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 6th July 2020.

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**Assurance Framework**

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**Regulatory and Statutory Reporting**

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**Board Governance**

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<td>239/20</td>
<td>Any other business</td>
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<td>Martin Havenhand, Chairman</td>
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<tr>
<td>240/20</td>
<td>Date of next meeting: Tuesday 4 August 2020</td>
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<td>Martin Havenhand, Chairman</td>
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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.

1100 Close of meeting.
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD VIRTUALLY ON TUESDAY 2 JUNE 2020

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
Mr S Hackett, Interim Director of Finance
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 A Brammer, Divisional General Manager, Clinical Support
Mr J Garner, Divisional Director, Surgery
Dr P Jha, Divisional Director, Medicine
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: Mr S Sheppard, Director of Finance

176/20 CHAIRMAN'S WELCOME AND APOLOGIES FOR ABSENCE

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

177/20 DECLARATIONS OF CONFLICTS OF INTERESTS

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

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.

Mr Hackett's interest, in terms of his joint role as interim Director of Finance at the Trust and as substantive Director of Finance at Rotherham Doncaster and South Humber (RDaSH), was noted.

Colleagues were asked that should any further conflicts of interest become apparent during discussions they should be highlighted.
PROCEDURAL ITEMS
178/20  MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 5 May 2020 were agreed as a correct record, subject to minor grammatical amendment.

179/20  MATTERS ARISING FROM THE PREVIOUS MEETING

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

180/20  ACTION LOG

The Board of Directors reviewed the action log and agreed that log numbers 12, 13, 16 and 18 - 26 would be closed. There were no outstanding open actions.

STRATEGY AND STRATEGIC PLANNING
181/20  REPORT FROM THE CHAIRMAN

The Board of Directors received and noted the report from the Chairman.

Mr Havenhand took the opportunity to thank colleagues across the organisation for their support which was greatly appreciated by the Board, especially during this challenging time.

182/20  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 staff engagement.

Dr Jenkins highlighted that he had taken the opportunity to meet with a group of Community colleagues at their Woodside base. He informed the Board that he had been impressed by their professionalism, their pride in the service and the service adaptions implemented as a consequence of COVID-19. However, this staff group were keen to see their profile, and that of the services they provided, elevated within the organisational structure. How this could be achieved would require further consideration.

The new virtual approach to Team Brief as a means to continue to engage with staff, had received positive feedback. It had proved to be more accessible to all levels of staff, and either viewed live, or played back at a more convenient time. Opportunities for further electronic communication would continue to be explored.

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

183/20  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.

Dominating the report were details of the actions being taken across the sector in terms of planning and positive collaborative working in relation to COVID-19.

The Board was informed that, although initially slow in being made available, testing was now more widely accessible across all settings, including the community and care homes. Additionally, a new antibody test, which was proving to be popular with staff, had been rolled out. Early data showed that across the South Yorkshire and Bassetlaw ICS, 13.7% of those tested had developed antibodies, and had therefore had, at some stage, COVID-19. However, there would be no relaxation in precautionary measures put in place at the Trust as yet, as it still had to be evidenced that this meant that they had immunity.

Another initiative, Test and Trace, had also been rolled out, and it was noted that, due to a required 14-day isolation period for any recent contact with someone testing positive and being named as a recent contact, there could be significant workforce challenges and planning implications.

The Trust continued to reinforce social distancing measures and use of personal protective equipment. The challenge would be that as the organisation moved towards resuming services, it would need to safeguard public confidence in accessing healthcare. New measures would include socially distanced waiting and communal areas, increased use of temperature checks, and more questions being asked of patients upon arrival. Where possible, virtual consultations would continue.

In terms of pre-surgery, it was noted that elective patients may be requested to self-isolate prior to surgery and be swab tested prior to admission. The Day Surgery Unit was currently piloting the process, which in due course would be extended across the whole of the Trust.

In terms of Care Homes, Dr Gardner reported that there had been a number of COVID-19 positive deaths from those settings, in addition to the normal pattern of inappropriate admissions identified as part of the stage one review of deaths. Feedback had been provided to the Local Authority and Rotherham Clinical Commissioning Group as to the care homes with high admission figures. However, the Trust continued to proactively support care homes to ensure that patients were looked after in their preferred place of death. Additionally, a business case was being developed to increase palliative care nurse staffing levels, oncology services and a frailty ward including palliative care provision.

The Board of Directors noted the report.

184/20  2020/21 TRANSFORMATION PLAN REPORT

The Board of Directors received the 2020/21 Transformation Plan Report which detailed the position against the revised 2020/21 Operational Objectives which had been agreed at the April 2020 Board meeting.
For 2020/21 there were four objectives and seven transformational priorities. As such, Mr Edgell questioned if further prioritisation of the key areas should take place as the Trust was also still addressing the COVID-19 actions.

In terms of objective four – financial stewardship – Mr Wright confirmed that in addition to the information contained within the report, further controls were being established to strengthen the financial framework with this work being undertaken with the support of the Internal Auditors. Revised committee structures supported timely reporting and monitoring, with the Executive Team being sighted on the month-end financial position.

Mr Barnes commented that it remained important for the Board to receive reconciled, independently verified and triangulated financial information, which it may not have previously received.

Mr Briggs provided information as to the actions being taken against priority 2 – outpatient transformation. As part of the phase 2 COVID-19 recovery measures, where virtual clinics could not continue, the outpatient environment was being reconfigured to facilitate social distancing. Additional equipment had also been put in place to limit movement between departments. Other locations such as Breathing Space and Rotherham Community Health Centre were also being assessed.

Whilst urgent and targeted diagnostics had remained accessible during the pandemic, work remained ongoing to reduce any backlog. In terms of diagnostics, Dr Shah commented that the continued provision of GP Out of Hours services on the main hospital site would inevitably lead to more tests being requested, thereby leading to additional diagnostic pressures. Whilst Mr Briggs confirmed that discussions continued with Rotherham Clinical Commissioning Group on this out of hours’ service, Dr Jenkins commented that in the new norm, patients may start to access services differently in the future.

In concluding the discussion, Mr Havenhand commented that the report demonstrated progress to date on the ambitious programme the Trust had in place during these unprecedented times, whilst also acknowledging that there may be a requirement for the programme to be modified during the year.

The Board of Directors noted the 2020/21 Transformation Plan report.

185/20  FIVE YEAR STRATEGY REFRESH

The Board of Directors received the report which provided a position statement on the refresh of the Five Year Strategy.

186/20  PEOPLE STRATEGY

The Board of Directors received the People Strategy 2020/23.

The Strategy had been considered by the People Committee who had suggested a number of amendments yet to be incorporated into the document presented.
However, People Committee members advised that this should not preclude the People Strategy being approved by the Board, although further consideration would need to be given ensure there was appropriate focus on community colleagues.

