will refer the matter back to the Line Manager.

4.2.2 Decision-making - Autonomous Authority

Any decisions regarding suspension, levels of disciplinary sanctions etc. must only be made by senior staff who have the necessary competencies and/or training. Decision makers must have autonomous authority to make such decisions.
4.2.3 Support available for Employees

The Trust recognises that involvement in the formal disciplinary procedure can be a stressful experience for employees, many of whom have not been previously involved in formal proceedings.

It must therefore ensure that all employees subject to formal proceedings are advised in writing at the start of formal proceedings of the following ways in which it can support their health and wellbeing:

- All employees will be advised in writing that they can access Occupational Health by a Line Manager referral or appropriate manager and given contact details.
- All employees will be advised in writing that they can access the 24-hour Employee Assistance Programme and given contact details. This confidential service is run independently from the Trust Occupational Health service.
- Employees can also search on the Trust Intranet site/“ the Hub” under “Colleagues” under “Wellness Matters” where there is a variety of useful resources related to both mental and physical wellbeing.

Where an employee who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this must be treated as “never event” which will be the subject of an immediate independent investigation commissioned and received by the Board. Further, the Board will take prompt action to address the identified harm and its causes.

4.2.4 Investigatory disciplinary hearing

In cases of relatively minor misconduct where it is likely that a counselling or first written warning may be given, it may be appropriate for an investigatory disciplinary hearing to take place. This will be decided by the Case Manager.

If the Case Manager decides that an investigatory disciplinary hearing is appropriate, then the Case Manager will appoint a Chairing Manager who will be supported by a member of the Employee Relations Department. The employee will be informed in writing 7 calendar days in advance of the investigatory disciplinary hearing of the details of the allegation(s) including copies of any evidence to be considered at the investigatory disciplinary hearing, details of the hearing, the right to be represented by a trade union represented or a work colleague (not acting in a legal capacity) and the right to put forward relevant mitigation.

The employee will be given the right to call any relevant witnesses and must notify the Chairing manager/ the member of the Employee Relations team of the names of the witnesses at least 3 calendar days in advance of the hearing.

The employee must also send to the Chairing Manager, 4 calendar days in advance of the hearing, copies of any evidence that they wish to be considered at the Investigatory disciplinary hearing.
The Investigatory disciplinary hearing will be held to consider the available facts and enable the employee to put forward any mitigation and/or defence.

The hearing will then be adjourned for a decision to be taken as to whether or not a disciplinary sanction is appropriate and reconvened for an outcome to be given.

The highest sanction that can be given is a first written warning other disciplinary sanctions are listed below.

Based on the findings if the Chairing Manager believes that the matters are more serious than initially anticipated, they will refer back to the Case Manager who will decide if it is appropriate to carry out a formal disciplinary investigation which may if there is a case to answer, lead to a full disciplinary hearing.

A written outcome of the investigatory disciplinary hearing must be sent to the employee within 7 calendar days of the hearing and a copy put on their personal file.

The employee will have right to appeal any formal sanction given (see the Appeal section below).

4.2.5 Allegations of Fraud

If a concern is raised regarding a suspicion of fraudulent conduct or the acceptance of bribes by an employee, the Line Manager must refer to the Counter Fraud Policy in the first instance and the Local Counter-Fraud Specialist to establish the correct course of action. If fraud is suspected, employees should only discuss this with the Counter Fraud Specialist, Director of Finance or the NHS Counter Fraud Authority. No discussions should take place at this stage with the employee about the allegation. All managers must refer to the counter fraud specialist for them to investigate the allegation and must not discuss it with anyone e.g. other colleagues, their manager.

4.2.6 Suspension

The Trust recognises that suspension from work can be an upsetting experience which may cause an employee to feel isolated without appropriate support.

A decision to suspend an employee must therefore only be made as a last resort when it is proportionate, time bound and when there is full justification for doing so.

The risk must be such that changing working practices, or alternative arrangements, could not remove it.

Suspension is only to be undertaken where there is a risk that the employee’s continued presence in the workplace:

- poses a risk to patients, members of staff, themselves or the Trust or
- jeopardises the conduct of an investigation (e.g. can interfere with witnesses
and evidence)

or

- in the case of bullying and/or harassment, there is a need to remove the alleged perpetrator or complainant from the environment.

- In addition to these reasons, there may be other exceptional reasons which necessitate suspension e.g. it may be appropriate to suspend in some instances when criminal proceedings are ongoing outside the Trust or there are safeguarding concerns.

The decision to suspend must be authorised by two senior managers.

The rationale for deciding to suspend must be detailed on the Suspension/Transfer of area/Alternative Duties Decision Making form (see the Management Guide – Disciplinary Policy).

The reason for making a decision to suspend must be explained to the employee before the suspension/transfer/alternative duties takes place.

Suspension is not a form of disciplinary action and is without prejudice. It is a neutral act and does not imply guilt and therefore there is no right to appeal against suspension.

The employee will be suspended on full pay (including enhancements) as if they had remained at work. Pay for enhancements will be based on an average of the last 3 months.

Employees must ensure that registration is renewed and current at all times during suspension.

Suspension without pay

- Suspension without pay may be necessary, for example where a person has been imprisoned and is therefore unavailable for work.

- Suspension without pay will also be necessary where an employee has failed to renew their professional registration and lower banded work for a non-qualified worker is not available. This is also applicable where an employee has failed to keep their training/qualifications updated as required as part of their role. In this instance there is a right to representation either by an accredited Trade Union representative/Professional organisation representative, or a workplace colleague employed by the Trust when the employee is met with to formally notify them of the suspension (see section 10 below).

The procedure for carrying out suspension

- Suspension in person
There is no entitlement to be accompanied at a suspension meeting by a work colleague or union representative. However, employees will be given the opportunity to attempt, to contact their representative for support but if they are not available, the suspension meeting will still proceed. In this instance they may be accompanied by a colleague.

One of the two senior suspending managers will hold the suspension meeting running through the suspension checklist with the employee (see the Management Guide – Disciplinary Policy). At the meeting the employee will wherever possible be given a clear explanation of the reason for the suspension and will also be given a leaflet detailing support that can be accessed. The employee will be sent the suspension letter by recorded delivery as soon as possible (see the Management Guide – Disciplinary Policy).

The Line Manager, or another appropriate senior colleague, will contact the employee later in the working day of the suspension or the following day to check how the employee is feeling and that he/she feels able to access support if appropriate.

If the Line Manager/other appropriate senior colleague cannot contact the employee, a letter must be sent to the employee’s home address by recorded delivery requesting that he/she contacts the Line Manager/senior colleague as soon as possible. The Line Manager/senior colleague must continue to try and contact the employee, keeping a written log of continued attempts.

- **Suspension by phone**

Any employee suspended by telephone by the Suspending Manager will be offered a meeting (venue to be agreed) by their Line Manager/other appropriate senior colleague within 7 calendar days. This will enable the employee to discuss any concerns and any support they may require in addition to that discussed in the initial telephone call. A date will be agreed during the suspension phone call and will be included in the suspension letter sent by recorded delivery (see the Management Guide – Disciplinary Policy).

- **Suspension by letter**

If it is not possible to suspend the employee by phone, then a letter will be sent by the Suspending Manager to the employee’s home address by recorded delivery or by hand delivery, requesting that they contact the Suspending Manager without delay and not to return to work or enter the Trust site until they have spoken with their Line Manager/other appropriate senior colleague. The Suspending Manager will make continued attempts to make contact with the employee, keeping a written log and keeping the Line Manager /other appropriate manager up to date.

If the employee has not contacted their Line Manager/other appropriate manager within 24 hours of the initial letter, the Suspending Manager will send by recorded post or by hand delivery a letter of suspension including the offer of a meeting (venue to be agreed) within 7 calendar days to discuss the suspension further and to check
on the employee’s health and wellbeing and any appropriate support needs

Support for employees during suspension

Whilst suspension is ongoing, the Line Manager/other appropriate senior colleague will contact the employee regularly to check how the employee is and that he/she is being supported as appropriate and will keep a written log of contact. The regularity of contact will be agreed between the parties. However, will not be less than 4 weekly contact.

Where an employee cannot be contacted

If the employee can’t be contacted and concerns arise regarding the employee’s wellbeing, then the Employee Relations Department must be contacted for advice.

Informing Professional Bodies of suspension

Depending on the nature of the allegation, the Trust’s Chief Executive/Medical Director may need to inform the relevant professional body of the allegation.

Suspension requirements (see the Suspension checklist in the Disciplinary Management Guide)

- The manager who carries out the suspension will ensure that the employee leaves the premises and inform them that they are only entitled to return with management permission for the purpose of investigating the allegations or for another specified reason. Permission will not be unreasonably withheld. There may be instances where the employee is unable to ask for permission such as if they require emergency treatment or need to accompany a relative in an emergency situation. In such circumstances the employee must inform the manager as soon as is reasonably practicable.

- A suspended employee may be required to return any Trust property during their suspension including laptops, mobile phones, smart card and ID cards.

- A suspended employee must also be advised that their IT accounts will be suspended during suspension, this will also include the suspension of Smart Cards for access to clinical systems not reliant on IT accounts. Employees must contact the Employee Relations Department if they need access to their work documents or IT account during their suspension to gain information that may assist the investigation.

- A suspended employee must not communicate about the matter for which they have been suspended other than with their trade union representative, work colleague accompanying them to meetings, the Investigating Officer or any trained clinician/counsellor providing professional support. If none of these are being used, the employee can communicate with another work colleague identified by the Trust or a trusted confidante not involved in the matter. If the employee has anyone they wish to put forward as a witness in support of their case, they must first raise this with the Investigating Officer before approaching
the individual

- Unless suspended without pay, suspended employees will continue to receive all normal remuneration (unless they are certified sick, in which case Occupational Sick Pay will apply) and therefore are required to be available during Monday to Friday, or whatever their normal working hours are, between 9:00am – 5:00pm to attend any required meetings. If normal working hours are outside these hours, reasonable arrangements may need to be made between 9.00am- 5.00pm.

- Employees are expected to follow local operational procedure in reporting sickness absences and when requesting annual leave. In cases where a member of staff is suspended and reports in as being sick, the sickness absence supersedes the suspension and will be recorded as such. However, the terms of suspension such as not coming onto Trust premises etc. still apply.

**Annual leave during suspension**

Annual leave must be booked as normal during suspension and will be deducted from the employee’s entitlement in the usual way. If an employee will not be available to attend work at their manager’s request on a specific day, they must book annual leave.

**Working outside the Trust during suspension**

Employees are not permitted to undertake work elsewhere in the Trust during suspension. If the member of staff does have a secondary post outside of the Trust they must ensure that their Line Manager and the Case Manager are made aware of this as depending on the reason for suspension, the Trust may have a duty of care to inform the other employer that a suspension has taken place. The secondary post must not be undertaken during normal contracted hours.

**Alternatives to suspension – Transfer of area/Alternative duties**

Where the risk of the employee remaining in the workplace can be sufficiently mitigated by a transfer of area/alternative duties, a meeting will be held with the employee to confirm the necessary arrangements and explain the rationale.

The decision will be authorised by two senior managers and the rationale for the decision will be detailed on the Suspension/Transfer of Area/Alternative duties Decision Making form.

This is not a form of disciplinary action and is without prejudice. It is a neutral act and does not imply guilt and therefore there is no right to appeal against the decision.

**Review of suspension/Transfer of area/Alternative duties**

Suspension from work/transfer of area/alternative duties will last no longer than is reasonably practicable to investigate the facts of the allegation against the employee. The suspension/transfer of area/alternative duties will be reviewed every 4 weeks by the Case Manager who will confirm the outcome of the review in writing.
to the employee. The Case Manager will also notify in writing the Executive Director of Workforce if any suspension/transfer of area/alternative duties is to be extended over 6 months including the justification for continued suspension/transfer of area/alternative duties. The Case Manager will also notify the employee in writing of that decision including the reasons why.

**Lifting the suspension/Transfer of area/Alternative duties**

If at any point during the investigation, it is deemed by the Case Manager that the suspension/transfer/alternative duties are no longer appropriate, the employee will be met with to explain the reasons for their suspension/transfer of area/alternative duties being lifted and they will be integrated back into their role or other appropriate role with appropriate support from their manager. Although suspension/transfer of area/alternative duties may be lifted, this does not automatically mean that there will be no disciplinary case to answer and the allegations may still be deemed as potential gross misconduct.

**4.2.7 Formal Investigation**

A formal disciplinary investigation is required to establish the facts relating to serious concerns about conduct.

**The Roles**

Before the formal investigation procedure commences the following will be appointed

1) A Case Manager - The Case Manager will be appointed where possible from a different division to that of the employee. He/she has a number of important responsibilities and duties (see the Management Guide – Disciplinary Policy) which include overseeing the disciplinary investigation and deciding the next steps once the investigation has been completed.

2) An Investigating Officer – The Investigating Officer will be responsible for carrying out the disciplinary investigation in accordance with the Investigation Flowchart (see the Management Guide – Disciplinary Policy) and producing the investigation report.

3) A member of the Employee Relations Department - He/she will support the Investigating Officer with the disciplinary investigation. Also the Employee Relations Department will assist the Case Manager as required in arranging the panel where a disciplinary hearing/appeal hearing is required.

**Potential conflict**

The Case Manager will ensure that there is no conflict of interest between the appointment of the Investigating Officer and the member of the Employee Relations Department.

**The Length of the Investigation**
The Trust is committed to completing formal investigations and holding any subsequent hearings in a timely manner. Consideration must therefore be given by the Case Manager to the size and complexity of the case and sufficient time and resources must be allocated for individuals to carry out their roles. Reasons for delays must be provided upon request and included in the investigation report.

**Investigation Communication Plan**

A written Investigation Communication Plan will be given at the start of the investigation by the Investigating Officer, as signed off by the Case Manager, to any employee who is subject to a formal disciplinary investigation (see the Management Guide – Disciplinary Policy).

**Reviewing the Investigation**

The appointed Case Manager will review and discuss progress of the case with the Investigating Officer and the member of the Employee Relations Department every 4 weeks or where this is not possible (for example annual leave) as soon as practicable. The Investigating Officer must report to the Case Manager any concerns about not having sufficient time or resources to complete the investigation in a timely manner.

**Carrying out the Investigation**

The appointed Investigating Officer with the support of a member of the Employee Relations Department will gather all the facts about the alleged misconduct from all relevant sources. This may include gathering statements, written evidence and interview(s) with witnesses and other evidence. Guidance on “Writing a Statement for a Disciplinary Investigation” is provided below for potential witnesses - Appendix 4. In most cases this will involve arranging a formal investigation meeting with the employee to discuss the facts. A formal investigation meeting may not be necessary if;

(1) The Investigating Officer believes the facts have already been established and

(2) The employee agrees that it is reasonable to proceed directly to a disciplinary hearing.

**The Investigation meeting**

The Investigating Officer will give the employee as much notice as possible of the investigation meeting. Unless otherwise agreed by the employee, no less than 7 calendar days’ written notice of the investigation meeting must be given which must include the details of the allegation/s.

The employee may be accompanied at the investigation meeting by a trade union representative or workplace colleague employed by the Trust. An Employee Relations representative must be involved at this stage.

Should the employee be unable to attend the first date given due to a valid reason, one further investigation meeting date will be offered. Should the employee fail to attend the second investigation meeting, the Investigating Officer may base their findings on...
Please check the intranet to ensure you have the latest version of the available information before presenting his/her conclusions and any recommendations in the Investigation report. In exceptional circumstances, the employee may be given the option to respond in writing to the allegation/s rather than attend an Investigation meeting.

There is an expectation that all employees will provide statements/attend investigation meetings as requested except in exceptional circumstances. Other employees, requested to attend as witness, are entitled to reasonable notice of the Investigation meeting.

**The Investigation report**

Having investigated all the facts, the Investigating Officer with support from the Employee Relations representative will produce an Investigation report which details the relevant facts, the findings and conclusions (see the Management Guide – Disciplinary Policy). The report must also include details of any organisational/systems shortfalls and recommendations for any lessons to be learnt. The Investigation report will then be given to the Case Manager who will make the decision as to how the case is to proceed including whether it should proceed to a disciplinary hearing.

**The Investigation outcome**

The employee will be informed in writing by the Case Manager of the decision which may be one of the following:

i) There is not a case to answer and therefore no action will be taken.

ii) A decision to use a counselling route rather than proceeding to a disciplinary hearing. This will be fed back at an outcome meeting held by the Investigating Officer and the member from the Employee Relations team.

iii) A decision to progress the case to a disciplinary hearing. If the Case Manager deems it appropriate to progress the case to a disciplinary hearing, the Investigating Officer will be advised accordingly.

The Case Manager with support from the Employee Relations team will appoint a chair and a panel for the hearing. The hearing must be chaired by a senior member of staff with the appropriate level of authority as detailed in Levels of Disciplinary Authority - see Appendix 2.

To maintain impartiality, the Investigating Officer and the member of the Employee Relations department supporting the Investigating Officer, must not form part of the disciplinary hearing panel. Any perceived conflict of interest about the constitution of the panel must be raised with the Employee Relations Department.

**4.3 DISCIPLINARY HEARINGS**

**4.3.1 The Hearing Procedure**

The disciplinary hearing must be arranged for the earliest possible date. Where the
employee wishes to be accompanied by a union representative, the representative must be given as much notice as possible of the hearing date.

The senior manager appointed to chair the hearing will write to the employee, no less than 7 calendar days prior to the hearing, inviting them to a disciplinary hearing giving them the following details:

- The names and job titles of those forming and assisting the disciplinary hearing panel to include a member of the Employee Relations Department.
- The date, time and venue of the hearing
- The reason for the hearing.
- The allegation/s
- The employee’s right to be accompanied by a union representative or work colleague during the hearing and to present evidence/call witnesses including the requirement that the employee is required to inform the panel members of the names of any witnesses they wish to call at least 5 calendar days in advance of the hearing and that the witnesses must be told to keep the information confidential at all times.
- A list of the witnesses to be summoned
- Copies of any documents including the management statement of case, any statements which were gathered during the investigation and any other supporting documentation which may/may not be used during the hearing.

**Attendance at the hearing**

There is an expectation that the employee will attend the hearing as requested except in exceptional circumstances. Should the employee be unable to attend the first date given due to a valid reason, the employee will be invited to propose a further date no more than two weeks after the original hearing date, which the Trust will endeavour to accommodate. Should the employee fail to attend the second hearing without a good reason (evidence may be requested), the panel will make a decision based on the evidence made available to them on the day which in cases of gross misconduct may include dismissal.

If the chosen representative is unable to attend the second date for the hearing, the employee will need to find an alternative representative.

The employee may send written representations to the hearing should they be unable to attend or alternatively their representative may attend on their behalf. However, in these circumstances the employee will then not have the opportunity to respond to any questions that the panel may have as their representative will not be able to do this on their behalf.

When a disciplinary hearing is arranged and the employee suffers from a long-term health condition, managers must consider whether it would be appropriate to offer
reasonable adjustments to the Trust’s usual hearing location or format. This could include offering to conduct the hearing at a Trust venue other than the employee’s work base, or exceptionally by way of telephone conference. Advice must be sought from Occupational Health if needed.

The disciplinary hearing process

The disciplinary hearing will be conducted as set out in Appendix 5.

During the disciplinary hearing either party may ask the panel for an adjournment at any point.

Where the allegation relates to professional clinical misconduct and the panel chair is not of the relevant profession, the panel chair may seek impartial professional advice. The facility to request independent expert from outside the Trust will be available when necessary.

Once all the facts have been discussed, the disciplinary hearing will be adjourned for all the facts to be given full consideration prior to any decision being made. The length of the adjournment will vary in each case.

The panel chair may reconvene the hearing and inform the employee of their decision verbally which will then be confirmed in writing within 7 calendar days of the date of the hearing. The employee will also be advised of the right to appeal. In some cases, longer consideration may be required and therefore the hearing will either be reconvened at the earliest possible opportunity in order to announce the outcome or the employee will be informed in writing of the decision. A decision will be made regarding a suitable timeframe for decisions and this will be agreed at the end of the hearing.

4.3.2 Disciplinary sanctions available at the hearing

The decision by the disciplinary hearing manager/panel may include:

- **No action** to be taken of any kind

- **Counselling/Discussions** will be undertaken by the Chairing manager/Panel chair and senior Employee Relations representative in the form of a directed discussion with the employee focusing on the improvements required of the employee’s conduct, behaviour or performance. Written confirmation of this will be kept as a record on the employee’s personal file. This will be shared with the employee’s Line Manager, who will then monitor the outcomes.

- **Formal disciplinary sanctions**
  For all cases where a formal disciplinary sanction is given (i.e. a first written warning or final written warning), or the employee is dismissed, a copy of the outcome letter from the hearing will be placed on the employee’s personal file confirming the findings, the issue of a sanction and the level of sanction, and the active period of the warning. Information should also include an identification of
the behavioural corrections necessary, the consequences should these not be achieved and the right to appeal.

The level of sanction will depend on the severity of the misconduct, any mitigating factors and the previous employment record. These will not automatically be followed sequentially.

- **First written Warning**
  A first written warning must be given for misconduct where previous informal action proved ineffective, i.e. minor misconduct continues or where a first written warning would a proportionate sanction in all the circumstances regarding the employee’s conduct/behaviour.

- **Final Written Warning**
  Given when:

  There has been serious misconduct but not sufficient to warrant dismissal, or where a previous written warning has been ineffective or is considered inappropriate in all the circumstances.

- **Alternative to dismissal**
  As an alternative to dismissal, in certain situations a disciplinary panel may wish to consider:

  - Downgrading and/or transferring to another post and/or another location (this must be accompanied by a disciplinary sanction, i.e. a first written or final written warning, and the panel must record its expectations on how improvements should be made. This is likely to include action such as a development/action plan or a training agreement.)

  - Extension of any existing warning period.

  - The issue of a warning with a longer than usual period of validity

  - Where an employee is downgraded or transferred as a disciplinary sanction, they will not be entitled to pay protection.

  Please see **Appendix 1** for time limits on the different sanctions and **Appendix 2** for Levels of Authority for Imposing the different sanctions.

- **Dismissal**
  Dismissal may be considered as an outcome of a disciplinary hearing in cases where an employee commits further misconduct whilst subject to a live final written warning.

  Dismissal in these circumstances will be with the appropriate period of notice or payment in lieu of notice whichever is deemed appropriate.
• **Summary Dismissal**
  In a case of gross misconduct, an employee may be dismissed even if they do not have any previous disciplinary warnings. Dismissal in these circumstances may be without notice or payment in lieu of notice and is effective on the date the dismissal decision was confirmed to employee.

4.3.3 **Sanctions and Pay Progression**

Consideration must be given to the imposition of a disciplinary sanction on pay progression.

As part of the Agenda for Change new pay deal reached in 2018, staff have to demonstrate that there is no formal disciplinary sanction on their file in order to progress to the next pay step.

The panel must refer to the Pay Progression Policy when they are intending to issue a disciplinary sanction that will be live when the next pay step is due.

The Trust will monitor the disciplinary sanctions imposed to ensure that sanctions are not being disproportionately being applied to groups with protected characteristics and that there is no inequity.

4.4 **LIVE WARNINGS**

A warning is issued from the date of the hearing. If a further instance of misconduct occurs during the duration of the warning, it may be considered at a further hearing.

4.5 **RIGHT TO REPRESENTATION**

The Trust encourages all staff who are members of a recognised trade union or professional organisation and who are subject to a disciplinary investigation to speak to their representative. If this is an employee of the Trust, they will be given reasonable time off with pay.

The Trust will allow accredited trade union representatives reasonable paid time off to attend union-provided training courses on disciplinary issues and will support the unions in raising awareness of and tackling these issues amongst their members.

There is no right at any point in the disciplinary procedure to be accompanied by anyone who is not a recognised Trade Union/Professional Organisation representative or work colleague.

Disciplinary proceedings are not legal proceedings. There is no entitlement to legal representation within these procedures.

4.6 **REASONABLE ADJUSTMENTS**

Reasonable adjustments will be made at any stage if necessary during this procedure if employees inform the Employee Relations Department of their disability or language requirements e.g. an interpreter can be arranged to ensure allegations are fully understood.
4.7  CONFIDENTIALITY

All disciplinary matters are deemed to be confidential and must not be discussed by any employees involved in a disciplinary process with anyone other than their trade union representative or work colleague accompanying them to meetings, the Investigating Officer and any trained clinician/counsellor who is providing professional support to the employee. The employee may call witnesses to the hearing with permission from an appropriate person to do so. It should also be made explicitly clear to any witnesses that they also must not discuss the allegations with anyone.

Failure to comply with this may mean that disciplinary action is instigated against those who have breached confidentiality.

All written documents/records (e.g. written statements, reports, minutes) and proceedings relating to matters dealt with under this policy are and must remain confidential. However, the Trust may be required to provide such information when requested by the relevant professional body of the employee (i.e. NMC, HCPC).

All written documents/records will be redacted as appropriate to ensure confidentiality.

4.8  SAFEGUARDING

The Trust has a legal obligation to ensure that referrals are made, where appropriate, to the Independent Safeguarding Authority (ISA), the Disclosure and Barring Service or other relevant professional bodies in circumstances where they have dismissed or removed a member of staff or volunteer from regulated activity because they have harmed or posed a risk of harm to a child or vulnerable adult.

Safeguarding concerns may arise at any time during an investigation and the Case Manager must refer them as a matter of urgency to the Senior Designated Safeguarding Officer (The Chief Nurse) or the Deputy Senior Designated Officer (The Deputy Director of HR) who will consider such concerns in accordance with the Trust Safeguarding Vulnerable People policy.

4.9  FAILURE TO RENEW PROFESSIONAL REGISTRATION OR TO KEEP TRAINING/QUALIFICATIONS UPDATED

Where an employee has failed to renew their professional registration or failed to keep training/qualifications up to date as required, Employee Relations will appoint a Case Manager who will decide whether the matter should be dealt with by an Investigatory disciplinary meeting or a disciplinary hearing (please refer to the Standing Operating Procedure for Staff Professional Registration Responsibilities).
4.10 ALLEGED OR ACTUAL CRIMINAL OFFENCES

Staff must notify their manager and the Employee Relations Department if they are charged with or convicted of a criminal offence as soon as they are aware. Police enquiries, cautions, criminal proceedings or convictions relating to a criminal offence should not necessarily be regarded as constituting either a reason for disciplinary action or a reason for not pursuing internal disciplinary action.

The decision whether to take disciplinary action or not, will take into account whether the caution, charge or conviction is one that is relevant to the employee’s employment, or makes them unsuitable for the type of work undertaken.

The Trust may not need to wait for the outcome of police enquiries or court hearing before commencing an investigation and bringing the matter to a conclusion. Liaison with the Police may be advisable, depending on the situation as any potential investigation undertaken by the Trust may impede the criminal investigation. The Trust therefore will consider the circumstances of the case and, following advice before making a decision to proceed with the internal Trust investigation into the allegation against the employee, or delay it.

4.11 UNAUTHORISED ABSENCE

In circumstances where an employee fails to attend for work without prior approval they will be deemed as having unauthorised absence.

Employees are expected to notify their Line Manager 1 hour before their shift starts if they are going to be absent from work (see the relevant section of the Trust Managing Attendance policy for absence notification requirements). They are also expected to certify their absence and remain in reasonable contact with their Line Manager (or other designated person) as required. Employees who absent themselves from work during normal working hours due to sickness must gain the permission of their Line Manager (or the person in charge at the time) beforehand.

The Line Manager, or other designated person, will investigate the reasons for non-compliance with the above requirements and disciplinary action may be taken.

In cases of unauthorised absence, this must be recorded on ESR and Pay Services informed straight away to ensure that their pay is stopped. The employee must be informed verbally if possible and then this must be followed up in writing.

Disciplinary action where an employee cannot be contacted

In cases where an employee has persistently failed to make contact as requested, the employee will be invited in writing to attend a disciplinary hearing. The invite letter will be sent to the employee’s last known address by recorded delivery or hand delivered to that address and will enclose a copy of the investigation report prepared by the Line Manager to be referred to at the hearing. The letter must state the date,
time and location of the hearing, and that the employee has a right to be accompanied by a trade union representative or work colleague employed by the Trust. The letter must also state the fact that the hearing will take place in the employee’s absence, should they fail to attend without notifying the nominated Panel Chair of a reasonable reason for non-attendance, in advance. The letter must make it clear that unauthorised absence is considered as potential gross misconduct offence, and that one of the potential outcomes of the hearing is summary dismissal (i.e. dismissal without notice).

The Trust has a duty to inform officials at the UKVI within 10 calendar days if any employee who is sponsored by the Trust under any Certificate of Sponsorship arrangements (or any other legitimate work permit arrangements reliant on UKVI status) does not attend work, without permission. Managers must contact Employee Relations if they have an absent employee who falls into this category.

4.12 FREEDOM TO SPEAK UP

The Trust may receive allegations via the Freedom To Speak Up Policy and/or via the Freedom To Speak Up Guardian. These allegations will be investigated in accordance with the Disciplinary Policy and any other applicable policy.

Where an employee has previously spoken up via the Trust’s Freedom To Speak Up Policy and/or via the Freedom to Speak Up Guardian and they are subject to investigation themselves, clarity will be sought to identify whether any allegation is motivated by a desire to cause detriment to the employee because they spoke up. If such evidence is found, appropriate action will be taken.

4.13 DISCIPLINARY RECORDS

A copy of the outcome letter from the disciplinary case, including any sanction imposed, will remain on the employees’ personal file indefinitely as a record; however, in cases where a formal sanction has been issued, the warning will of course be expired, “spent”, after the allotted period of time. Expired outcomes will not be included in any future proceedings unless relevant.

Any written documents or records (including those relating to appeals), must be stored confidentially and separately from the employee’s personal file by the Employee Relations department. A copy of the outcome letter must also be sent to the Line Manager to be held locally and a copy is to be placed on the employee’s personal file. They will be retained for a period of up to 10 years, which is the minimum requirement for governance purposes after which time they can be destroyed.

4.14 ACTION IN THE EVENT OF RESIGNATION PRIOR TO COMPLETION OF PROCESS

In the event that an employee makes the decision to resign from the Trust prior to the completion of the full disciplinary process, a decision will be made by the Case
Manager (with advice from the Chief Nurse as appropriate) in conjunction with the Employee Relations Department, as to whether the process must continue and reach an outcome. The employee must be sent the outcome in writing. Any reference requests received by the Trust in relation to the employee will reflect the decision taken.

4.15 APPEAL PROCEDURE

All employees have the right to appeal against any formal disciplinary sanctions.

All appeals must be notified in writing and addressed to the Executive Director of Workforce within 14 calendar days of receipt of the written confirmation of the disciplinary sanction imposed. Employees must clearly state their grounds for appeal.

An appeal panel for an imposed sanction up to and including a final written warning will normally be heard by the next level of line management with support from Employee Relations.

An appeal panel for dismissal cases will be made up of 3 people. The panel will comprise of at least 1 Executive Director or Non-Executive Director plus 2 other members taken from the following categories:

- Clinical Director;
- General Manager;
- Deputy Director
- HR Business Partner.