The Board, in considering the Strategy questioned its links to the organisation’s other strategies and plans, such as the Transformation Plan, and whether it would support the delivery of the Trust's other priorities.

Mr Ned indicated that whilst there may be a minor disconnect, he considered the Strategy to be a reasonable way forward and should be approved in order to move to the delivery phase. Dr Jenkins fully supported this statement.

In order to further engage with colleagues, it was planned that a ‘plan on a page’ would be developed in due course to support the Divisions and the wider Trust to put into place the required actions. ACTION – Director of Workforce

The Board of Directors approved the People Strategy 2020/23.

OPERATIONAL PERFORMANCE

187/20 COVID-19 REPORT

The Board of Directors received the report which detailed the comprehensive actions taken by the Trust in response to COVID-19, and to continue delivery of other areas of essential care.

Discussion had taken place in earlier sections of the meeting in relation to activities associated with COVID-19 and as such those discussions were not repeated.

Mr Briggs indicated that this was the fifth month of work linked to the pandemic, with the organisation now looking toward the recovery phase whilst remaining cautious of any second wave of the infection.

Colleagues had been exceptional throughout the pandemic whilst working in difficult circumstances, he advised. Some of the arrangements were now being scaled back, such as the COVID-19 helpline and silver/gold command meetings, enabling, where possible, colleagues to take some time off duty.

The Board of Directors noted the report.

188/20 ASSURANCE COMMITTEE UPDATES

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

i. The Quality Committee had nothing further to highlight to the Board that was not covered by the Quality Report, later on the agenda.

ii. The People Committee had nothing further to highlight to the Board.
iii. The Finance and Performance Committee highlighted that their focus for future meetings would be on the capital programme, particularly in relation to medical equipment and the managed equipment programme. This was in addition to the cost base in terms of what it was and what it should be.

iv. The Audit Committee wished to raise the matter of the moderate assurance Head of Internal Audit Opinion for 2019/20. The Committee were of the opinion that there was a requirement to ensure appropriate action was taken during 2020/21 to improve individual outcomes following reviews by the Auditors in order to support the year end Opinion.

189/20 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.

189/20(a) QUALITY REPORT

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

The report provided information on a number of metrics and also outlined the proposed nine quality improvement priorities for 2020/21.

In terms of these quality improvement priorities, Mr Edgell expressed concern regarding a number of overlapping criterion, and those which had multiple elements and targets. He questioned if this would result in too many actions being undertaken across the organisation rather than concentrating on a smaller number.

Dr Gardner explained that the priorities had been considered by the Quality Assurance Committee, albeit some time ago, and had been the subject of debate and amendment at that time. Although it was acknowledged that there were a number of priorities which could be perceived as overlapping, they were different and would provide increased assurance and evidence to support future plans.

In terms of the other sections of the general report, the Board noted the comment from Dr Gardner that he anticipated that the Hospital Standardised Mortality Ratio would soon start to improve due to the interventions and actions which had been established, including appropriate recording of activity.

Ms Wood took the opportunity to highlight two new services which had been established to ensure a continued positive patient experience during COVID-19. These services were Patient Communication Support and a Patient Property Service. Further details on both were documented within the report.
Mrs Craven commented that she was interested to know as to whether the ICS reconfiguration of the hyper acute stroke services implemented in 2019, was delivering the anticipated improved patient outcomes.

The Board of Directors noted the Quality Report and approved the 2020/21 Quality Improvement Priorities.

189/20(b) OPERATIONAL PERFORMANCE REPORT

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

Mr Briggs reported that performance against the Emergency Care pilot standards continued to be maintained, as did delayed transfer of care. In terms of the latter, Rotherham was considered to be one of the best performing areas in the north of England. This information would be shared with Rotherham Metropolitan Borough Council who were a key partner in delivery of this target.

ACTION – Chief Operating Officer

The Board of Directors noted the report.

189/20(c) WORKFORCE REPORT

The Board of Directors received and noted the Workforce Report presented by the Director of Workforce. It was noted that the content of the report would be restructured to align with the key priorities documented within the People Strategy.

189/20(d) FINANCE REPORT

The Board of Directors received the Finance Report presented by the Interim Director of Finance which was in two sections. The first outlined the emergency financial plan for 2020/21 in light of COVID-19 and the second detailed the financial position for April 2020.

Mr Hackett confirmed that nationally there would be no cost improvement requirement for the first four months of the financial year. However, the Trust would continue to analyse run rates and expenditure, and based upon planning guidance, develop the programme from month five.

Mr Havenhand commented that it would be important for the Trust to have a cost improvement programme due to the financial risks which had been carried forward from 2019/20.

Whilst the cash flow position could be viewed as being healthy, the Board was reminded that this was as a result of two allocations received in month one. The cash flow position would continue to be monitored by the Finance and Performance Committee.
The draft capital expenditure plan had been submitted to the South Yorkshire and Bassetlaw ICS, with feedback pending in relation to affordability within the ICS control total.

The Board of Directors noted the Finance Report.

**190/20  DIGITAL STRATEGY REPORT INCLUDING ENGAGEMENT AND DATA QUALITY**

The Board of Directors received and noted the Digital Strategy Report including Engagement and Data Quality.

Mr Smith commented that the report did not include the new ways of working as a result of COVID-19, such as an increased use of video conferencing and home working, which could be embedded as part of future working methods. Mr Wright confirmed that these formed part of a separate post COVID-19 exercise, but would ensure they were incorporated into future reports.

**ACTION – Deputy Chief Executive**

Mr Wright additionally highlighted that the funding attached to the Digital Aspirant Programme had yet to be confirmed.

**ASSURANCE FRAMEWORK**

**191/20  GOVERNANCE REPORT**

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

The Board of Directors specifically noted the amendments made to the 2018/19 Accounting policies for inclusion in the 2019/20 Annual Report and Accounts. These amendments incorporated the changes resulting from the publication of 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.

Additionally, the Board of Directors approved the assurance mapping of the Trust’s objectives, including COVID-19, to the Board Assurance Committees.

**192/20  BOARD ASSURANCE FRAMEWORK**

The Board of Directors received the Board Assurance Framework (BAF) quarter four report which confirmed that each Board Assurance Committee had considered the risks assigned to them and the recommendations to the Board in terms of their risk score.

Mr Barnes, as Chair of the Audit Committee, confirmed that the BAF, in its entirety, had been considered at the Committee’s 20 May 2020 meeting as recommended by the Internal Auditors. However, following discussion by the
Committee an escalation had been made to the Board in terms of insufficient progress having been made during 2019/20 to address these strategic risks.

Ms Milanec highlighted that the summary table within the report demonstrated the views of the Audit Committee. It would be the norm that for each quarter there should be positive progress in mitigation of the BAF risks. This viewpoint was supported by Dr Jenkins.