The appeal hearing is not intended to repeat the detailed investigation of the disciplinary hearing but to focus on specific factors which the employee may feel have been dealt with unfairly or not considered sufficiently, such as for example:

- An inconsistent, inappropriate or excessively harsh sanction
- Extenuating circumstances;
- Bias of the manager holding the original disciplinary hearing
- New evidence subsequently coming to light;
- Potential unlawful discrimination;
- The disciplinary action taken was for a different reason than the one given.

An appeal panel also has the right if they think it is appropriate to down grade the sanction given at the original disciplinary hearing, or alternatively if the panel feel the sanction is not sufficient they can make the decision to impose a higher sanction. This exercise will only take place following a re- hearing of the evidence heard at the original disciplinary hearing.

An Employee Relations representative must be appointed to make the necessary arrangements for the appeal hearing and to ensure that a fair and consistent process is carried out.

The appeal hearing must be heard as soon as is reasonably practical.
At least 10 calendar days prior to the appeal hearing, the person making the appeal and the management representative must exchange specific and relevant documentation which they intend to use at the appeal hearing. The Employee Relations representative will be responsible for ensuring that both parties exchange their documentation on time and that the appeal panel receives copies of the full documentation.

Failure by either party to provide this information in time for the hearing could lead to postponement of the hearing for a further 5 calendar days, after which time the appeal will take place with what existing information has been made available.

Employees have the right to be represented by a trade union representative or a work colleague during the appeal hearing.

The appeal hearing decision will be final and there is no further internal right to review. The employee will be sent written confirmation of the appeal outcome within 14 calendar days of the appeal hearing.

Appeals against dismissal do not affect the employee’s effective date of termination unless the decision is rescinded and the employee's appeal upheld in full, in which circumstances the employee will resume their employment with the Trust as having never left the Trust and be paid as if they had been at work for the period between the dismissal and reinstatement.

4.16 BOARD MONITORING

The Board will receive a quarterly report containing details of disciplinary cases completed including brief details of the reason for the procedure, justification for any suspensions/exclusions, outcomes including sanctions, lessons learnt and any impact on patient care.

The Board Executives will take immediate action if there is any evidence that disciplinary sanctions are being disproportionately applied to employee groups with protected characteristics.

5. DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

**Appeal Hearing** - This is the meeting at which the employee and the presenting manager state their case regarding disciplinary action that has been issued.

**Codes of Business Conduct, rules and standards** - These set the standards of conduct at work

**Disciplinary Action** - This is the sanction that is given to the employee following the disciplinary hearing and can range from formal counselling to summary dismissal.

**Disciplinary hearing** - This is the meeting at which the employee and the Investigating Officer state their case regarding the disciplinary issue before a panel. The panel will usually have the panel chair, an Employee Relations representative
and, where necessary, a professional advisor. The professional advisor may be internal or external to the Trust.

**Disciplinary Investigation** - This is conducted by the Investigating Officer and is the process by which evidence is collected and collated into a report.

**Employment Representatives** – Trade Union Representatives or work related colleagues

**Formal Action** - This is an action taken to address misconduct matters and which may result in a disciplinary warning/alternative to dismissal

**Panel chair – Disciplinary hearing** - This is the senior manager who chairs the panel which hears the evidence presented at the disciplinary hearing. The panel will decide what disciplinary action is taken if any.

**Informal Action** - This is action taken to address misconduct matters but which will not result in a disciplinary warning

**Investigating Officer** - This is the manager identified by the Employee Relations Department to undertake a disciplinary investigation, produce a report of their findings and share the investigation report with the Case Manager. The Case Manager then decides if the employee has a “case to answer” and if the case must progress to a disciplinary hearing. The Investigating Officer will also present the Trust's case at a hearing.

**Case to Answer** - This is where a conclusion has been made following a disciplinary investigation and based on the balance of probability that the employee has committed in the opinion of the Investigating Officer a potential disciplinary offence.

**Management Notes** - At any stage of the informal or formal procedure and during meetings, management notes will be taken. These notes will be sent to the employee. The employee will be given the opportunity to add comments at the end of the notes but will not be able to change them. The management notes including the employee's comments will be used in evidence if necessary.

**Summary Dismissal** – immediate dismissal by an employer on the grounds of gross misconduct

**Employee Relations Department** – Part of the Human Resources Department

### 5.2 Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ACAS</td>
<td>Advisory, Conciliation and Arbitration Service</td>
</tr>
<tr>
<td>ESR</td>
<td>Electronic Staff Record</td>
</tr>
<tr>
<td>HCPC</td>
<td>Health and Care Professions Council</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<tr>
<td>JPF</td>
<td>Joint Partnership Forum (Formerly the Joint Consultation and Negotiating Committee) i.e. Management and Staff side joint committee.</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
</tbody>
</table>
6. REFERENCES
N/A

7. ASSOCIATED DOCUMENTATION

Alcohol and Drugs Policy
Capability Policy
Dress Code Policy
Grievance Policy
Managing Attendance Policy
Management Guide – Disciplinary Policy
Pay Progression Policy
Pre and Post Professional Checks Policy
Safeguarding Children Policy
Safeguarding Vulnerable Adults Policy
Smoke Free Policy and Code of Conduct
Standards of Business Conduct
Standard Operating Procedure- Staff Professional Registration Lapse
Whistle-blowing Policy
### TIME LIMITS FOR SANCTIONS

<table>
<thead>
<tr>
<th>Outcome/Sanction</th>
<th>Time Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal discussions/counselling</td>
<td>File note – will not be referred to after 12 months</td>
</tr>
<tr>
<td>Counselling as an outcome from a disciplinary investigation</td>
<td>Letter summarising discussions – will not be referred to after 12 months</td>
</tr>
<tr>
<td>Counselling as an outcome of disciplinary hearing</td>
<td>Letter summarising discussions – will not be referred to after 12 months</td>
</tr>
<tr>
<td>First written Warning</td>
<td>6-9 months</td>
</tr>
<tr>
<td>Final Written Warning</td>
<td>9-18 months</td>
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</tbody>
</table>
APPENDIX 2

LEVELS OF DISCIPLINARY AUTHORITY

**NB.** It is expected that the panel chair will be of a higher band than the employee who is going through the disciplinary process. However, in some circumstances there may not be an officer of an appropriate grade within the organisation. In this circumstance, advice should be sought from the Executive Director of Workforce as to who may constitute an appropriate person.

<table>
<thead>
<tr>
<th>Disciplinary Sanction</th>
<th>Minimum Level of Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal Discussion/counselling</td>
<td>Line Manager</td>
</tr>
<tr>
<td>Counselling as an outcome from a disciplinary investigation</td>
<td>Investigating Officer and HR advisor</td>
</tr>
<tr>
<td>Counselling as an outcome of a disciplinary hearing</td>
<td>Manager (band 7 and above) and HR advisor</td>
</tr>
<tr>
<td>First written Warning (highest sanction available in an investigatory disciplinary hearing)</td>
<td>Manager (band 7 and above) and HR advisor</td>
</tr>
<tr>
<td>Final Written Warning</td>
<td>Manager of 8a and above and Senior HR advisor</td>
</tr>
<tr>
<td>Dismissal/demotion/redeployment/action short of dismissal</td>
<td>Managers of 8a (appropriately trained) and above and Senior HR advisor</td>
</tr>
<tr>
<td>Suspension (by 2 people)</td>
<td>Head of Dept./Matron/Director or Associate or Deputy Director or Manager with delegated authority Plus Employee Relations representative/appropriate senior manager or on call</td>
</tr>
<tr>
<td>Suspension (by 2 people)/Discipline of Very Senior Managers/Directors/Non-Executive Directors</td>
<td>This can only be carried out by a person of a higher grade with the advice of the Executive Director of Workforce Plus Employee Relations representative/ or appropriate senior manager on call</td>
</tr>
</tbody>
</table>
DISCIPLINARY RULES

These rules and standards of behaviour apply equally to all staff. They are necessary for the efficient and safe performance of work and for the maintenance of satisfactory employment relations. In order to make staff aware of the likely consequences of breaking any of these disciplinary rules, they have been categorised as gross misconduct and misconduct. Except in cases of gross misconduct, an employee will not be dismissed for a first breach of discipline. It is not possible for any set of disciplinary rules to cover all circumstances that may arise and this list is not exhaustive.

1. GROSS MISCONDUCT

Gross misconduct is behaviour which is considered to be so serious because of its nature or consequences that it goes to the root of the contract and justifies the Trust no longer allowing an individual’s continued employment. Commission of gross misconduct may lead to summary dismissal (dismissal without notice). Examples of gross misconduct include (but is not an exhaustive list):

- Violence or other exceptionally offensive behaviour, including fighting; Ill treatment or serious neglect of patients;
- Dishonesty, e.g. theft or fraud, including falsification of timesheets, qualifications, expenses claims;
- Being under the influence of or affected by the abuse of substances, e.g. alcohol or drugs, other than those which have been medically prescribed;
- Serious damage to Trust property or equipment;
- Serious breaches of health and safety rules or regulations or endangering self or others;
- Breaches of confidentiality relating to patients;
- A serious clinical act or omission which is significantly prejudicial to the service;
- Bullying, harassment, discrimination and other specific issues contained in the Trust’s Harassment and Bullying in the Workplace or Equal Opportunities Policies;
- Criminal conduct outside work which is relevant to the employee’s job and which makes them unsuitable for the duties and responsibilities of their post;
- Undertaking paid or unpaid work for a different employer that affects an employee’s ability to undertake the full range of their work responsibilities; such as working for another employer when they are off sick;
- Failure to declare any “conflict of interest” which could be seen to result in actual or potential financial or material gain;
- On-going refusal to carry out a reasonable management instruction;
- Actions or omissions which have the potential to bring the service into disrepute;
- Persistent failure to produce proof of immigration status when requested to do
so by the trust without reasonable excuse:

- Gross misuse of the Trust's email and internet facilities, e.g. the searching, viewing, downloading or distributing of sexually explicit material;
- Acts of misconduct as set out below where the act or omission, or the impact of it, is sufficiently serious to constitute a breach of contract;
- Gross negligence;
- Unauthorised absence from duty for which no acceptable reason has been given;
- Inappropriate use of social networking including any other activity which potentially brings the Trust into disrepute;
- Sleeping whilst on duty at work;
- Misuse of Trust time;
- Perpetration of a serious hoax that has an adverse impact on the Trust;
- Gross insubordination;
- Misuse of Trust property including machine/equipment/vehicles;
- Abuse of any agreed local flexible working process;
- Fraudulent claiming of expenses

2. EXAMPLES OF MISCONDUCT

Examples of misconduct other than gross misconduct include (this is not an exhaustive list):

- Refusal to carry out a reasonable management instruction; Minor neglect of duty;
- Wilful poor performance;
- Behaviour/action likely to cause offence including inappropriate language;
- Unacceptable standards of dress and appearance;
- Causing minor damage to property;
- Failure to observe operational regulations and Trust Standing Orders, the consequences of which are not prejudicial to the service;
- Failure to complete patient records accurately and in a timely manner;
- Failure to give proper support to other members of staff;
- Serious breach of any policy or procedure of the Trust;
- Timekeeping;
- Absenteeism
APPENDIX 4

GUIDANCE ON WRITING A STATEMENT FOR A DISCIPLINARY INVESTIGATION

Presentation

The statement or report must be typed or written as neatly as possible in black ink. If the statement or report is typewritten then it must be saved as “read only”.

Reports must be addressed to the Investigating Officer.

All statements should be written in the first person singular (i.e. I saw, I gave, I was asked etc.)

The statement must be signed and dated at the bottom of the statement.

Content

Statements must include the following: -

Name, position held, qualifications, number of years’ experience in the relevant field, and where you are based.

The statement should be as accurate and giving as much detail as possible, particularly with regard to dates and times.

The statement must detail your involvement. Hearsay evidence (information from any other source, including third parties) can be included if relevant.

If you are the person that allegations have been made against, you must also include any mitigation (reasons) for your actions.

You must ensure that the content of the statement is a true account to the best of your knowledge.

If you are in a union, ensure that your representative goes through your statement with you before submitting it.

If you are having difficulties submitting your statement by the agreed date, ensure that you contact the Investigating Officer as soon as possible to explain the reasons why and to ask whether another date can be agreed.

Double check your statement before signing and dating it. Take a copy of your statement for future reference.
PROCEDURE OF A DISCIPLINARY HEARING

The following procedure must be followed at all Disciplinary Hearings

During the procedure either party may request a short adjournment at any stated time which will not be unreasonably refused.

1. All parties including the Panel members will be introduced to each other and a brief outline of the proceedings given by the Chairman of the panel.

2. The Investigating Officer supported, where relevant, by an HR representative will present their case and call any witnesses.

3. The employee and/or their representative will have the opportunity to ask questions of the Investigating Officer and their witnesses.

4. The Panel members will have the opportunity to question the Investigating Officer and their witnesses.

5. The Management representative may re-examine their witnesses on any matters referred to in their examination by the Panel members or the employee and/or their representative.

6. At this stage a witness may be released or asked to remain available should the panel or either party feel that further questions or clarification may be required later in the hearing.

7. The employee and/or their representative will present the case for the employee and call any witnesses.

8. The Investigating Officer, supported by a HR representative, where present, will have the opportunity to question the employee and their witnesses.

9. The Panel members will have the opportunity to question the employee and their witnesses.

10. At this stage a witness may be released or asked to remain available should the panel or either party feel that further questions or clarification may be required later in the hearing.

11. The Investigating Officer and the employee and/or their representative will have the opportunity to sum up their cases. Neither party shall introduce any
12. Nothing in the above procedure shall prevent the panel from inviting either party or witnesses to describe or clarify any statement that they have made.

13. Should the panel believe that further investigation or evidence is required, then an adjournment may be called to enable this to take place. The hearing will be reconvened as soon as is practicably possible.

14. Following the ‘summing up’ both parties will withdraw from the hearing.

15. The panel will deliberate in private, only recalling both parties to clarify points of uncertainty on evidence already given. If recall is necessary, both parties will be requested to return notwithstanding that only one is concerned with the point giving rise to doubt.

16. Prior to the disciplinary hearing the panel will not be made aware of any other current warnings issued to the employee. However, such warning may be notified to, and considered by the panel before they reach a final decision.

17. The Panel members after listening to both cases will consider the evidence presented and decide if a disciplinary sanction is warranted and what this should be.

18. The panel will reconvene to announce their decision to both parties verbally where possible. In any event the individual will be notified of the decision in writing within 7 calendar days of the hearing.
PROCEDURE FOR A DISCIPLINARY APPEAL HEARING

The following procedure must be followed at all Disciplinary Appeal Hearings. During the procedure either party may request a short adjournment at any stated time that will not be unreasonably refused.

1. All parties including the Panel members will be introduced to each other and a brief outline of the proceedings given by the Chairman of the panel.

2. The employee and/or their representative will present the case for the employee and in exceptional circumstances call any witnesses.

3. The Management representative (supported by a manager who may be an HR representative) will have the opportunity to question the employee and their witnesses (if called).

4. The Panel members will have the opportunity to question the employee and their witnesses.

5. The employee and/or their representatives may re-examine their witnesses on any matters referred to in their examination by Panel members or the Investigating Officer.

6. At this stage a witness may be released or asked to remain available should the panel or either party feel that further questions or clarification may be required later in the hearing.

7. The Management representative who may be supported by a manager (who may be a Human Resources Representative) will present their case and call any witnesses.

8. The employee and /or their representative will have the opportunity to question the Management representative and their witnesses.

9. The Panel members will have the opportunity to questions the Management representative and their witnesses.

10. The Management representative may re-examine their witnesses on any matters referred to in their examination by Panel members or employee and ‘or their representative.
11. At this stage a witness may be released or asked to remain available should the panel or either party feel that further questions or clarification may be required later in the hearing.

12. Both parties will have the opportunity to sum up their cases. Neither party shall introduce any new evidence at this stage which has not previously been submitted. Reasonable time will be allowed for either party to prepare to ‘sum up’, if required. The employee or their representative shall speak last.

13. Nothing in the above procedure will prevent the panel from inviting either party or representative to describe or clarify any statements they have made.

14. Should the panel believe that further investigation or evidence is required, then an adjournment may be called to enable this to take place. The hearing will be reconvened as soon as practicably possible.

15. Following the ‘summing up’ both parties will withdraw from the hearing.

16. The panel will deliberate in private only recalling both parties to clarify points of uncertainty on evidence already given. If recall is necessary, both parties will be requested to return notwithstanding that only one party is concerned with the point giving rise to doubt.

17. The panel will reconvene to announce their decision to both parties verbally where possible. In any event, the individual will be notified of the decision in writing within 7 calendar days of the hearing.
THE TRUST CORE VALUES

AMBITIOUS

We set high standards for the services we deliver. We aim to be an outstanding Trust and we are enthusiastic about delivering excellent health care for our patients. We have high expectations of ourselves and others.

CARING

We embrace the importance of giving the highest possible quality of care for our patients. We also care for each other as colleagues and for the community, our resources, our environment and our future.

TOGETHER

We value the importance of working together with patients, carers and families to ensure that we provide high quality patient centered care. We are committed to working with partners and stakeholders across Rotherham, South Yorkshire and Bassetlaw to develop sustainable services for the population we serve.
DISCIPLINARY POLICY

SECTION 2

DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING
8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

The Joint Partnership Forum.

9. APPROVAL OF THE DOCUMENT

This document was approved by:

The Joint Partnership Forum.

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Trust Document Ratification Group.

11. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

Once the document has been ratified the author will make arrangements for the Website Summary Form to be published to the Trust’s Internet via the Equality and Engagement Manager.

12. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years unless such changes occur as require an earlier review.

The Executive Director of Workforce is responsible for the review of this document.
### 13. DISSEMINATION AND POLICY COMMUNICATION PLAN

<table>
<thead>
<tr>
<th>To be disseminated to</th>
<th>Disseminated by</th>
<th>How</th>
<th>When</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Staff excludes doctors and dentists</td>
<td>DRG Administrator</td>
<td>As an all staff email via the Communications Team</td>
<td>When Mgt. Guide and Case Manager Training complete</td>
<td>Managers to inform staff without readily available email access of the policy</td>
</tr>
<tr>
<td>All Staff</td>
<td>DRG Administrator</td>
<td>Placed on Trust intranet site for staff to access</td>
<td>When Mgt. Guide and Case Manager Training complete</td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>Line Managers</td>
<td>Via Team Meetings</td>
<td>When Mgt. Guide and Case Manager Training complete</td>
<td></td>
</tr>
</tbody>
</table>

### 14. IMPLEMENTATION AND TRAINING PLAN

<table>
<thead>
<tr>
<th>What (specific section of the document)</th>
<th>How (e.g. production and completion of documentation)</th>
<th>Associated action (e.g. where are forms kept, who restocks them?)</th>
<th>Lead</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divisional Group training sessions</td>
<td>Invitations to go out to managers from HR to attend training</td>
<td>N/A</td>
<td>Deputy Director of HR</td>
<td>As and when required</td>
</tr>
<tr>
<td>On the job training for managers when dealing With disciplinary</td>
<td>One to one meeting/training sessions</td>
<td>N/A</td>
<td>HR Department/department Heads</td>
<td>As and when required where a requirement for organisational change is</td>
</tr>
<tr>
<td>Case Manager Training</td>
<td>Request to attend training sessions to go out to managers from HR</td>
<td>N/A</td>
<td>Deputy Director of HR</td>
<td>As and when required</td>
</tr>
</tbody>
</table>
15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

<table>
<thead>
<tr>
<th>Audit/Monitoring Criteria</th>
<th>Process for monitoring e.g. audit, survey</th>
<th>Audit / Monitoring performed by</th>
<th>Audit / Monitoring frequency</th>
<th>Audit / Monitoring reports distributed to</th>
<th>Action plans approved and monitored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Effectiveness</td>
<td>Audit</td>
<td>Employee Relations</td>
<td>Annually</td>
<td>Executive Director of Workforce</td>
<td>Deputy Director of Human Resources</td>
</tr>
<tr>
<td>Total number of staff going through the disciplinary process</td>
<td>Report generated via Electronic Staff Record</td>
<td>Employee Relations</td>
<td>Quarterly</td>
<td>Executive Director of Workforce to disseminate to the Board</td>
<td>Deputy Director of Human Resources</td>
</tr>
<tr>
<td>Training Learning &amp; Development</td>
<td>Discussions with managers/staff side representatives during and post consultation to look at any training gaps/needs</td>
<td>Employee Relations</td>
<td>Ongoing</td>
<td>Executive Director of Workforce</td>
<td>Deputy Director of Human Resources</td>
</tr>
<tr>
<td>Staff Awareness</td>
<td>Survey via Communications to establish staff awareness of the policy</td>
<td>Employee Relations</td>
<td>Every 3 years</td>
<td>Executive Director of Workforce</td>
<td>Deputy Director of Human Resources</td>
</tr>
</tbody>
</table>
**EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL**

**Document Name:** Disciplinary Policy  
**Date/Period of Document:** January 2020 – January 2023

**Lead Officer:** Senior HR Advisor  
**Job title:** Senior HR Advisor

---

**Function**  
**Policy**  
**Procedure**  
**Strategy**  
**Other:**

---

**Describe the overall purpose / intended outcomes of the above:**

Describe the main aim, objectives and intended outcomes of the above: **To ensure that managers and staff within the organisation are aware and understand Trust processes and procedures regarding the management of unacceptable conduct within the organisation including the legal requirements and investigation processes and potential outcomes. Excluding Doctors and Dentists.**

---

**You must assess each of the 9 areas separately and consider how your policy may affect people of different groups within those areas.**

### 1. Assessment of possible adverse (negative) impact against a protected characteristic

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Religion and belief</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>![X]</td>
<td></td>
</tr>
</tbody>
</table>

---

**You need to ask yourself:**

- Will the policy create any **problems** or **barriers** to any community or group?  ![Yes](X) ![No] (Positive)
- Will any group be **excluded** because of the policy?  ![Yes](X) ![No] (Negative)
- Will the policy have a negative impact on **community relations**?  ![Yes](X) ![No] (Negative)

**If the answer to any of these questions is Yes, you must complete a full Equality Impact Assessment**

### 2. Positive impact:

**Could the policy have a significant positive impact on equality by reducing inequalities that already exist?**

**Explain how will it meet our duty to:**

<table>
<thead>
<tr>
<th>Step</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eliminate discrimination, harassment and / or victimisation</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>2. Advance the equality of opportunity of different groups</td>
<td>![X]</td>
<td></td>
</tr>
<tr>
<td>3. Foster good relationships between different groups</td>
<td>![X]</td>
<td></td>
</tr>
</tbody>
</table>

### 3. Summary

**On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="X" alt="HIGH" /></td>
<td><img src="X" alt="LOW" /></td>
</tr>
<tr>
<td><img src="X" alt="MEDIUM" /></td>
<td><img src="X" alt="MEDIUM" /></td>
</tr>
<tr>
<td><img src="X" alt="LOW" /></td>
<td><img src="X" alt="HIGH" /></td>
</tr>
</tbody>
</table>

**Date assessment completed:** January 2020

**Is a full equality impact assessment required?**

- ![Yes](X) ![No] (Positive)

**Date EIA approved by Equality and Diversity Steering Group:**

---

**Page **44** of 44**

**DISCIPLINARY POLICY**

Please check the intranet to ensure you have the latest version

---

**Version 5**
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>195/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Annual Report and Accounts 2019/20</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Steve Hackett, Interim Director of Finance</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B7: The Annual Report is a key governance mechanism through which the organisation demonstrates its accountability to both Parliament and to its stakeholders.</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note [ ] Approval [√] For information [ ]</td>
</tr>
</tbody>
</table>

**Executive Summary (including reason for the report, background, key issues and risks)**

This final version of the Annual Report and Accounts for 2019/20 is presented to the Board of Directors following review by the Trust’s External Auditors and Audit Committee.

It should be noted that the deadline for submission of the Annual Report to NHS Improvement / England has been amended to 25 June 2020 due to the pressures caused by the COVID-19 pandemic.

For the same reason the Annual Report and Accounts for 2019/20 will not be laid before Parliament before its summer recess which ends on 8 September 2020.

Due to regulations which state that we must not publish our annual report and accounts until after they has been laid before Parliament, the document does not appear in this pack, but has been sent out to Board Members separately.

**Recommendations**

The Board of Directors is requested to review and approve the Annual Report and Accounts for 2019/20 which was presented to the Audit Committee, the day before June Board Meeting.

**Appendices**

None
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>196/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Audit Committee Annual Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Anna Milanec, Director of Corporate Affairs / Company Secretary</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B7: To align with good governance practices in other sectors, the HFMA NHS Audit Committee Handbook recommends that the Audit Committee provides an annual report to the organisation’s Governing Body.</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision □ To note √ Approval □ For information □</td>
</tr>
</tbody>
</table>
| Executive Summary (including reason for the report, background, key issues and risks) | The Healthcare Financial Management Association (HFMA) recommends that the Audit Committee Annual Report details the manner in which the Committee has discharged its responsibilities and met its Terms of Reference during the year.  
The final Audit Committee Annual Report for 2019/20 was presented to, and approved by, the Audit Committee at its meeting on 1 June 2020. |
| Recommendations | It is recommended that the Board of Directors note this final version of the Audit Committee’s Annual Report.  
The report will be presented to the July 2020 Council of Governors’ meeting. |
| Appendices | 1. Final Audit Committee Annual Report 2019/20 |
Introduction
The purpose of this report is to provide a formal account to the Board of Directors and the Council of Governors of the work of the Audit Committee during 2019/20 and to describe the way in which it has discharged its role and responsibilities during the year.

Committee Membership and Meetings
The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA)\(^1\).

The Committee was chaired throughout the year by Joe Barnes, a Non-Executive Director with relevant financial experience. From April 2019 to January 2020 four of the Non-Executive Directors were members of the Audit Committee, all of whom were considered to be independent. From February 2020 three Non-Executive Directors were members of the Committee, all of whom were 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 attend the Audit Committee.

The Committee has met on five occasions throughout the financial year and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation’s business.

<table>
<thead>
<tr>
<th>Audit Committee</th>
<th>Joe Barnes (Chair)</th>
<th>Lynn Hagger</th>
<th>David Hannah</th>
<th>Barry Mellor</th>
<th>Nicola Bancroft</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2019</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 April</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>22 May</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>11 September</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>11 December</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2020</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 March</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td><strong>Attendance</strong></td>
<td>5/5</td>
<td>5/5</td>
<td>4/4</td>
<td>3/3</td>
<td>1/1</td>
</tr>
</tbody>
</table>

From April 2019 to January 2020 Joe Barnes was Chair of the Audit Committee with Barry Mellor as Vice-Chair and Lynn Hagger and David Hannah as members. From February 2020 Joe Barnes continued as Chair, Nicola Bancroft joined the committee as Vice-Chair and Lynn Hagger continued as a member.

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\(^1\) Fourth edition, 2018
Principal Areas of Review
This annual report is divided into nine sections reflecting the nine key duties of the Committee as set out in the terms of reference (updated in November 2018).

1. Integrated governance, risk management and internal control
   • The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, External Audit opinion and other appropriate independent assurances and considers that the AGS is consistent with the Committee’s view of the Trust’s system of internal control. Accordingly, the Committee supported Board approval of the AGS for 2018/19 at its 22 May 2019 meeting
   • The Committee has reviewed the Board Assurance Framework (BAF) on a quarterly basis throughout the financial year
   • A quarterly review of the Trust’s risk register items scoring 15 and above has been undertaken by the Audit Committee
   • Progress updates relating to the Trust’s own review of risk management and resulting action plan have been received by the Committee in year
   • The operational effectiveness of policies and procedures was reviewed by the Committee throughout the year through the receipt of Internal Audit reports and oversight of the implementation of Internal Audit recommendations at each Committee meeting
   • The adequacy and effectiveness of the organisation’s financial control systems have been reviewed by the Committee throughout the year through the receipt of regular reports detailing breaches of Standing Financial Instructions (SFIs), single tender actions and losses and special payments; additionally the Committee reviewed the work of Internal Audit relating to the integrity of the general ledger and financial reporting as well as key financial systems and the work of External Audit relating to the financial statements
   • As reported in the Trust’s Annual Report for 2019/20 the following areas were the significant issues considered by the Audit Committee during 2019/20:
     o Annual Governance Statement 2018/19
     o Annual Report and Accounts 2018/19
     o Quality Account and Report 2018/19
     o Head of Internal Audit Opinion 2018/19
     o External Audit ISA 260 review 2018/19
     o Internal Audit (TIAA) annual work plan for 2019/20
     o Internal Audit (360 Assurance) annual work plan for remainder of 2019/20 as well as draft Internal Audit annual work plan for 2020/21
     o Counter Fraud self-review tool for 2019/20, draft annual work plan 2020/21 and risk assessment for 2020/21
     o Board Assurance Framework 2019/20
     o Trust’s Risk Register (scores of 15 and above)
     o Annual Review of Standards of Business Conduct
     o Annual Report of the Audit Committee 2018/19
     o Freedom to Speak up Guardian Annual Update 2018/19
     o Changes to Accounting Policies 2019/20

   Exceptional items considered were:
   ▪ External Audit 2018/19 de-brief
   ▪ Operational Plan 2018/19 objectives
   ▪ General Data Protection Regulations
   ▪ Internal Audit procurement process during 2019/20
   ▪ External Audit procurement during 2020
- Cyber security report
- Requirements of International Financial Reporting Standard (IFRS) 8 relating to operating segments
- Counter Fraud Service Engagement Meeting on 24 January 2020
- Governance Diagnostics

Review of:
- Internal Auditor effectiveness
- External Auditor effectiveness

The significant risks identified by the External Auditors (PwC) at the 2019/20 audit planning meeting on 13 March 2020 were:
- Risk of management override of controls
- Risk of fraud in income recognition
- Risk of fraud in expenditure recognition
- Financial sustainability
- Carrying value of property, plant and equipment

The Committee confirms that there are no outstanding areas of significant duplication or omission in the organisation’s systems of governance.

2. Internal Audit

From April until May 2019 the Committee worked with TIAA as its Internal Audit provider to strengthen the Trust’s internal control processes. From June 2019 onwards the Committee worked with 360 Assurance as its Internal Auditors reviewing and strengthening the organisation’s internal control processes.

In addition, in year the Committee also:
- Received and reviewed the Annual Report and Head of Internal Audit Opinion at the 22 May 2019 Audit Committee meeting
- Reviewed and approved the TIAA Audit Strategy and Annual Internal Audit plan at its 23 April 2019 meeting
- Received the revised Internal Audit plan from 360 Assurance at its 11 September 2019 meeting
- Considered the major findings of Internal Audit and sought assurance that management have responded in an appropriate manner and that the Head of Internal Audit Opinion and AGS reflect any major control weaknesses
- Met privately with the Internal Auditors prior to the 25 February 2020 Committee meeting
- Undertook the annual review of the effectiveness of the Internal Audit function in September 2019 and noted that since 360 Assurance had only been appointed from August 2019 it was too early to comment on their effectiveness but a positive start.