The Board of Directors noted the report, and approved the scores as determined by the Board Assurance Committees for quarter four. Additionally, in noting the escalation from the Audit Committee, it was agreed that there would be a requirement for the mitigating actions for each risk to be assessed as to whether they were supporting reduction of the risk.

193/20  RISK MANAGEMENT REPORT

The Board of Directors received and noted the Risk Management Report which included the risk register for those scored 15 or above.

In terms of the specific risks, Dr Gardner questioned the reduction in the risk score for risk 5100 - Risk of inappropriate care and safety for patients within available resources due to operational challenges – and indicated that outside the meeting he would discuss the matter further with the Chief Nurse.

**ACTION – Executive Medical Director**

Ms Wood advised the Board that a revised risk management reporting framework had been presented to the Audit Committee as a means to address comments made. This new approach would provide enhanced information relating to the risks and also detail the actions being taken to reduce the risks. The framework had been supported, and for consistency, would be the format used for reporting to all the Board assurance committees.

194/20  DISCIPLINARY POLICY

The Board of Directors received the revised Disciplinary Policy, with Mr Ned confirming that there had been no significant changes to the previous version.

It was highlighted by Mr Barnes that previously a Non-Executive Director, who could bring an independent view to the proceedings, had been a member of an Appeals Panel. Although the revised policy no longer included such arrangements, he suggested that, if possible, this approach should continue.

The Board of Directors approved the Disciplinary Policy, including the addition of a Non-Executive Director as a member of Appeals Panels where possible.

**ACTION – Director of Workforce**

REGULATORY AND STATUTORY REPORTING

195/20  ANNUAL REPORT AND ACCOUNTS 2019/20

The Board of Directors received the Annual Report and Accounts 2019/20.
Mr Barnes confirmed that the Audit Committee had considered all relevant documentation associated with the Annual Report and Accounts, including the opinions from both the Internal and External Auditors.

All associated work had concluded and as such the Audit Committee would recommend to the Board the approval of the Annual Report and Accounts 2019/20. This would be subject to inclusion of further information in the disclosure associated with the carbon energy contract in the Annual Report. Once the wording was agreed it would be circulated for completeness to the Board. ACTION - Interim Director of Finance

The Board of Directors approved the 2019/20 Annual Report and Accounts and thanked colleagues for their work in completing the process within the required timeframes.

196/20 AUDIT COMMITTEE ANNUAL REPORT

The Board of Directors received and noted the Audit Committee Annual Report, approved by the Committee at its meeting held the preceding day. The Audit Committee Annual Report was scheduled to be submitted to the 15 July 2020 Council of Governors meeting.

197/20 ANNUAL BOARD CERTIFICATIONS (NHSI)

The Board of Directors received the annual Board certifications 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.

Following discussion by the Audit Committee held the preceding day, minor revisions had been made to the supporting appendices which had been circulated prior to the meeting.

The Board of Directors in noting the evidence provided in appendix 2, approved the compliance statements and delegated authority for the statements to be signed by the Chairman and Chief Executive on behalf of the Board, and for the document to be placed onto the Trust website.

ACTION – Director of Corporate Affairs / Company Secretary

198/20 LEARNING FROM DEATHS REPORT (ANNUAL)

The Board of Directors received and noted the 2019/20 Learning from Deaths Annual Report, which included a number of detailed appendices outlining processes in place.
Mr Barnes, as Chair of the Audit Committee, highlighted to the Board that the Committee had requested that the Executive Directors reflect upon the proposed timing of the internal audit review relating to learning from deaths, currently scheduled for the end of 2019/20. Mr Wright confirmed that the matter had been included on the Executive Team meeting agenda for discussion later in the week.

**ACTION – Deputy Chief Executive**

**BOARD GOVERNANCE**

**199/20 ANY OTHER BUSINESS**

There were no items of 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 comments having been received in terms of managing expectations as to when services will return to some level of normality, the Trust being in a positive position with regards to re-usable sterile surgical gowns and early discussions in terms of the bed base a part of the recovery plan.

**200/20 DATE OF NEXT MEETING**

The next meeting of the Board of Directors would be held on 7 July 2020.

Martin Havenhand
Chairman

date
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<th>Log No</th>
<th>Meeting Date</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>
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<td>27</td>
<td>02-Jun-20</td>
<td>People Strategy</td>
<td>186/20</td>
<td>“Plan on a page” to be developed (to support divisions and other stakeholders)</td>
<td>DoW</td>
<td>31-Aug-20</td>
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<td>28</td>
<td>02-Jun-20</td>
<td>Operational Report</td>
<td>189/20b</td>
<td>Information to be shared with RMBC re UECC being one of the best performing A&amp;E departments in the north of England.</td>
<td>COO</td>
<td>07-Jul-20</td>
<td>Completed.</td>
<td>Recommend to close</td>
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<td>29</td>
<td>02-Jun-20</td>
<td>Digital Strategy Report</td>
<td>190/20</td>
<td>Future reports to include examples of new ways of working as a result of COVID-19.</td>
<td>DECO</td>
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<td>30</td>
<td>02-Jun-20</td>
<td>Risk Management Report</td>
<td>193/20</td>
<td>MD and ChN to discuss proposed reduction in risk score for 5100 - &quot;Risk of inappropriate care and safety for patients within available resources due to operational challenges.&quot;</td>
<td>ChN / MD</td>
<td>07-Jul-20</td>
<td>Upon reflection, it was agreed that the risk score should not be changed. (COO)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>31</td>
<td>02-Jun-20</td>
<td>Disciplinary Policy</td>
<td>194/20</td>
<td>Appeals Panels section to be amended with including of a NED as a member, where appropriate</td>
<td>DoW</td>
<td>07-Jul-20</td>
<td>The document is in the process of being amended to reflect NED involvement where appropriate.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>32</td>
<td>02-Jun-20</td>
<td>Annual Report and Accounts</td>
<td>195/20</td>
<td>Inclusion of further information re Carbon Energy Contract to be added to the annual report, and circulated to Board.</td>
<td>Interim DoF</td>
<td>07-Jul-20</td>
<td>Both elements completed.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>33</td>
<td>02-Jun-20</td>
<td>Annual board certifications</td>
<td>197/20</td>
<td>Statements to be signed off and displayed on the Trust website.</td>
<td>Co Sec.</td>
<td>30-Jun-20</td>
<td>Both elements completed.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>34</td>
<td>02-Jun-20</td>
<td>Learning from Deaths Report</td>
<td>198/20</td>
<td>Executive to consider the timing of the internal audit review relating to learning from deaths audit with a view to bring forward from the end of 2020/21.</td>
<td>DECO</td>
<td>07-Jul-20</td>
<td>Executive discussed and agreed with the proposal to bring forward the audit to Q2.</td>
<td>Recommend to close</td>
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</table>
## Public Report from the Chairman

**Agenda item**
224/20

**Executive Lead**
Presenter: Martin Havenhand, Chairman

**Link with the BAF**
The Chairman’s report reflects various elements of the BAF

### Purpose

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

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

The report covers the following issues:
- Governors Member Engagement
- Improvement Plan
- The Rotherham Together Partnership
- Yorkshire and Humber Chairs Meeting
- Community Health Services Covid-19 Webinar on Workforce and Volunteer Responders

### 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 2 June 2020.

2.0 Governors Member Engagement Group

2.1 The Council of Governors agreed to establish a Governors Member Engagement Group. The group has met on three occasions and it has established as its objective to fill all the public vacancies on the Council of Governors.