Through internal audits carried out throughout 2019/20, the final Head of Internal Audit opinion was:

*I am providing an opinion of moderate assurance that there is a generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation’s objectives at risk.*

In providing our opinion we consider three areas:
- Board Assurance Framework and strategic risk management
- Internal audit plan out-turn
Follow up of internal audit actions

Board Assurance Framework (BAF) and strategic risk management: moderate assurance. We raised some high risk actions in our Stage 1 review in November 2019; these were acted upon and progressed in quarter 4.

Internal audit plan outturn: limited assurance. We have issued a number of core reviews with a limited assurance opinion. Risk-based reviews have also led to a range of significant issues being raised.

Follow up of actions: significant assurance. The Trust has implemented 80% of actions in line with original timeframes.

This Opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated.

The table below details the assurance ratings assigned to internal audits completed during 2019/20:

<table>
<thead>
<tr>
<th>Review</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Quality Assurance (TIAA)</td>
<td>Reasonable Assurance*</td>
</tr>
<tr>
<td>Staff Engagement Review</td>
<td>Limited Assurance</td>
</tr>
<tr>
<td>Integrity of General Ledger and Financial Reporting</td>
<td>Significant Assurance</td>
</tr>
<tr>
<td>Compliance with the General Data Protection Regulation</td>
<td>Significant Assurance</td>
</tr>
<tr>
<td>Governance and Risk management</td>
<td>Limited Assurance</td>
</tr>
<tr>
<td>Key financial systems - payroll</td>
<td>Significant Assurance (indicative opinion)</td>
</tr>
<tr>
<td>Key financial systems – fixed assets</td>
<td>Limited Assurance</td>
</tr>
<tr>
<td>Data Security Standards</td>
<td>Significant Assurance</td>
</tr>
<tr>
<td>Divisional quality governance</td>
<td>Limited Assurance</td>
</tr>
<tr>
<td>Learning from deaths</td>
<td>In progress</td>
</tr>
</tbody>
</table>

* This is an assurance rating used by TIAA but not by 360 Assurance

3. External Audit

- During 2019/20 the Trust’s external audit provider, PwC LLP, did not provide any non-audit services whilst it was appointed as External Auditor.
- The Committee reviewed and commented on the reports prepared by External Audit as part of their year-end audit for 2018/19 at the May 2019 Committee meeting and on the 2018/19 audit de-brief document presented at the September 2019 meeting.
- The annual review of the effectiveness of the External Audit function was undertaken in September 2019.
- At the Audit Committee meeting on 11 September 2019 it was agreed to recommend to the Council of Governors to tender the External Audit service as the contract extension.
would conclude in September 2020. The Council of Governors agreed to this recommendation at their meeting in October 2019. The re-procurement of the External Audit service was further discussed at the February 2020 meeting as a change in approach was required due to a significant reduction in the number of organisations on the procurement framework that were in a position to submit a bid for the contract when tendered by the Trust. The Committee therefore approved the proposal to proceed with a shortened procurement process.

- Audit Committee members met privately with the External Auditors before the 22 May 2019 Committee meeting
- The Audit Plan for 2019/20 including PwC’s assessment of audit risks was not received until late in the audit process and was therefore presented to the May 2020 Audit Committee meeting at which point it was approved.

4. Other Assurance Functions
- The Committee reviewed the Board Assurance Framework (BAF) on a quarterly basis throughout the financial year. In December 2019 360 Assurance provided the Audit Committee with their Head of Internal Audit Stage 1 memo which made six recommendations for improvements to the BAF. At the February 2020 Audit Committee meeting the Head of Internal Audit Stage 2 memo concluded that two of these recommendations had been implemented and that the remaining recommendations were in progress. Two additional recommendations were completed at the same Audit Committee meeting and the remaining 2 recommendations were scheduled for completion during Q1/Q2 2020/21.
- The Annual Standards of Business Conduct Report was reviewed by the Committee in September 2019 and approved for publication
- The Standards of Business Conduct were revised and shortened and in May 2019 the Audit Committee recommended their submission to the Board of Directors for approval. The Board of Directors approved the Standards of Business Conduct at its 28 May 2019 meeting following which the Standards were disseminated across the organisation.
- The Committee received a report on Cyber Security at its February 2020 meeting which provided assurance relating to the continuing actions taken to mitigate against organisational cybersecurity risks

5. Financial Reporting
- The Committee reviewed the systems for financial reporting, including budgetary control, throughout the year through the receipt of regular reports detailing losses and special payments and single tender actions
- In addition, reports relating to breaches of the Standing Financial Instructions (SFIs) were presented to the Committee by the Director of Finance on 23 April and 11 September 2019 and a verbal update was provided to the 25 February 2020 meeting.
- The work of Internal Audit relating to financial control systems also provided independent assurance to the Audit Committee relating to the organisation’s financial reporting systems during 2019/20
- At its February 2020 meeting the Committee considered the Trust’s Accounting Policies and Accounting Guidance for 2019/20. At this meeting the proposed changes to the organisation’s Accounting Policies were recommended by the Committee for approval by the Board of Directors. In addition, the Committee also considered the requirements of International Financial Reporting Standard (IFRS) 8 relating to operating segments
- The 22 May 2019 Audit Committee meeting focussed on the Trust’s Annual Report and Accounts for 2018/19 including the receipt of:
  - The Annual Report including the:
    - Annual Governance Statement; and
Quality Report
Other disclosure statements relevant to the Committee’s Terms of Reference
- Annual Financial Statements
- Reports from the External Auditors (PwC):
  - Financial statements representation letter
  - International Standard on Auditing (ISA) 260
  - Quality Report Representation Letter
  - Review of Quality Report
- Reports from the Internal Auditors:
  - Head of Internal Audit Opinion
- The Audit Committee assured itself that all the documents supporting the Annual Report and Accounts and the Annual Report and Annual Financial Statements themselves represented a true, fair and accurate representation of the Trust’s position at the end of the 2018/19 financial year

6. Counter Fraud
- The Audit Committee noted the Counter Fraud progress report and self-review tool at its 23 April 2019 meeting
- Quarterly Counter Fraud progress reports were received during the year
- The report from the Counter Fraud Authority’s Engagement Meeting with the Trust on 24 January 2020 was received at the February 2020 Committee meeting including the action plan from the meeting
- The draft Counter Fraud work plan for 2020/21 was received and noted at the February 2020 committee meeting

7. Annual Report
- The Trust’s Annual Report for 2018/19 contained a report from the Audit Committee relating to the manner in which it had discharged its responsibilities during the year
- This report from the Audit Committee contained all the elements required of such a report as detailed in NHS Improvement’s NHS Foundation Trust Annual Reporting Manual 2018/19 as confirmed by the External Auditors during their annual audit for 2018/19

8. Whistleblowing Policies
The annual report from the Trust’s Freedom to Speak Up Guardian was received at the 23 April 2019 Audit Committee meeting.

9. Other matters
- The Committee reviewed the appropriateness of single tender actions which had been approved by the Executive
- The Audit Committee also gave due consideration to laws and regulations, and the provisions of the NHS Foundation Trust Code of Governance in discharging its role
- Committee members received the development and training that they needed to fulfil their role on the Committee during the year

Other matters worthy of note
The Committee has reviewed the process and controls the Trust has in place to achieve its financial obligations throughout the year.

The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process has also included calling managers to account when considered necessary to obtain relevant assurance. The
Committee also works closely with the Chief Executive, Director of Finance and Company Secretary to ensure that the assurance mechanism within the Trust is fully effective and that a robust process is in place to ensure that actions falling out of external reviews are implemented and monitored by the Committee.

**Cost/benefit analysis**

It is not possible to accurately quantify the benefits of the work of the Committee during the year, as it is impossible to determine the financial impact of risks mitigated and costs avoided and the proportion of these that could be apportioned to the Committee’s work.

The current and future costs associated with loss of reputation have also been mitigated as a result of the work performed by the Committee.

**Conclusion**

The Committee is of the opinion that this annual report is consistent with the Annual Governance Statement, Head of Internal Audit Opinion and the external audit ISA 260 review and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Report prepared by Lisa Reid, Head of Governance

On behalf of Joe Barnes, Chair, Audit Committee
June 2020
## Board of Directors’ Meeting
### 2 June 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>197/20</th>
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</thead>
<tbody>
<tr>
<td>Report</td>
<td>Annual Board of Directors’ Self Certifications</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Anna Milanec, Director of Corporate Affairs (non-voting) / Company Secretary</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B6 and B7</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision [ ] To note [✓] Approval [✓] For information [ ]</td>
</tr>
</tbody>
</table>

### Executive Summary (including reason for the report, background, key issues and risks)

The Board of Directors is required to annually approve and publish a self-certification in respect of:

- The Trust’s systems for compliance with provider licence conditions and related obligations (G06);
- Corporate Governance arrangements (FT4): and
- Training of Governors.

This report provides the evidence for the proposed certifications and details of risks where compliance is not confirmed (which need to appear on the Certification document, which will be published on the Trust’s website).

### Recommendations

The Board is asked **to note** the evidence provided in appendix 2 against the required compliance statements;

The Board is asked **to approve** the compliance statements provided in appendix 3, and **to approve** that delegated authority for the compliance statements to be signed by the Chairman and Chief Executive on behalf of the Board, and to be placed onto the Trust website.

### Appendices

- Appendix 1: Condition G6 – Systems for compliance with licence conditions and related obligations.
- Appendix 2: Evidence Schedule
- Appendix 3: Board of Directors’ Certifications
1.0 Introduction

1.1 This paper explains the process and requirements for self-certification of the annual compliance certifications by the Board of Directors, by stipulated deadlines.

1.2 NHS foundation trusts are required to annually self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), and have complied with governance requirements.

2.0 Certification G6 – Systems for compliance with licence conditions and related obligations

2.1 After reviewing whether processes and systems were implemented in the previous financial year and whether they were effective, NHS providers must complete a G6 self-certification annually and publish this on the Trust’s website by 30 June 2020\(^1\).

2.2 An extract from the Trust’s Licence is provided at Appendix 1 outlining the requirements of Licence Condition G6.

3.0 Certification 4 - Corporate Governance Statement

3.1 After reviewing whether the Trust has complied with the requirements of the NHS Foundation Trust Code of Governance during the previous financial year, NHS providers must complete a Corporate Governance Statement annually by 30 June and publish this on their website by 30 June\(^2\).

4.0 Certification – Governors’ Training

4.1 After reviewing whether the Trust has complied with the requirements of section 151(5) of the Health and Social Care Act 2012, Foundation Trusts must certify that they have provided the necessary training to their governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role.

4.2 This statement must be published annually on the Trust’s website by 30\(^{th}\) June\(^3\).

5.0 Annual Audit Process

5.1 The documentation takes into account the outcome of the Trust’s annual audit process of the 2019/20 financial year, and provides appropriate input regarding any potential risks identified by the external auditors.

5.2 The draft documentation was reviewed by the Audit Committee on 20 May 2020. It was subsequently updated with the final Head of Internal Audit Opinion and the External Auditors’ Audit Opinion on the Annual Report and financial statements 2019/20 and was presented to the Audit Committee on 01 June 2020 for recommendation to the Board of Directors to approve.

Anna Milanec,
Director of Corporate Affairs / Company Secretary

\(^1\) Previously, the certification was submitted to Monitor / NHSI – as reflected in the original wording of the Licence, as at Annex 1.

\(^2\) Ditto

\(^3\) Ditto
Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
   (a) the Conditions of this Licence,
   (b) any requirements imposed on it under the NHS Acts, and
   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.
Red text indicates wording of Certifications that the Board must provide for G6, FT4, and Governors’ Training

<table>
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<td>G06</td>
<td>Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts, and have had regard to the NHS Constitution</td>
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| FT4(2)| The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.                                                                 | - Lifting of Enforcement Undertakings in January 2015 relating to Board Governance;  
- In December 2019 the Trust became the first in England to attain ‘The Governance Framework’ accreditation from The Chartered Governance Institute;  
- Annual Governance Statement as part of the Annual Report and audited accounts 2019/20;  
- Accountability section of the Annual Report and audited accounts 2019/20;  
- 2019/20 External Auditors’ ISA 260 2019/20 issued unqualified audit opinion on the financial statements | Outstanding (strategic financial planning based) enforcement undertakings in place, leading to mandated support from NHSI, and segmentation 3. |
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<td>• Internal Audit – final Head of Internal Audit Opinion 2019/20: ‘moderate assurance’;</td>
<td>• During 2019/20 the role and functions of the Clinical Governance Committee and its sub-groups and their interface with the governance arrangements in the clinical Divisions has been the subject of a further</td>
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<tr>
<td></td>
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<td>• Internal Audit Plan – new Internal Auditors appointed during 2019/20 providing a ‘fresh pair of eye’ including a review of governance and risk management;</td>
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<td></td>
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<td>• Quarterly presentation of BAF at Board and Board Committees strengthened by recommendation from Internal Auditors that the full BAF should be received by both the Board of directors and the Audit Committee implemented for Q3 2019/20;</td>
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<td>• The Trust submitted a ‘Standards Met’ against the Data Security &amp; Protection Toolkit (DSPTK) 2019/20 on 31 March 2020 as agreed by the Board of Directors; Internal Auditors undertook DSPTK audit in March 2020 and gave ‘significant assurance’ rating;</td>
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<td>• Standards of Business Conduct reviewed on annual basis and annual report presented to Audit Committee. Once approved Annual Report is published on the Trust’s internet site;</td>
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<td>• NHS England’s Conflicts of Interest Guidance followed with information being published on the Trust website by the prescribed deadlines</td>
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<td>• Maintenance of the number of Standards of Business Conduct declarations made during 2019/20;</td>
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<td>• Significant increase in the number of declarations of interest made in 2019/20;</td>
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<td>• Mandatory and Statutory Training compliance monitored by the Board;</td>
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<td>• Appraisal compliance monitored by the Board;</td>
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<td>• Revalidation of doctors’ process monitored by the Board;</td>
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<td>• During 2019/20 the role and functions of the Clinical Governance Committee and its sub-groups and their interface with the governance arrangements in the clinical Divisions has been the subject of a further</td>
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<td>external review and the changes recommended by this review implemented.</td>
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<td>• Policy and Procedure for Supporting Staff to Raise Concerns at Work (Including Whistleblowing) in place and aligns to revised national Whistleblowing policy;</td>
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<td></td>
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<td>• Freedom to Speak Up Guardians in place;</td>
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<td>• New Lead Freedom to speak Up Guardian appointed during 2019/20 and increase in dedicated time for him to undertake the role. Quarterly and annual FTSU reports to Board of Directors and quarterly reports to Audit Committee;</td>
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<td>• Risk Management Strategy 2019-2024 and Risk Management Guidance approved by the Board in June 2019</td>
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<td>• Risk Management training continues for all staff at Bands 8A and above, and Board Members</td>
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<td>• Assurance walkabouts in place for Directors and Governors;</td>
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<td>• Adherence to Fit and Proper Persons requirements for Directors and Governors;</td>
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<td>• Formal confirmation of Level 2 of the standards of procurement in May 2018 (accreditation is valid for 3 years)</td>
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<td></td>
<td>• The Trust submitted a ‘Standards Met ’ against the Data Security &amp; Protection Toolkit 2019/20 on 31 March 2020 as agreed by the Board of Directors</td>
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<td>• External well-led review commissioned during 2018/19 from TGF and RSM. Recommendations fully implemented during 2019/20</td>
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<td>• CQC unannounced inspection in August 2019 to UECC resulted in improved rating of ‘Requires Improvement’ with a rating of ‘Good’ for Caring</td>
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</table>
| FT4(3) | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | As per 1. Above. In addition, the following guidance issued by Monitor / NHS Improvement / England has been considered / is followed by the Trust:  
• NHS Oversight Framework for 2019/20  
• Use of resources assessment framework  
• NHS Foundation Trust Code of Governance  
• NHS England / Improvement Weekly bulletin for NHS leaders  
• NHS Foundation Trust Governors: representing the interests of members and the public  
• NHS Foundation Trusts Audit Code  
• Annual Reporting Manual 2019/20  
• Department of Health Group Accounting Manual 2019/20  
• NHS foundation trusts: financial accounting guidance 2019/20  
• Approved Costing Guidance 2019/20  
• Guidance on pay for very senior managers in NHS trusts and foundation trusts (March 2018)  
• Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (June 2017)  
• Learning from developmental reviews of leadership and governance using the well-led framework (November 2018)  
• Getting the most from developmental and well-led reviews: commissioning external suppliers and working with peers (September 2017)  
• Use of Resources: assessment framework (August 2017)  
• Revised Never Events Policy and Framework (January 2018)  
• Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions (November 2017) | The Trust has in place, qualified compliance personnel, and a substantive Company Secretary (Chartered), who act in an advisory capacity to the Board with regard to corporate governance. |
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|        | • Special Measures for quality reasons: guidance for trusts (December 2017 in conjunction with CQC) | • Special Measures for financial reasons: guidance for trusts (March 2018)  
• Updated Fit and Proper Persons Regulations (CQC) with guidance from NHSI (January 2018)  
• Use of Resources assessment: a brief guide for acute non-specialist trusts (February 2018)  
• NHS Premises Assurance Model (February 2020)  
• National Patient Safety Alerts and the role of the National Patient Safety Alerting Committee (January 2019)  
• Guidance for trusts on agency use during COVID-19 pandemic (March 2020)  
• A remuneration structure for NHS provider chairs and Non-Executive Directors (November 2019)  
• A framework for conducting annual appraisals for NHS provider chairs (November 2019)  
• The NHS provider chair competency framework (November 2019)  
• The role of the NHS provider Chair – a framework for development (November 2019)  
• Freedom to Speak Up: guidance for NHS foundation trust boards (July 2019) | |
| FT4(4) | (a) Effective board and committee structures; | The Trust now has the following board committees in place in line with best practice in an acute FT:  
• Remuneration Committee  
• Nominations Committee (Execs)  
• Audit Committee  
• Quality Assurance Committee. (Quality Committee from 1 April 2020) | |
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<td></td>
<td>• Finance &amp; Performance Committee</td>
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<td>• Strategic Business and Planning Committee (ceased from 31 March 2020)</td>
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<td>• People Committee (from 1 April 2020)</td>
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<td>• Nominations Committee (Governors - NEDs)</td>
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<td>• Escalations from Committees to Board are standing part of the agendas</td>
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<td>• All Board committees have Terms of Reference which undergo annual review</td>
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<td></td>
<td>• Externally facilitated Board Development programme in place</td>
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<td>• Annual cycle of Board Business presented and agreed at every monthly Board meeting</td>
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<td>• Annual work plans in place for all Board Committees, which are presented and agreed at every monthly committee meeting</td>
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<tr>
<td>FT4(4)</td>
<td>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees, and</td>
<td>All Board committees, Trust Management Committee (ceased February 2020), and those reporting to the Trust Management Committee have Terms of Reference in place.</td>
<td>Work to be undertaken with regard to legacy committees which used to report to the Trust Management Committee to ensure appropriate escalation processes in place.</td>
</tr>
<tr>
<td></td>
<td>Codes of Conduct are in place for both Board members and Governors.</td>
<td>Codes of Conduct are in place for both Board members and Governors.</td>
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<td></td>
<td>Standards of Business Conduct policy revised in May 2019</td>
<td>Standards of Business Conduct policy revised in May 2019</td>
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<td></td>
<td>NHS England’s Conflicts of Interest Guidance implemented with effect from 1 June 2017</td>
<td>NHS England’s Conflicts of Interest Guidance implemented with effect from 1 June 2017</td>
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<td></td>
<td>Clear role descriptions for both Executive and Non-Executive Directors are in place as well as specific job descriptions</td>
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<td></td>
</tr>
<tr>
<td>FT4(4)</td>
<td>(c) Clear reporting lines and accountabilities throughout its organisation.</td>
<td>The Trust’s governance arrangements include Terms of Reference for all Board Committees, Senior Management Team (TMC), and standing committees reporting to the Committees established within the Trust’s governance structure.</td>
<td>Externally facilitated well-led review noted that greater clarity was required in relation to roles between Executives and Divisions. Following the establishment of a Task and</td>
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</table>
| FT4(5) | To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively; | • The Terms of Reference for committees include purpose, membership, duties, and reporting arrangements.  
• Board member appraisals (PDRs) and personal development plans in place  
• Staff within the organisation have a clear understanding of their annual objectives and expected behaviours (reflecting the Trust’s values)  
• The Audit Committee reviews the Annual Governance Statement. | Finish Group, work was completed during 2019/20 in this regard. |
| FT4(5) | External Auditors’ ISA 260 2019/20 issued unqualified audit opinion on the financial statements  
• Internal Audit annual work plan – agreed with Audit Committee after reference to the Executive Directors  
• Final Head of Internal Audit Opinion 2019/20: ‘moderate assurance’  
• Audit Committee annual work plan  
• Finance and Performance Committee annual work plan  
• Clinical Audit annual work plan  
• Integrated Performance Report – monthly tracking of performance / remedial actions  
• Monthly finance report presented to Board of Directors  
• Trust’s ‘going concern’ review  
• Board Assurance Framework (BAF) key risk monitoring by Board and Committees  
• Annual Plan strategic planning / scrutiny  
• Annual budget setting arrangements.  
• New monthly financial oversight groups (1 per Division) introduced during 2018/19 continued during 2019/20 (Also see 4d below). | 2019/20 External Audit ISA 260 issued a modified value for money ‘adverse’ conclusion due to:  
- continuing licence conditions re finances  
- financial performance during the year showing a deficit position prior to additional funding from the ICS and  
- no update to the CQC inspection results which have an overall “requires improvement” rating.  
Material uncertainty also raised in relation to going concern |
| FT4(5) | For timely and effective scrutiny and oversight by the Board  
The Performance Management Framework provides for: | CQC Inspection 2018 result of ‘requires improvement’.  
CQC unannounced inspection in August 2019 to UECC resulted in improved rating of ‘Requires Improvement’ |
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<td>Board of the Licensee’s operations;</td>
<td>• Monthly divisional performance meeting with the executive team. (Evidenced by action logs.)</td>
<td>CQC Re-inspection September 2018 – rating of ‘Requires Improvement’ for Well-led domain and retention of overall rating of ‘Requires Improvement’ + 3 requirement notices</td>
</tr>
<tr>
<td>FT4(5)</td>
<td>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;</td>
<td>• Quality Improvement Strategy 2019 – 2024 and 9 Quality Priorities in place during 2019/20 approved by Board of Directors in March 2019</td>
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<td>• Safe and Sound Framework launched in April 2019 (Trust’s quality governance framework supports delivery of Quality Improvement Strategy 2019 – 2024)</td>
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<td>• Trust’s Quality Improvement Plan approved by Board of Directors in March 2019 delivers the quality aspects of the Operational Plan and includes implementation of the Safe &amp; Sound Framework along with delivery of 9 Quality Priorities and an improved UECC CQC rating.</td>
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<td>• Quality Accounts produced annually</td>
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<td>• Quarterly and Annual Responsible Officer, Guardian of Safe Working and Freedom to Speak up Guardian reports to Board of Directors</td>
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<td>• Issues in each area are escalated as appropriate to the regular Divisional Performance meetings.</td>
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<td>• Risk Registers and BAF updated</td>
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<td>• Quality reports, including complaints, incidents, etc.</td>
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<td>• Nursing and Doctor revalidation</td>
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<td>• Results of all external agency visits, inspections and accreditations (e.g. PLACE inspections) reported to both Clinical Governance Committee and Quality Assurance Committee with appropriate oversight agreed to ensure implementation of recommendations from external agencies</td>
<td>Outstanding financial planning enforcement undertakings given to NHS Improvement (Monitor), with section 111 in place. However, at the time of writing this report, ongoing independent review is being undertaken with regard to the processes used to monitor financial management during Q4 2019/20 due to the worsening financial position and outturn.</td>
</tr>
<tr>
<td>FT4(5)</td>
<td>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern);</td>
<td>• SFIs, scheme of delegation in place  • Mandatory training for all budget holders  • Monthly budget statements and corporate financial reports issued to all budget holders  • Allocated (financial) business managers allocated to divisions  • Internal audit programme and specific fiancé-related audits  • Monthly activity and performance reports to complement financial information  • Reporting of SFI waivers, SFI breaches and losses and compensations to the Audit Committee  • External audit of the accounts and testing of systems  • Finance &amp; Performance Committee scrutiny of financial performance and related issues.  • SLM was further rolled out and a maturity assessment undertaken during 2019/20  • Performance management arrangements are in place to hold divisions to account for delivery of service and financial performance.  • Personal accountability of budget holders reinforced through training and objectives/appraisal  • Monthly / regular reporting directly to NHS Improvement</td>
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<tr>
<td>FT4(5)</td>
<td>(e) To obtain and disseminate accurate, comprehensive,</td>
<td>• All KPIs are aligned to the Performance Framework and have been agreed by Board of Directors</td>
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236
<table>
<thead>
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<td></td>
<td>timely and up to date information for Board and Committee decision-making;</td>
<td>• Reports are provided in a timely manner to ensure that relevant parties have the opportunity to comment or query any potentially spurious figures.</td>
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<td>• Financial reporting is timetabled on a monthly basis with a view to reporting within 10 working days of month end.</td>
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<td>• The Trust operates an integrated finance and procurement system containing source data for supplier expenditure, invoiced income, cash receipts as well as fixed assets for capital charges. Other information is interfaced from other systems, e.g. SLAM, Payroll, Pharmacy, Orthotics and Logistics on line to give a comprehensive view of income and expenditure before estimates are added.</td>
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<td>• There is a comprehensive reconciliation of all balance sheet codes to ensure no transactions have been miscoded.</td>
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<td>• Finally, there is a comprehensive review process of out-turn performance involving all the accountants and the Director of Finance, before finalising reported information to the Trust.</td>
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<td>• Data quality assurance kite mark approved by Board of Directors in February 2016 (assurance reviewed annually).</td>
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<td>• Data quality assessment of each data item within Board IPR completed during Q1 and Q4 2019/20</td>
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<td>FT4(5)</td>
<td>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;</td>
<td>• The use of a Board Assurance Framework detects risk to accomplishment of strategic objectives and allows for early detection and mitigation.</td>
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<td>• Quarterly risk management report to Board of Directors and Board Committees</td>
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<td>• Executive Team Meeting with wider stakeholder input than previous Executive Team Meeting. Started Feb-20</td>
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<td>• Risk Management Strategy 2019-2024 and Risk Management Guidance approved by the Board in June 2019</td>
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| FT4(5)| (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and | • Annual process in place to develop business plans and secure board approval before the start of each financial year and before submission to NHS Improvement  
• Processes in place to review business plans via corporate committees, Board.  
• Strategic plans approved by Board of Directors.  
• Feedback from NHS Improvement considered by the Board.  
• Review of processes included in internal audit plan.  
• Revised template for Business Cases introduced in December 2015 and process reiterated in March 2017, March and April 2019.  
• Business Case Appraisal Group introduced in March 2019 to ensure business cases presented for approval to Business Investment Committee are robust |                             |
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| FT4(5) | (h) To ensure compliance with all applicable legal requirements. | • Audit Committee, duties include responsibilities for independently monitoring, reviewing and reporting to the Board of Directors on the process of governance and, where appropriate, facilitates and supports through its independence the attainment of effective processes.  
• Remuneration Committee, duties include ensuring compliance with NHS Improvement’s Code of Governance relating to executive pay.  
• Quality Assurance Committee, duties include assurance on the effective management of risk, safety, quality and performance across the Trust.  
• Strategy & Business Planning Committee (now ceased), remit included ensuring effective arrangements are in place with regard to workforce issues, strategy, transformation and business planning. This committee ceased from 31 March 2020 and oversight of strategic, transformation and business planning matters reverted to the Board of Directors  
• Finance and Performance Committee, duties include oversight of financial functions and financial governance.  
• The Board of Directors receive and review specific reports and updates on performance and assurance, clinical, quality and patient issues, strategy, staff issues and regulatory / legal issues and these reports highlight risks to non-compliance to standards  
• The Board of Directors receive and review minutes and papers from the Board Committees and the Council of Governors, and has issues escalated from both Trust and Governor meetings. This enables the Board of Directors to assess, understand and identify lessons learnt, addressing any current or future risks to quality and non-compliance with legal requirements.  
• Constitutional review and updated governance documentation  
• Qualified and experienced professionals in integral posts provide added assurance with regard to the legal framework, and risk management procedures provide further oversight as to legal compliance. | |