2.2 The group is chaired by the lead governor Gavin Rimmer and they have produced a terms of reference which is being presented to the Council of Governors Meeting on the 15 July.

2.3 They are recommending the proposed mission statement “The Rotherham NHS Foundation Trust Public Governors have an important role in representing the public voice and diversity of the local community and influencing the continual improvement of health services for the people of Rotherham”.

2.4 Because we have a number of vacancies, additional elections have been organised during the summer with the results being declared towards the end of September 2020.

2.5 To assist in raising the profile of these elections the governors have produced an action plan and associated communication material which will be published and circulated shortly.

3.0 Improvement Plan

3.1 Richard Jenkins and myself met with Sir Andrew Cash and Alison Knowles to review the Trust’s Improvement Plan. This plan will now be submitted to the regional director of NHSi/E.

4.0 The Rotherham Together Partnership

4.1 A virtual meeting of The Rotherham Together Partnership took place on the 17 June and the agenda focused on the COVID pandemic situation and implications for the Rotherham Place.

4.2 The Rotherham Chief Executive’s Group made a joint presentation covering the local situation and how they had collectively responded the challenge of COVID. Our Deputy Chief Executive, Michael Wright, represented the Trust and made an excellent contribution to how the Trust had responded and made particular reference to the increased capacity of critical care beds from 14 to 50 beds. He also acknowledged the tremendous response from our colleagues in adapting to the situation and undertaking different roles.

4.3 The Executive Group are now looking at how they will be operating during the next phase of recovery.

4.4 The South Yorkshire Local Resilience Forum Strategy has its overall aim “to coordinate a strong partnership recovery that is sensitive to the need of those affected by the COVID 19 pandemic and enables the rebuilding and restoring of the health, social, economic and political wellbeing of the communities of South Yorkshire in the short, medium and long term”.

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5.0 Yorkshire and Humber NHS Chairs Meeting 30 June 2020

5.1 I joined this meeting virtually and we received contributions from Peter Wyman, the Chair of the Care Quality Commission, Chris Hopson, Chief Executive of NHS Providers and Richard Barker, Regional Director of NHSi/E

6.0 Community Health Services Covid-19 Webinar on Workforce and Volunteer Responders

6.1 Nicola Bancroft, Non-Executive Director, joined this webinar on behalf of the Trust and below is a brief summary of the event.


Key messages

- Bromley Healthcare has adapted its 35 NHS community health services in response to Covid-19 to deliver c56k face to face consultations and 21k virtual consultations
- There was 30% staff redeployment informed by a skills assessment, non-clinical teams were reprioritised and vulnerable staff were allocated to manage the single point of access for discharge across key pathways to ensure no patients were missed
- The auto-scheduling tool was implemented in record time to help remove silos, minimise travel time and ensure equitable staff allocation, resulting in reduced agency usage and on time appointments
- The Covid-19 monitoring service was set up within 2 days, with a 24/7 hotline for patients and a multidisciplinary team who referred patients to the rapid response team as required
- All nurses had iPads and smartphones to view, via a dashboard, GP shared records, reallocate visits and update information
- Learning is being captured and individual teams are now creating restart and escalation plans, which will consider redeployment and staffing needs.

Secondly, Neil Churchill, Director of Experience, Participation and Equalities Group, NHSEI, gave an update on the NHS Volunteer Responder Service.

Key messages

- The scheme aims to help vulnerable people who have been advised to shield, and to support the healthcare system to respond to Covid-19 pressures
- The scheme is being delivered by NHSEI in partnership with the Royal Voluntary Service, complimenting existing local volunteering schemes
- Key services include: collection of shopping, medicines and other essential goods, together with social support to help prevent loneliness and isolation
- Majority of referrals have been self-referrals, with the largest number of professional referrals coming from local authorities, followed by GPs, community pharmacists and social prescribing link workers
- By the end of May, almost 67k clients have been supported by the scheme with c7k tasks undertaken per day. Take-up has been prevalent in areas of high deprivation
- Going forward, the plan is for the scheme to continue but in localized form. Local systems will own their local scheme and design specific roles/tasks.

Martin Havenhand
Chairman
June 2020
### Board of Directors’ Meeting
#### 7 July 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>225/20</th>
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<tbody>
<tr>
<td>Report</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>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. ICS CEO Update Report for June 2020</td>
</tr>
</tbody>
</table>
1.0 Covid-19

1.1 The Trust has continued to adapt its response to the developing pandemic. As we move through phase 2 of the NHS response there has been a slow increase in some planned activities. Over the last week or so, TRFT and neighbouring trusts have seen a significant step up in pressure on the UECC which has required some flexibility in how the inpatient beds are allocated between areas. Phase 3 planning has commenced across the ICS which involved consideration of whether, as Covid-19 activity falls, whether some hospital sites may cease having Covid-19 inpatients in order to facilitate recovery of other patient care. In addition, the ICS has agreed a process, under the guidance of regional virologists, that would allow patients who have recovered from Covid-19 to no longer be counted in our daily sitreps and would not need to remain in a Covid-19 ward. This is likely to produce a circa 30% drop in case numbers and will facilitate the safe reconfiguration of the inpatient bed base to respond to phase 3.

1.2 In addition, the trust has been engaged in planning for winter and working through how the inpatient bed base will need to be reconfigured as we exit the current phase of the pandemic. This work is informed by bed modelling support from ECIST and is likely to lead to the introduction of a medical short stay unit, expansion of the Same Day Emergency Care unit, embedding the Acute Surgical Unit processes, introduction of a frailty unit and related changes.

1.3 The Trust has continued to undertake risk assessments for staff who may be at risk of worse outcomes should they contract the virus, including BAME colleagues, using an approach based on expert advice. As knowledge develops in this area, we will modify our response accordingly. There is a national and regional drive to ensure 100% of such staff have been offered a risk assessment by the end of July.

1.4 As part of our approach to holistically supporting staff wellbeing, a letter has been sent to the children of staff who requested it, to thank them for supporting their parents through the pandemic.

2.0 Black Lives Matter

2.1 It’s impossible to not have been affected by the recent international concern that followed the killing of George Floyd. Whilst the horror of his death feels far removed from the day to day events at TRFT, it has importantly raised a range of issues about how fair and equitable our society is and the reality that there are deep seated societal issues that have direct bearing on our work. As an organisation we serve a diverse population in Rotherham and our staff are very diverse too across a range of characteristics, broader than ethnicity. We have an obligation to carefully reflect on how we can go further to address these issues within the areas that we have influence. As an initial step in doing so, the Team Brief in July will be used as a listening event and a discussion to start to explore our staff’s views on how we should approach these complex issues in a measured and thoughtful way. It will be important for the Board to consider how it can ensure the Trust takes these issues on board in a meaningful way.

3.0 72nd Birthday

3.1 On the 5th July, the NHS celebrates its 72nd birthday. It does so in extraordinary times and this provides us with an opportunity to celebrate the work of our staff and partners but also to reflect on the losses that have resulted from Covid-19.
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Andrew Cash, System Lead</th>
</tr>
</thead>
</table>

**Sponsor**

**Is your report for Approval / Consideration / Noting**

For noting and discussion

**Links to the STP (please tick)**

- [✓] Reduce inequalities
- [✓] Join up health and care
- [✓] Invest and grow primary and community care
- [✓] Treat the whole person, mental and physical
- [✓] Standardise acute hospital care
- [✓] Simplify urgent and emergency care
- [✓] Develop our workforce
- [✓] Use the best technology
- [✓] Create financial sustainability
- [✓] Work with patients and the public to do

**Are there any resource implications (including Financial, Staffing etc)?**

N/A

**Summary of key issues**

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 May 2020.

**Recommendations**

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.
South Yorkshire and Bassetlaw Integrated Care System

CHIEF EXECUTIVE REPORT

June 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 May 2020.

2. **Summary update for activity during May 2020**

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

The Covid-19 pandemic has affected everyone in South Yorkshire and Bassetlaw. Over recent weeks fewer people have tested positive for Covid-19, fewer people are being admitted to hospital and fewer people are dying of Covid-19 in care homes as well as hospitals. The curve appears to have been flattened as a result of the lockdown and there is a marked improvement in the number of cases.

The focus is now on the following priorities in SYB:

1. Shielding the vulnerable - providing wrap around services for those over seventy-years-old that require them as well as those under seventy-years-old with underlying health conditions.
2. Test and trace – working with Local Authorities, public health and environmental colleagues to increase testing, address outbreaks and improve knowledge of community infection rates.
3. Reassessing capacity in the NHS and delivering services is the ‘new norm’ – embedding and recalibrating services to deliver routine care and continue offering innovations e.g. virtual consultations.
4. The NHS supporting the local economy – for example, supporting people safely back to work.
5. Workforce – ensuring that staffing levels across SYB health and care are stabilised and that ongoing recruitment is supported.

2.2 **National update**

On May 11th, the Government published ‘Our Plan to Rebuild: The UK Government’s Covid-19 recovery strategy’ - a detailed 50-page plan which sets out guidance for Phase Two.

It is based upon a five-tier measure to gauge and respond to the ongoing threat from coronavirus. It outlines a continuation of a number of key elements from within the original lockdown arrangement. These include hand hygiene, social distancing and to only leave the home for essential purposes.

The Plan sets out the importance of innovative operating models for health and care settings, strengthening them for the long term and making them safer for patients and staff in a world where Covid-19 continues to be a risk. This will likely include using more tele-medicine and remote monitoring to give patients hospital-level care from the comfort and safety of their own homes. Capacity in community care and step-down services will be bolstered, health screening services expanded and the infrastructure for active travel also expanded. There is also a commitment to invest in preventative and personalised solutions to ill-health. Much of this ambition is already outlined in SYB’s Five Year Plan and along with the extensive preparations made to mitigate...
against the longer-term impacts of delayed and paused medical procedures and screenings, we are already in an excellent position.

2.3 Regional Update

An ICS Leaders Conference intended to aid thinking towards resetting systems took place on 13th May with the four Integrated Care Systems across North East and Cumbria and Yorkshire and the Humber. This was a useful exercise in which leaders shared presentations on specific areas of transformation.

A further workshop took place on May 21st facilitated by military partners with leaders across North East and Cumbria and Yorkshire and the Humber to stress test the restoration and sustainment of health and care services in a Covid-19 environment. The session looked in detail at contingency plans for four possible Covid-19 scenarios: a) a continued decline in infection rates; b) a second peak; c) a second peak that coincided with seasonal flu; d) a fluctuating infection rate over a sustained period. This was also a very useful exercise which ensured leaders had a greater understanding of the scale of the potential medium-to long-term impacts of Covid-19 and the response to its mitigation, in particular in terms of population and staff mental health and economic impacts.

2.4 Test and Trace

As part of the Government’s Recovery Strategy: Plan to Rebuild, a new Test and Trace approach was announced on May 28th.

NHS Test and Trace brings together four tools to control the virus.

- **Test**: increasing availability and speed of testing will underpin NHS Test and Trace.
- **Trace**: when someone tests positive for coronavirus the NHS Test and Trace service will use dedicated contact tracing staff, online services and local public health experts to identify any close recent contacts they’ve had and alert those most at risk of having the virus who need to self-isolate. This will be complemented by the rollout of the NHS Covid-19 App in the coming weeks.
- **Contain**: A national Joint Biosecurity Centre will work with local authorities and public health teams in PHE, including local Directors of Public Health, to identify localised outbreaks and support effective local responses, including plans to quickly deploy testing facilities to particular locations. Local authorities have been supported by £300m of new funding to help local authorities develop their own local outbreak control plans.
- **Enable**: Government to learn more about the virus, including as the science develops, to explore how we could go further in easing infection control measures.

In addition to testing to tell if someone has the virus, antibody testing is also now underway. This is a key part of the Government’s testing programme and will play an increasingly important role as we move into the next phase of responding to the coronavirus pandemic.

2.5 Personal Protective Equipment (PPE)

The supply chain for PPE is now more stable. Following the call out from the Sheffield City Region Mayor, Dan Jarvis, dozens of offers from South Yorkshire businesses have been received and are being worked through. So far, five suppliers are manufacturing gowns, including two which are providing hand sanitiser and aprons.

Many of the offers have been directed to the NHS England procurement scheme, where companies who can produce at scale contribute to the national effort to supply PPE to the rest of the country.