239
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| FT4(6) | (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; | • Self-declarations, meetings with NHS Improvement  
• PDR appraisals  
• RemCom and NomCom Board approved ToRs  
• Register of Interests  
• Standards of Business Conduct / NHSE Conflicts of Interest Guidance  
• Pre-employment checks / Fit and Proper Person criteria adhered to;  
• SID in place;  
• Clarity on the Board of Directors who is entitled to vote;  
• At least half of the Board of Directors (excluding Chairman) comprise independent NEDs;  
• Appointment of NEDs is staggered  
• Company Secretary in place to support  
• Majority of Executive Team is substantive (April 2020)  
• Board development programme in place and continuing on a quarterly basis  
• External Well-Led review during 2018/19, implementation of action plan completed during 2019/20  
• Externally facilitated well-led review concluded that: 'The Trust has a fully recruited, experienced Board and is strong in strategy, governance and business change leadership'.  
• 1:1 induction provided to new appointments during 2019/20 by the Company Secretary | Three members of the executive team left the organisation during 2019/20 (Chief Executive and two Deputy Chief Executives). Interim appointments to both posts made in February 2020.  
Two Non-Executive Directors reached the end of their terms of appointment during 2019/20 and two new Non-Executive Directors joined the Trust in October 2019 and January 2020 respectively preserving clinical expertise and enhancing financial / audit expertise. |
| FT4(6) | (b) That the Board’s planning and decision-making processes take timely and appropriate account of quality of care considerations; | • Approved Quality Improvement Strategy 2019 – 2024 and 9 Quality Priorities in place during 2019/20  
• Quality Accounts  
• Board Assurance Visits | |
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<td></td>
<td>• Patient stories at alternative Board of Directors meeting so that those who are not clinicians have awareness of issues</td>
<td>• Internal Auditor reports on data quality (August 2019 ‘Reasonable Assurance’)</td>
<td>CQC action plans</td>
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<td>• Five Divisional Directors attend Board of Directors meeting</td>
<td>• Externally facilitated well-led review found that: The Trust is sighted on quality, safety and performance and discussed at Divisional, Committee and Board meetings. The Quality and Safety Committee is focused on all aspects of quality and safety...it is clear oversight arrangements are robust. Information provided through the Balanced Scorecard, Quality Report and Finance Reports is robust and the minutes provide good evidence of challenge and interrogation of data.</td>
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<td>• QAC has powers delegated by, and reports to the Board.</td>
<td>• Integrated Performance Report was introduced at the Board of Directors meeting in May 2014.</td>
<td>Feb 2020 Data Quality report to Board: 7 of the 30 performance indicators have 3 or more criteria assessed as Amber or Red. However report states that all performance</td>
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<td>• QIAs are approved by the Chief Nurse / Medical Director.</td>
<td>• The Trust’s Internal Auditors undertake data quality reviews.</td>
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<td>• Board work plan has contributions from all Board members.</td>
<td>• Data Quality kite mark included against all indicators in the Board Integrated Performance Report indicating the extent to which the indicator meets the 6 criteria of good quality data (granularity,</td>
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<td>• Monthly IPR with quality indicators</td>
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<td>• Standalone quality reports and clinical reports presented to Board</td>
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<td>• Board and committee structure support quality of care considerations</td>
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<td>• Regular reports to Board of Directors on complaints, Serious Incidents, Inquests and Claims</td>
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<td>• Friends and Family test for users as well as for staff</td>
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<td>FT4(6)</td>
<td>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;</td>
<td>• FT4(6) (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;</td>
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<td>contemporaneousness, completeness, sign off, system data source and auditable process)</td>
<td>indicators have a least a ‘reasonable’ assurance rating.</td>
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<td>FT4(6)</td>
<td>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and</td>
<td>• The Trust actively engages Governors in seeking feedback on the quality of its services through PLACE assessments and Governors’ Surgeries&lt;br&gt;• Friends and Family test&lt;br&gt;• Quality Priority Showcases open to members of the public to help shape the quality improvement priorities each year&lt;br&gt;• Patient &amp; Public Involvement Strategy ratified during 2019/20&lt;br&gt;• New Engagement &amp; Inclusion Officer recruited in Q4 2019/20&lt;br&gt;• Quality Assurance Committee engages with directors to seek assurance on the quality of services.&lt;br&gt;• QAC is attended by two Governors&lt;br&gt;• Regular meetings with HealthWatch Rotherham, Rotherham Clinical Commissioning Group (RCCG), local Health &amp; Wellbeing Board and others.&lt;br&gt;• Patient Surveys&lt;br&gt;• Staff Surveys&lt;br&gt;• Externally facilitated well-led review found that: ‘Better communication and engagement are required as some staff felt they did not see enough outputs from engagement and the staff survey identified concerns around performance management and downward communication.’</td>
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<td>FT4(6)</td>
<td>(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving</td>
<td>• Clinical Governance Committee in place&lt;br&gt;• The Quality Committee reports to Board.&lt;br&gt;• Board of Directors’ approved ToRs (clear responsibilities)&lt;br&gt;• Clinical division structure supports accountability.&lt;br&gt;• Ward dashboards and nursing metrics</td>
<td>CQC inspections found inadequate leadership and escalation systems in urgent and emergency care services in September 2018. Immediate action taken to improve the position, with ongoing monitoring.</td>
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|     | quality issues including escalating them to the Board where appropriate. | • Performance meetings which include Clinical Risks / Risk Register, weekly Harm Free Care meetings (which are reported to executive directors).  
• Executive Team Meeting with wider stakeholder input than previous Executive Team Meeting. Started Feb-20  
• Executive job descriptions  
• Regular reports to Board of Directors on complaints, Serious Incidents, Inquests and Claims | At unannounced inspection of UECC in August 2019 CQC noted that ‘…there were changes in the leadership team and immediate action was taken to strengthen and improve management visibility, oversight of the unit and its performance’. The CQC ‘…were assured that the management team and the executive team including the board were fully sighted on the challenges faced by the department and had plans to address them.’  
August 2019 UECC CQC rating for well-led improved to ‘Requires Improvement’ |
| FT4(7) | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | • Pre-employment checks  
• PDR appraisal outcomes  
• Medical Revalidation and appraisal process  
• Nursing revalidation and appraisal process  
• Monthly Nurse Staffing review at Board of Directors  
• HR policies and procedures  
• Board Development Programme is in progress, and ongoing with external facilitation  
• Fit & Proper Person test for members of the Board of Directors and for Governors  
• In December 2019 the Trust became the first in England to attain ‘The Governance Framework’ accreditation from The Chartered Governance Institute | Impact of COVID-19 on staff absence |
## Governors’ Training

The Board is satisfied that during the financial year most recently ended, the Licensee has provided the necessary training to its governors, as required under section 151(5) of the Health and Social Care Act, to ensure that they are equipped with the skills and knowledge they need to undertake their role.

- NHS Providers provided a bespoke session to Governors in July 2019 on membership and engagement
- Operational Performance (September 2019)
- Induction session for new Governors and refresher for current (December 2019)
- Digital Strategy (December 2019)
- Quality and Safety (February 2020)
- Annual Business Planning Cycle (February 2020)
At its meeting on the 05 May 2020 the Board of Directors made the following declarations in relation to Provider Licence Conditions G06, FT4 and Training of Governors.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Statement</th>
<th>Declaration</th>
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<tbody>
<tr>
<td>G06</td>
<td>Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution, and the Licensee continues to meet the criteria for holding a licence.</td>
<td>Confirmed for 2019/20</td>
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<td>FT4(2)</td>
<td>The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.</td>
<td>Confirmed for 2019/20</td>
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<tr>
<td>FT4(3)</td>
<td>The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time</td>
<td>Confirmed for 2019/20</td>
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<td>FT4(4)</td>
<td>The Board is satisfied that the Trust implements: a) Effective board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees c) Clear reporting lines and accountabilities throughout its organisation</td>
<td>a), b) and c) confirmed for 2019/20</td>
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The Board is satisfied that the Trust effectively implements systems and/or processes:

a) To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively  
b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations  
c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions  
d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern)  
e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making  
f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence  
g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery  
h) To ensure compliance with all applicable legal requirements  

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|  | a) Not confirmed for 2019/20  
  2019/20 External Audit ISA 260 issued a modified value for money ‘adverse’ conclusion due to:  
  - continuing licence conditions re finances  
  - financial performance during the year showing a deficit position prior to additional funding from the ICS and  
  - no update to the CQC inspection results which have an overall “requires improvement” rating.  
  Material uncertainty also raised in relation to going concern  
  
  b) confirmed for 2019/20  
  
  c) Not confirmed for 2019/20  
  CQC inspection result from Sept 2018 overall: ‘requires improvement’. UECC Aug 2020 CQC inspection improved overall service rating to: ‘requires improvement’. Action plans implemented to improve areas highlighted, with regular monitoring.  
  
  d) Unable to confirm for 2019/20 at the time of writing. Legacy, outstanding financial planning enforcement undertakings given to NHS Improvement (Monitor) have not yet been removed by regulator. At the time of writing this report, ongoing independent review is being undertaken with regard to the processes used to monitor financial management during Q4 2019/20 due to the worsening financial position and outturn.  

  e) Confirmed for 2019/20  
  
  f) Confirmed for 2019/20  
  
  g) Confirmed for 2019/20
| FT4(6) | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided
b) That the Board’s planning and decision-making processes take timely and appropriate account of quality of care considerations;
c) The collection of accurate, comprehensive, timely and up to date information on quality of care
d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care
e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources
f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate | h) Confirmed for 2019/20 |
| FT4(7) | The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the | Confirmed for 2019/20 |

a), b), c), d), e) confirmed for 2019/20
f) Confirmed for 2019/20
| Governor Training | The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. | Confirmed for 2019/20 |

Signed, for and on behalf of the Board of Directors.

Dr Richard Jenkins,  
Interim Chief Executive

Martin Havenhand,  
Chairman
# Board of Directors’ Meeting
2 June 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>198/20</th>
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<tbody>
<tr>
<td>Report</td>
<td>Learning from Deaths Report (Annual)</td>
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<tr>
<td>Executive Lead</td>
<td>Dr Callum Gardner, Executive Medical Director</td>
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<tr>
<td>Link with the BAF</td>
<td>B1; B2; B4</td>
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<th>Purpose</th>
<th>Decision ☐ To note ✓ Approval ☐ For information ☐</th>
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**Executive Summary**

This report forms the annual Learning from Deaths report for FY 2019/2020. It is an amalgamation of the quarterly reports published to the Board.

The Trust cleared 100% of the backlog of mortality reviews from FY18/19 and the quality of care was assessed. There were no cases where the reviewer felt that the care was well below what they would expect from the organisation and there were no cases where the clinicians felt the death was entirely preventable.

The Trust introduced the Medical Examiner service in FY19/20. This is an independent doctor working with colleagues to highlight areas where further scrutiny is required, to quickly alert the Serious Incident Panel if cases need escalating, to ensure appropriate referral to the Coroner, and to converse with families about the care given to their loved ones, in order to trigger further quality improvement work when families are concerned.

An external review body undertook a Learning from Deaths review and published the report with themes and trends highlighted for the Trust to use as quality improvement projects. Overall, the team did not highlight a significant number of deaths where care was poor, although there is work to do to move care from *adequate* to *excellent*, which is the ultimate goal of the mortality review process.

The mortality review policy has been amended in line with national guidance, and the Trust now uses a two-stage mortality review process. All Stage-1 reviews are now undertaken by the Medical Examiner; those that are flagged as requiring a more in-depth Structured Judgement Review (SJR), are then undertaken within the divisions.

The Trust’s Internal Auditors undertook a review of cases that had had a Stage-1 review, in order to quality assure the Medical Director that appropriate cases were being escalated. This came back with positive results and the full report will be shared through the Audit Committee, Clinical Governance Committee and the Quality Committee.
The mortality dashboard will be re-introduced in June 2020 and will provide a clear visual on the number of deaths and the number of reviews (by division), along with the timeframes in which such reviews were completed.

The Medical Director is in the process of trying to recruit 2 more Medical Examiners and additional MEOs, in order to strengthen the ME service and to enable a 7-day service.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>It is recommended that the Board note this report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendices</td>
<td>1. Mortality Review Pathway</td>
</tr>
<tr>
<td></td>
<td>2. Standard Operating Procedure for Mortality Reviews</td>
</tr>
<tr>
<td></td>
<td>3. Medical Examiner’s Flow Chart</td>
</tr>
</tbody>
</table>
1.0 Mortality Process

1.1 The Trust has worked extremely hard to improve the mortality review process for patients who have died in order to provide assurance over the quality of care they had received, as the previous Learning from Deaths annual report highlighted that mortality governance had stalled. All divisions currently have regular meetings where mortality is discussed and reviewed; these follow a standardised agenda throughout the divisions, but equally have the ability to discuss issues pertinent to the individual service. An example is haematology, where all issues following chemotherapy are discussed.

1.2 The Trust introduced the electronic two-stage review process. The first stage aims to highlight any issues with care, which then triggers a second more in depth multidisciplinary review (SJR) where quality of care is graded. This grade, along with comments, will be disseminated throughout the divisions for thematic analysis and improvement work and is due to be published on a monthly dashboard, which will be reintroduced in June.

2.0 Mortality Review Backlog

2.1 The Trust underwent a significant review of outstanding mortality cases from April 2018-March 2019, which involved the review of over 800 deaths. 100% of those deaths within the year were reviewed. There were areas where the Trust could improve, but there were no cases where the reviewer felt that care fell well below the standard they would expect from the organisation. There were also no cases where the clinician thought the death was entirely preventable.

2.2 The Trust’s Internal Auditors quality-assured the review process and gave assurance to the Medical Director that appropriate quality issues were identified and escalated.

3.0 Mortality Data and Actions from Alerts

3.1 The Trust successfully moved from CHKS to Dr Foster for the provision of the mortality data. This has proved very worthwhile, as the collaborative teams have worked well on reviewing why the HSMR was a national outlier.

The mortality data is being reported with the following headings (the 3 C’s), in order to maintain focus on each of these areas with a view to improving the hospital mortality performance:

1. Quality of Care
2. Case mix
3. Coding

3.2 The quality of care is assessed by the two-stage process and themes and trends following reviews are put into quality improvement projects, whereby the Clinical Effectiveness team can keep a log of the outcomes. The AMD for Clinical Effectiveness is working closely with the mortality teams. A newsletter is to be published whereby all the divisions can see the issues and the outcomes.

3.3 The Dr Foster team meets monthly with the Trust in order to identify trending alerts of diagnosis codes for further review and is a source of expertise to help identify areas that require particular focus in order to maximise effectiveness and quality improvement.
3.4 There has been extensive work with clinicians and coders to identify areas where documentation and clinical coding can be improved. Clinicians are now prompted to make a primary diagnosis as early as possible and have been asked to document “treated as”, instead of the previous entries which could not be coded for. The recording of “attending consultant” versus “responsible consultant” on Meditech will also aim to ensure the entire admission can be coded for in the mortality statistics.

3.5 Changes to local guidance within the Trust have allowed the coders greater flexibility when using risk stratification entries such as CURB65 when coding for severe pneumonia. This also applies to BMI and obesity documentation, and more recently COVID 19 and viral pneumonia.

3.6 The pneumonia alert continues to trend within the Trust and therefore work continues to address this. By appropriately (and documenting) identifying severe pneumonia and sepsis, this enables appropriate action in the care of the patient and also ensures that the patient’s expected death rate is in line with the severity of their illness. The re-launch of the Trust’s community-acquired pneumonia care bundle, along with consistent calculation and documentation of a patient’s CURB65 score, will help to further improvements around the care of patient with pneumonia.

3.7 Work has started with the discharge teams to enable identification of patients who were fit for discharge but remained in hospital and subsequently developed a “hospital-acquired pneumonia” or other hospital-acquired infection. The aim is clearly to ensure timely discharge to avoid infection and to enable appropriate reviews of such cases, with a view to identifying other areas for improvement in the quality of care.

3.8 The Safe & Sound Deteriorating Patient & Sepsis Group has representation from all divisions and sepsis training is widespread. The Trust has also introduced widespread use of the laboratory test “procalcitonin”; this enables clinicians to determine bacterial infections and to tailor the use of antibiotics for individual patients.

3.9 The Trust alerted with intestinal obstruction without hernia and, following an in-depth review of all of these cases, various improvements were identified but none of significant concern. Most of the patients had pseudo-obstruction, which does not require surgical intervention and is common towards end of life. It is worthy of note that this still has a trigger in the published mortality report. This is not because there continues to be a problem, but because until the number of deaths attributable to this falls below expected it will not fall off the radar. This is a perfect example of why mortality reviews from alerting diagnosis codes is vitally important, as this could be seen as being neglected as it continues to trigger.

3.10 It has become apparent from a detailed analysis of how the Trust code NELs, that 1/3 of NELs have been getting coded as “observations”, and therefore not counted (as they should be) in the HSMR data; as such, this has now been rectified from the 1st April 2020, and the modelling would suggest that this will significantly positively impact on the HSMR.

4.0 Medical Examiner’s Service

4.1 The Medical Examiner’s office has been functioning since April 2020. The service currently runs with a Lead ME and an MEO and has already been shown to reduce the number of inappropriate Coroner referrals, improve relationships with families, and highlight concerns immediately with the teams involved to avoid complaints. The ME has currently reviewed 80% of the deaths occurring in hospital and many community deaths for HM Coroner.
4.2 All learning disabilities cases are referred for an SJR. Furthermore, all deaths involving patients discharged from hospital and readmitted within 30 days are equally reviewed, with the aim to ensure appropriate admissions to hospital, in line with patient wishes, and to enable a review of their previous discharge to ensure that the treatment and decision to discharge was appropriate.

4.3 There is a closer working relationship with HM Coroner/Officers and the Trust, whereby the Medical Director has greater oversight of referred cases and reasons. The Serious Incident Panel reviews all cases where there has been a Coroner’s referral and surrounding investigations are timely to enable the legal team to prepare comprehensively.

4.4 Weekly percentages of cases referred for a full SJR are reported via the weekly Harm Free meeting. The average rate of SJR requirements is 20%, which is in line with previous forecast and the national picture. The outcomes of these reviews are discussed divisionally with escalation to the Trust Mortality group. All cases where in which significant quality of care issues were identified are reviewed in the Serious Incident Panel. These cases can be highlighted by the Medical Examiner following initial review and ensures that learning can be quickly disseminated if necessary. Changes to Datix are currently in train in order to make this process easier and electronic, thus in turn enabling data capture and monitoring of referrals.