2.6 Planning for Phase 3 and Phase 4
Prior to the coronavirus outbreak, the SYB Integrated Care System set out ambitious transformation plans to significantly improve population health and reduce health inequalities across SYB in the Five Year Plan 2019-2024. In the new landscape, leadership teams are now reviewing their plans and looking ahead to align their restoration and reset models. Work has been taking place within the ICS PMO to capture and review ICS work to inform the priorities during Phases 3 and 4.

In addition, a third letter from NHS England and NHS Improvement outlining the next steps for Phase 3 is expected shortly. It is anticipated that it will set out the approach to Phase 3 planning, which SYB will want to align to the reset work underway. The expectation is that a formal planning round will take place early June with a first submission 22 June and a final submission 13 July. This will subsequently be agreed nationally in early August. It is likely to be a light touch planning round with funding envelopes for integrated care in place.

2.7 Engagement

Work is underway to look at how the ICS can continue to engage with patients and the public. In the SYB Five Year Plan, ICS partners committed to two public events twice a year, which would feed into the Guiding Coalition meetings. The ICS is still very much committed to engaging with the public in this way and is exploring the use technology and working with the VCSE sector as an enabler for these conversations. Work is also underway to build a new online Citizen’s Panel, with up to three thousand people from South Yorkshire and Bassetlaw who want to give us their views and are representative of our population.

As partners consider which of the transformations that have taken place during the pandemic could be continued in their new form, there is also a need to consider the legal duties to inform and involve. Plans are being develop to ensure that there are adequate opportunities for people to have their say, especially on whether any transformations become permanent.

2.8 Supporting 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.

Additional support to care homes across SYB includes:

- Virtual ward rounds to give care home staff access to senior medical advice and expertise.
- Video tutorials on safe use of PPE to demonstrate the use of and safe disposal of items.
- Deployment of specialist hospital equipment to help deep clean rooms.

In addition, the Government announced an extra £600 million to support care home providers through a new Infection Control Fund on 14th May. Following the recently announced Adult Social Care Action Plan, the funds are allocated to Local Authorities and are in addition to the funding already provided to support the Adult Social Care sector in its Covid response. This fund will be made available to the 349 care home providers in SYB to reduce the rate of transmission in and between care homes. This is a welcome step in the efforts to reduce transmission between sites across health and care settings as well as any potential impact on communities.

2.9 Supporting Voluntary, Community and Social Enterprise organisations

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On May 20th, the Government pledged £750m to support voluntary, community and social enterprise (VCSE) organisations which are supporting COVID response efforts, including £150m which will come from dormant bank and building society accounts. The voluntary sector is a crucial partner in SYB work – they have a fantastic reach into the communities we serve, and a wealth of expertise on everything from tackling social isolation to better understanding the health profiles of different resident populations – and this is very welcome news.

3. Finance update

As a result of Covid-19, from April until at least July 2020, Trusts are funded on a block contract basis. The expectation is that Trusts and Commissioning organisations will break even during this period. Further detailed guidance is expected on how this will operate.

Revised Trust capital plans were required to be submitted on 28 May. The ICS has been given a capital financial envelope of £84.7m for 2020/21 excluding certain categories of capital spend.

Planning guidance will be issued shortly which will need to be completed by July 2020.

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

Date 29 May 2020
**Board of Directors’ Meeting**  
7 July 2020

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<tr>
<th>Agenda item</th>
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<td><strong>Report</strong></td>
<td>National, Integrated Care System and Integrated Care Partnership Report</td>
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<tr>
<td><strong>Executive Lead</strong></td>
<td>Michael Wright, Deputy Chief Executive</td>
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<tr>
<td><strong>Link with the BAF</strong></td>
<td>B7, B10 and B11</td>
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<td><strong>Purpose</strong></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 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.

The Chairman and Deputy Chief Executive recently attended the Rotherham Together Partnership meeting. A presentation covering the Place COVID-19 response was delivered from Place partners including the Trust.

National guidance continues to be reviewed and discussed at ICS, Place and Trust level.

The whole system continues to focus on the recovery stage of the pandemic as well as planning for future outbreaks. Linked to this, the ICS has organised a scenario based stress test exercise, which is planned to take place on 1st July 2020. The Trust will present as part of a wider Rotherham Place based team.

**Recommendations**  
The Board is asked to note the content of this paper

| **Appendices** | Appendix A – Rotherham Partnership Presentation |
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 June has been on delivering the most appropriate, coordinated response to the national and global COVID-19 emergency and the transition into the recovery phase of this response.

2.0. **National Update**

2.1. On 18th May 2020, the Government launched the NHS Test and Trace programme. This is considered a central part of the government’s recovery strategy. Under NHS Test and Trace any individual who tests positive will be asked to share information about their recent contacts. If they meet the criteria for close contact, they will be contacted by the Test and Trace programme and asked to self-isolate for 14 days.

2.2. Alongside the launch of Test and Trace further guidance was published to support the reduction in healthcare acquired COVID-19 cases and limit the impact of Test and Trace on healthcare staffing availability. The guidance outlined the need for hospitals to, where possible, make areas COVID-19 secure, all staff to wear a facemask in any setting that is not considered COVID-19 secure and all hospital visitors to wear a face covering.

2.3. Other national advice and guidance continues to be received by the Trust. This has had a focus on service recovery. This guidance is received, logged, and acted upon as required.

3.0. **South Yorkshire and Bassetlaw Integrated Care System (System)**

3.1. The ICS is holding a Stress Testing workshop in early July 2020. The workshop is facilitated by military colleagues and will provide an opportunity to stress test the integrated health and care plans within the ICS for the remainder of this financial year.

3.2. The COVID-19 Strategic Health Co-ordination Group has transitioned into the Health and Care Management Team (HCMT). The group will continue to meet weekly (except for the 2nd week of the month which will continue to be the Health Executive Group meeting. This further reflects the move from management of the pandemic and its peak towards managing the recovery and a return to business as usual. Therefore, the focus of this group has been on key areas of recovery including:

- Exploring plans for the co-horting of COVID-19 patients on a single site across SYB if numbers continue to decline and plateau
- The establishment of a South Yorkshire and Bassetlaw Operational Delivery Network for Critical Care and the restoration of Critical Care capacity
- The use of the Independent Sector to support elective capacity as the national contract has been extended until the 31st August 2020
- Follow up, rehabilitation and holistic support for patients who have had COVID-19
- Other planning and modelling for Phase 3 including activity and capacity modelling
4.0. **Rotherham Integrated Care Partnership (Place)**

4.1. The Rotherham Place established a Place Level Gold Command meeting, chaired by the Chief Officer of Rotherham Clinical Commissioning Group or the Chief Executive of Rotherham Metropolitan Borough Council. The key areas of focus continue to be testing, PPE and support to Care Homes.