4.5 The service will be expanding with further 2 MEs and MEO cover in the near future, with the intention of facilitating a 7-day service.

5.0 Learnings from Reviews

5.1 There are various sources of learning from the deaths currently within the Trust, and triangulation of all of these will be widely reported in the coming months. Themes from divisional mortality reviews, themes from mortality alerts reviews, themes from SI and red incidents reports involving patients who died, themes from patients with learning disabilities who died, and also themes arising from inquests, are being triangulated so that improvement projects can have the biggest impact; such triangulation is also forming on of this Financial Years’ Quality Priorities.

5.2 The Trust welcomed an external review team, arranged and facilitated by the Medical Director with the support of NHS Improvement, in order to help identify and advise on the Learning from Deaths agenda. With their support, we organised an externally facilitated mortality review of 102 patients who died with a respiratory diagnosis and 48 who died within 30-days of discharge and who had a diagnosis of CCF; these diagnostic groups were chosen as the Trust has been alerting on these two ICD codes. The report was presented to Trust colleagues as part of the Grand Round. This was followed by attendance at the Clinical Effectiveness meetings where each division had the opportunity to network with the review team. The report was also published in full to the Quality Assurance Committee and the Board.

5.3 The themes and trends that were identified in the report related to documentation, nutrition, fluid balance and end of life care. These themes have been picked up by the various teams to improve. It is worthy of note that once the palliative care team were involved, then there was excellent care delivered with dignity and compassion. Work to avoid readmission starts with identification of cases where a “failed discharge” could have been foreseen.

253
5.4 The Trust’s first Learning from Deaths Nurse Band 7 has now started within the organisation. She currently sits within the Medical Examiner’s service, in order to have an overview of the extensive agenda, but is working closely with the legal department and the Clinical Effectiveness team and will be coordinating the standardised mortality meetings and the outputs from these. Her expertise will be invaluable at driving forward the themes from reviews, such as end of life care.

5.5 Some of the case reviews have highlighted unexpected admissions to critical care and this is subject to continuous scrutiny by the critical care team and outreach. These cases are also reported to the weekly Harm Free meetings in the Trust, chaired by the Medical Director. The learning from these reviews and the mortality from intensive care patients is discussed in monthly governance meetings and significant issues highlighted to individual divisions following the peer reviews.

5.6 There has been widespread learning from some incidents involving intensive care patients within the division of surgery and the Trust, for example on the identification of misplaced feeding tubes. A quality improvement project involving Diagnostic Imaging, Practice Development, and Endoscopy teams, chaired by the Medical Director, has taken place to ensure that serious incidents and/or Never Events such as these don’t recur. It is now mandatory for the radiology team to report the placement of NG tubes prior to their use.

5.7 Electronic observations using the NEWS2 criteria have been successfully introduced, ensuring that appropriate admissions trigger a senior review in a timely manner. The “code red” system of alerting a deteriorating patient is used. The Safe & Sound Deteriorating Patient & Sepsis Group meets monthly to drive this work.

5.8 Electronic prescribing has been successfully introduced across the Trust. This has seen a reduction in medication errors and a reduction in the omission of critical medicines.

5.9 Since January 2019, a new system has been in place whereby any maternity incident that meets the criteria of “Each Baby Counts” will be investigated externally by the Healthcare Safety Investigation Branch (HSIB). The sad maternal death within the Trust was extensively investigated both internally and externally and the Trust had no significant issues related to its care of this patient.

5.10 The SJR rolling teaching sessions are to commence in July 2020 with the ME and the Learning from Deaths nurse coordinating, the roll-out of these having been delayed due to COVID-19.

6.0 Summary

6.1 The concept of reviewing deaths is embedded within the Trust, and the Learning from Deaths agenda is strengthening with the introduction of the Learning from Deaths nurse and the Medical Examiner service.

6.2 Triangulation of all the opportunities of learning from various sources will enable maximum effectiveness and dissemination of the themes and trends, such that improvements in quality of care, case mix and coding continue to take place.

Dr Carrie Kelly  
Medical Examiner  
May 2020
Learning from Deaths – scrutiny of deaths of patients in our care

1. All deaths reviewed by the Medical Examiner (ME)
   - Review of the death certificate
   - First stage mortality review undertaken by the ME within 1 month of death

Families and Carers are able to access support from the Medical Examiner’s Office. The Medical Examiner, or the Medical Examiner Officer is available to meet with the family, offer condolences and support where needed.

Family and carers are invited to ask questions about the death of their loved one.

2. Full Structured Judgement Review (SJR)
   - This will be undertaken by a trained professional within 2 months (within the divisions), undertaking a full case record review of the quality and safety of the care provided prior to the patient’s death, addressing any questions raised by the family or the Medical Examiner.
   - This will occur for all deaths of people with a learning disability, serious mental illness or Dr Foster alerts.

Serious Incident (SI) Panel
   - Escalation of the death to the SI Panel, where there are concerns with regards to serious harm due to actions or omissions occurring
   - Duty of Candour – Family to be informed in line with statutory requirements of Duty of Candour
   - SI completed within 12 weeks from declaration of SI

Case presentation to divisional Mortality and Morbidity meeting (M&M)
   - All full SJR’s will be presented to the M&M meetings within the division by the identified reviewer within 8 weeks of the death occurring
   - Presentation of a monthly report, detailing all deaths and the outcome from the initial mortality review and full SJR’s (Scoring and Judgements)

Outcome
   - Duty of Candour where moderate harm and above to be undertaken
   - Confirmation of scoring, judgements, if harm has occurred and agreement of any ‘problems in care’ for reporting to the trust-wide mortality group and within the quarterly board report

Feedback to Trust wide Mortality group
   - Monthly report detailing the outcome from the initial mortality review and full SJR’s
   - Monthly report to provide a breakdown of all scoring of the SJR’s and the themes from the judgements made for all divisions

Clinical Governance/Quality Committee
   - Presentation of Mortality report, detailing outcome of all deaths and resultant scoring and judgements from both the initial mortality review and full SJR’s from all the divisions.

Trust board
   - Presentation of quarterly report to public board, detailing outcome of all deaths and resultant scoring, judgements, deaths due to a ‘problem in care’ and learning to date

Author: Allyson Kent (May 2020)
Appendix 2 – Standard Operating Procedure – Mortality Reviews

Introduction
To standardise the process for undertaking Mortality Reviews; by reviewing the case records of adults who die within The Rotherham NHS Foundation Trust (TRFT), using the Structured Judgement Review (SJR) methodology.

Purpose
To define the two-stage Structured Judgement Review (SJR), that will ensure that all deaths are reviewed in a timely manner, in every department, across the organisation.

- Every death, where a family members or carers, or staff have raised significant concerns and or a patient with a learning disability and or a serious mental illness will have a full Structured Judgement Review undertaken on the quality and safety of the care provided within the Trust.
- All elective deaths
- All HMSR outliers
- Selected non-elective deaths
- Locally agreed areas for SJR of 40-50 cases, ie DNACPR, Falls, Deteriorating patients, Sepsis

Procedure

1. Involving family and Carers

Families and carers are able to access support from the Trust’s bereavement services, which includes practical advice on collecting death certificates, registering a death, along with where to find local bereavement support or counselling if needed. The family will be able to meet with the Medical Examiner (ME), Medical Examiners Officer (MEO) during office hours Monday to Friday.

The Trust will ask if they have any comments, questions or concerns about the care their loved one received or the circumstances of their death. This will be undertaken by the Medical Examiners Team.

If a family member or carers raises significant concerns, this will automatically trigger a 2nd Stage SJR. Significant concerns are any concerns that cannot be answered at the time or is not answered to the family’s satisfaction or does not reassure them, should trigger a coronial review. This may be done by any medical professional and, or in discussion with the Medical Examiner’s Office

2. First stage SJR

All patients who die in hospital will have a first stage SJR undertaken by the Medical Examiner within 7 days of the death occurring, using the Trust agreed proforma in Meditech.
The Medical Examiner (ME) will review the overall care provided to the patient during this episode of care, by undertaking a case record review. This review will focus upon the assessment, investigation and diagnosis, clinical monitoring, treatment and management plan, along with a review of the communication and organisational issues.

The ME will score the overall care provided between 1-5 as guided by the Royal College of Physicians

1 - Very Poor Care
2 - Poor Care
3 - Adequate Care
4 - Good Care
5 - Excellent Care

Any first stage SJR, with an overall score of either 1 or 2 will trigger a second stage Structured Judgement Review (SJR)

The ME will inform the mortality lead within the division, of the scoring/outcome of the first stage of the mortality review and the requirement for the completion of the second stage SJR

The mortality lead will report the outcomes from all initial reviews to their divisional Mortality and Morbidity Meeting and the Hospital Mortality & Quality Alerts group.

3. Second Stage SJR

A SJR must be undertaken by a clinician trained in this methodology and be independent of the responsible Consultant.

A SJR will be completed within 8 weeks from the date of allocation and sent to the governance lead/mortality leads/medical examiners office (MEO) for collation and thematic analysis.

A date for presentation at the divisional M&M meeting will be confirmed with the reviewer.

Deaths which occur on ICU will have an initial review by the ICU Consultant, alongside the responsible Consultant; this is important as both are involved in delivering care, so both perspectives need to be considered.

The Medical Examiner’s office will liaise with the family, inviting questions and provide a copy of the report if they wish, in line with the being open principles.
4. Presentation of SJR’s to the divisional Mortality & Morbidity Meetings

- All SJR’s will be shared within the relevant divisional Mortality and Morbidity (M&M) meetings, with multi-disciplinary team involvement from the relevant teams.

- The time required for the discussion of each case will inevitably vary depending on the individual circumstances. Typically cases are discussed between 10 and 30 minutes, dependent upon the complexity of the case.

- If there is not enough time to cover each case in sufficient detail, the meeting should be extended. It is best practice not to discuss a single case over more than one meeting.

- All deaths will be presented to the M&M meeting at the first meeting, following the completion of the SJR.

5. Identifying cases for discussion

The Medical Examiner will agree a set of criteria by which cases are identified for discussion, which are approved at the Hospital Quality and Alerts Group, this will remove the possibility of bias. There will also be a criteria for the prioritisation of cases, to ensure that the most critical issues receive the appropriate amount of attention.

Examples of criteria may be:

- Surgical in-patient deaths
- Deaths following a fall
- Unplanned readmissions under any specialist within 30 days of a previous discharge
- Serious near miss
- Return to theatre within the same admission – planned or unplanned
- Other incidents classified by the divisional governance teams as being of major concern.

6. Preparation of case presentation

Once the cases for review have been identified, they should be allocated to the relevant Consultant/Practitioner for preparation of the case. The date for presentation will be agreed at the point of the allocation of the SJR, allowing 4 weeks for the completion of the review.

In order to minimize potential barriers to the discussion arising from attendee’s different communication styles, the use of the Situation, Background, Assessment, Recommendation and Decision (SBARD) will be used.
S - Situation - Patient – a brief description of the patients relevant clinical history to include: age, co-morbidities, previous investigations, admitting diagnosis, the assessment, investigation and diagnosis, the clinical monitoring, treatment and management plan and the details of the adverse outcomes

B - Background - Events - a summary of the events that have occurred that led to the adverse outcome. Outline any relevant information, such as the decision to change a treatment plan, including the reasons why? Changes in the patient circumstances, patient observations

A - Assessment - Analysis: The presenter should give a summary of their analysis of the contributing factors that led to the adverse outcome.

Consideration may be given to the following:

- Human factors – such as a teamwork, design, distractions, communication, workload, or working practices
- System factors: Technical issues with equipment, staffing issues, availability and quality of resources and processes for accessing them, deficiencies in pathways, waiting list prioritisation, on call, handover, training, volume of activity
- Patient factors – elevated risk due to co-morbidities, rapid or unexpected patient deterioration

R - Recommendation - Key learning points: The presenter should highlight any key learning points from the summary of the case and of any literature/NICE guidance reviewed.

7. Case discussion; the decision, agreement of findings and next steps will be made following the presentation of the case.

Following the presenters summary of the case, the chair of the meeting will open up the discussion to the wider group.

This will ensure that a thorough discussion has taken place, exploring any contributing factors which was not mentioned in the case presentation. Everyone present has the opportunity to ask questions with the focus upon learning and quality improvement in the division and across the organisation.

D - Decision - Agreement of findings, scoring phases of care, care overall and of next steps will be agreed following the case discussion.

8. Agreement of a ‘Death due to a problem in care’

Following the presentation and discussion, the Chair will reach agreement if the death was due to a problem in care. A process for addressing any disputes should be agreed, this may be by a majority vote, seeking further clarification on best practice or referral to the SI Panel.
9. Outcomes from SJR’s
In order for M&M meetings to bring about service improvement, well planned case presentation and constructive discussion of cases must be followed by a robust process for sharing findings and implementing actions for improvement.

- All SJR’s which result in overall care scores of 4 or 5 will be shared with the Governance/Mortality leads/teams to feedback the good and excellent care found within the teams.

- Any SJR that results in an Overall Care Score of 3 will be shared with the team to discuss and agree potential areas for action or improvement.

- Any SJR that identifies moderate harm or above has occurred, the reviewer will meet with the family in line with the Duty of Candour principles, explaining the findings and actions to be taken to reduce any reoccurrence should be outlined.

- An SJR with an ‘Overall Care Score’ of 1 or 2, identifying potential ‘problems in care’, will be escalated to the Serious Incident Panel. A DATIX must be completed, if not already done so.

- Any SJR that finds serious omissions have occurred, will be escalated to the Divisional Director and Medical Director.

- Commission a wider review of systems and processes to understand if the case is indicative of a wider problem by undertaking a quality and safety review using SJR methodology (approx. 40 cases) in the particular area or agree a wider audit of practice against the relevant NICE quality standards.

10. Identifying patterns and wider thematic learning
Individual cases discussed at the M&M meetings can inspire changes to working practices and bring about improvements to patient care. It is important that the meetings monitor themes and trends from the case presentations, which is vital to prevent, where possible reoccurrence and drive the quality improvement within the division and across the organisation.

- A monthly quantitative and qualitative report will be presented to the divisional Morbidity and Mortality meetings, detailing the findings and themes from the first and second stage SJR’s. This report will be shared with the Hospital Mortality and Quality Alerts Group, providing assurance of the effectiveness of the M&M meetings and of quality improvement.

- All mortality/governance leads within each division will provide a thematic review of the cumulative findings of the SJR’s undertaken.
This will be presented to their Mortality and Morbidity meeting and to the Hospital Mortality and Quality Alerts group.

- The themes, trends and resultant learning from all SJR’s will be integrated into the quarterly mortality dashboard presented to the public section of the board.

11. Quality Improvement

All themes identified from undertaking the SJR’s will be discussed within the Mortality and Morbidity Meeting/ HMQAG and form part of the Quality Improvement Plan for the division/Organisation.

Allyson Kent
Learning from Deaths Nurse
April 2020
Medical practitioner verifies death and discusses cause of death with consultant.
Referral to Medical examiners office
Please include certifying doctors contact details.

Urgent body release required

Certifying doctor meets with ME to discuss cause of death.
Medical records must be available
Does this case need referral to coroner?

Yes

Agreement on cause of death

MCCD issued

Certifying doctor completes first part of cremation form

MEDICAL EXAMINER
- Case note review + decision for SJR?
  - Cause of death agreed
  - Speaks to relatives
  - Examines deceased
  - Completes part 2 cremation form

No

Concerns raised/ further advice required

Referral to coroner by certifying doctor

Concerns raised/ further advice required

See urgent release flow chart