4.2. The Chairman and Deputy Chief Executive attended the Rotherham Together Partnership meeting on 17th June 2020. A COVID-19 Partnership Response presentation was given (Appendix 1). This outlined three local boards which will be a critical part of the local outbreak control plans. These are:

- **COVID-19 Health Protection Board**: Responsible for the development of local outbreak control plans by Directors of Public Health
- **Strategic Coordinating Group**: Gold emergency planning group to support, coordinate and partner with broad local groups to support delivery of outbreak plans (e.g. police, NHS etc)
- **Local Outbreak Engagement Board**: Provide political ownership and public facing engagement and communication for outbreak response.

4.3. The First Health Protection Board was held on the 9th June. A draft COVID-19 Outbreak Control Plan has been produced.

4.4. As reported in June, the Rotherham Place took a decision to pause a number of key workstreams as a consequence of COVID-19. However, discussions have now started as to how these can best be restarted. A number of the programme groups have now started to meet again (virtually) and are considering if the priorities for the programmes need to be updated considering COVID-19 and the ‘new normal’.

4.5. The COVID-19 ‘Hot Site’ at RCHC has been relocated due to the low number of attendances. Therefore, TRFT services at RCHC have been able to return and recommence.

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

**Michael Wright**  
Deputy Chief Executive  
July 2020
Covid 19 Partnership Response

Rotherham Together Partnership
15 June 2020
Introduction

• Novel corona virus

• Came from Wuhan in China

• Recognised 31st December 2019

• Pandemic announced by WHO on 12th March

• The following slides provide an overview of the response by the Rotherham Together Partnership
Government responding to the advice of Government scientists - on 7 March those with symptoms were asked to self-isolate for 7 days

Introduction of shielding for the most vulnerable and called on the British public to cease non-essential contact and travel

Government announced the closure of schools

Entertainment, hospitality and indoor leisure venues were closed

Government took decisive steps to introduce the ‘Stay at Home’ guidance

Prime Minister announced the new ‘Stay Alert’ message signalling the next phase of relaxing lock-down measures
Rotherham Partnership Covid-19 Command and Recovery Structure

- Rotherham Together Partnership Chief Executives’ Group (Gold Group)
- Safer Rotherham Partnership
- Rotherham Safeguarding Children’s Partnership
- RTP Covid 19 Multi Agency Silver (Tactical Coordinating Group) (formerly Pandemic Flu)
- Health and Wellbeing Board
- Building Stronger Communities Group
- Business Growth Board
- Rotherham Safeguarding Adults Board
- Rotherham Surveillance Cell
Local picture

Rotherham Covid-19 Silver Command established to:

• Consider the causes, characteristics & effects of Covid 19, agreeing and coordinating and appropriate action

• Ensure the appropriate treatment is available when developed and to reduce the further risk of spread and improve outcomes for those that are infected

• Follow national, regional and local Covid 19 recovery and restoration plans

• Ensure effective communication/emotional & mental wellbeing advice and support for staff and the public
Key statistics and headlines
ROTHERHAM COUNCIL COVID-19 RESPONSE
Stats show total numbers from 23 March to 8 June 2020

1,130 volunteer offers
1,844 food parcels
3,871 Community Hub calls answered
131 emergency homes to avoid homelessness
1,412 rent arrears and tenancy support calls

3,118 requests for help through the Community Hub
435 organisations and businesses join Community Hub
6,962 Safe and Well calls to vulnerable people
51,249 PPE items supplied

748 Council Tax application deferrals
3,666 Business Grants paid = £41,430,000
13,255 visits to vulnerable children and families
THE ROTHERHAM COMMUNITY HUB
Stats show total numbers from 23 March to 8 June 2020

3,118 Requests for help through the Community Hub
1,130 Volunteer offers
435 Organisations and businesses join Community Hub

1,214 Supported with prescriptions
1,326 Food delivery support
280 Helped with loneliness
79 Pets cared for
337 Advice and Support signposting
605 Other people helped
Integrated health and social care
The Rotherham Foundation Trust

• **Capacity** – Critical Care capacity increased from 14 to 50 beds. Staff redeployed to provide necessary care (including receiving appropriate refresher training).

• **Activity** - All non-urgent face-to-face activity cancelled (or converted into non-face-to-face – approximately a 75% reduction in elective admissions in April. All referrals triaged on the telephone to establish urgency.

• **Infection Prevention and Control** - Wards, theatres and Critical Care activity split into ‘red’, ‘green’ and ‘amber’ areas, to ensure appropriate Infection and Prevention Control

• **Covid Activity** - 538 positive inpatients, of which 328 have recovered and 181 have sadly died

• **Workforce** – For last 12 weeks, between 200-250 staff have been off sick for Covid-related reasons (e.g., shielding, self-isolating or unwell with Covid)
Rotherham Clinical Commissioning Group

Key areas:

• GP services going digital
• Primary care hot site
• Primary care home visiting
• Care home support
• Digital mental health support
• Talk before you walk
Adult Social Care

• Clinical lead allocated to each care home
• Infection Control Grant provided to Care Homes and Home Care Providers
• Training and support mechanism in place for infection control
• Supply of PPE during the initial supply challenge
• Regular dialogue with Providers
• Registered Care Home Deaths 102
Test and Trace Service

An integrated and world-class Covid-19 Test and Trace service, designed to control the virus and enable people to live a safer and more normal life.

- **Test**: Rapid testing, at scale, to control the virus and identify its spread
- **Trace**: Integrated tracing to identify, alert and support those who need to self isolate
- **Contain**: Using data to target approaches to flare ups, at a local and national level
- **Enable**: Improving knowledge of the virus to inform decisions on social and economic restrictions

Continuous data capture and information loop at each stage that flows through Joint Biosecurity Centre to recommend actions.

Underpinned by a huge public engagement exercise to build trust and participation.

Note: Test, Trace, Contain, Enable diagram is illustrative only.
Local plans will centre on 7 themes:
1. Care homes and schools
2. High risk places, locations and communities
3. Local testing capacity
4. Contact tracing in complex settings
5. Data integration
6. Vulnerable people
7. Local boards
Local Boards

• **COVID-19 Health Protection Board** - Responsible for the development of local outbreak control plans by Directors of Public Health

• **Strategic Coordinating Group** - Gold emergency planning group to support, co-ordinate and partner with broad local groups to support delivery of outbreak plans (e.g., Police, SIRE, NHS etc)

• **Local Outbreak Engagement Board** - Provide political ownership and public-facing engagement and communication for outbreak response
There are four phases to the national recovery and transformation programme, with key dependencies between each phase

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase</strong></td>
<td>Covid-19 level 4 incident response</td>
<td>Covid-19 level 4 incident response and critical services switch-on</td>
<td>Ongoing covid-19 management and NHS open for business</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>Enable NHS to deal with peak covid-19 demand</td>
<td>Identify critical services risks and impacts during Covid-19 preparation and peak</td>
<td>Ensure capacity in place for ongoing covid-19 activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start to restore safe service levels for critical services, lock in service innovation and signal re-start to some routine services</td>
<td>Return critical services to agreed standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop monitoring tools to measure and reassure</td>
<td>Address backlog of services</td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td>CEO/COO letter to NHS issued 17 March 2020</td>
<td>Letter to NHS issued 29 April 2020</td>
<td>Letter to NHS / light touch planning guidance planned for issue late May/early June 2020</td>
</tr>
</tbody>
</table>
## Agenda item 227/20

### Report COVID-19 Report

### Executive Lead George Briggs, Chief Operating Officer

### Link with the BAF B1, B2

### Purpose

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

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

As we are aware, 2020/21 is proving to be a difficult year for the NHS across the country. COVID-19, the first global health pandemic in over ten years, is the most severe such episode in the history of the NHS.

- 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
- Stopping elective services to free up personnel and reduce risks to patients and staff
- In Phase 2 of the pandemic we are developing and managing a recovery programme

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 Board note the information.

### Appendices

1. Update May 2020
2. Risk Register June 2020
1.0 COVID-19 Context

1.1 The COVID-19 virus first became known to the World Health Organisation on 31 December 2019, when a handful of cases of a pneumonia-like virus with an unknown cause was detected in China. Three months later and the virus has spread globally to over 200 countries, with over 950,000 confirmed cases and over 48,000 deaths as of 1 April 2020, but this is rising daily. In the UK at this over half a million people tested, there had been over 135,000 confirmed cases and over 18,000 deaths.

1.2 There is currently no vaccine available, and there are no antiviral medications which are known to be effective.

2.0 The Impact on the Rotherham NHS Foundation Trust

2.1 The Trust is recording the ongoing number of positive patients and staff in the hospital, recording recovery and deaths, linking into Rotherham Community Services. This has created a need to separate areas of the Trust into Red, Amber and Green with additional high dependency facilities and care over the last few months and, so far, this has not exceeded our capacity to provide such care.

2.2 As well as the direct impact of the virus, there is a prolonged secondary impact on the organisation from the reduction in normal services which the Trust has had to implement in order to manage the demand from COVID-19. All non-essential elective care has been cancelled and the reductions in treatments across all services, including cancer, has created a significant medical and surgical backlog which we are now planning to manage.

3.0 Our Response to COVID-19

3.1 The table below risk register and attached recovery structure highlights our updated plans and risks.

George Briggs  
Chief Operating Officer  
June 2020
Update on TRFT response to COVID – 19

The action plan below details the measures that have been enacted in response to the pandemic:

<table>
<thead>
<tr>
<th>Priority Measure</th>
<th>Actions taken</th>
<th>Timescale</th>
<th>RAG</th>
<th>Local Actions/Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to phase a return to normal inpatient and critical care capacity</td>
<td>Commence non-urgent elective operations from 15th June in a phased approach over the next three months.</td>
<td>We commenced this in June 20</td>
<td>TRFT have now commenced a phased plan to manage elective patients. Emergency admissions, urgent cancer treatment and other clinically urgent care has continued and provisions have been made as part of the bed reconfiguration phasing. Areas within the hospital have previously been configured to create cohort areas for potential and confirmed COVID positive patients (red area) suspected COVID patients (Amber) and non COVID positive patients (green area). These have been adjusted over June to increase Green capacity and reduce Red capacity. Plans to develop a SYB COVID facility are underway with the RHH as the proposed site.</td>
<td></td>
</tr>
<tr>
<td>Continue to discharge all hospital in patients who are medically fit to leave.</td>
<td>ASAP</td>
<td></td>
<td>As at 12th June there were 45 (107 in April) empty acute beds on the acute site. The Trust has implemented plans to reduce the numbers of beds on each ward, these beds are empty not closed and will be mobilised when required. There were 0 delayed transfers of care. With 21 people over 21 days (super stranded). Continuing Health Care Team (RCCG) and RMBC actions to support hospital discharges/ patient flow include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Any patients requiring an individual funding request to have the assessment completed in a short term bed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• CHC nurses to support Integrated Discharge Team with documentation</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Status</td>
<td>Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free up community &amp; intermediate care beds</td>
<td>Ongoing</td>
<td>A daily review of all patients within the non-acute bed base is taking place detailing estimated date of discharge and outstanding actions agreed by partners within therapies and RMBC. A detailed review of all current intermediate and community beds and potential additional capacity within community facilities is taking place. Empty community beds will also be used for surge and to support clearing the acute trust of medically fit for discharge patients. 40 additional beds have been identified. Staffing resource is being redirected to assess and discharge as many people from intermediate care beds. Additional support available from RMBC social work to facilitate these discharges across all 5 units within the community. A number of unused Intermediate care beds in RMBC are closing in June 2023.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare and respond to large numbers of</td>
<td></td>
<td>The Trust have increased oxygen supplies on site and a secondary plan for any potential spike in cases is under preparation bids submitted week of 15th June. Equipment to support additional ventilated beds has been ordered and is expected July 2023.</td>
<td></td>
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</tr>
</tbody>
</table>
| Respiratory patients requiring support | Increase capacity | Support staff and maximise health & | TRFT have implemented a COVID-19 staff helpline 06.00 – 19.00, 7 days a week. This supports employees and managers with enquiries and advice relating to COVID absence or self-isolation, signposting to other support | Segregate all patients with respiratory problems | Phase 3 June 20 | Areas within the hospital have been reconfigured to create cohort areas for potential and confirmed COVID positive patients (red area) and non COVID positive patients (green area).

The UECC has separate areas to segregate potential COVID patients from non COVID patients; this includes a separate red and green RESUS utilising the Rapid Assessment and Treatment area. In addition, to facilitate separation, UECC Paediatrics has moved to the Children’s Assessment Unit. Majors non COVID patients are being assessed and moved to the combined AMU ASU at the door or in ambulances.

Inpatient ward areas have been segregated to facilitate red and green areas for admission.

Plans are agreed to reduce red capacity on a phased approach as demand for COVID positive patients decreases.

The Intensive Care Unit is remaining on A3/A4 during this phase.

Enhanced health &

Ongoing
<table>
<thead>
<tr>
<th>staff availability</th>
<th>wellbeing support</th>
<th>mechanisms; e.g. risk assessment process for vulnerable or high risk groups. The helpline also co-ordinates the booking process and assessment for staff swabbing. And antibody testing, discussion is underway across Rotherham place re a combined facility.</th>
<th>All staff are now instructed to wear masks and maintain 2-meter distancing rules. Masks are being worn across clinical and non-clinical areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted testing for COVID-19 for symptomatic NHS staff</td>
<td>Ongoing</td>
<td>Staff testing is in place at Woodside as a drive through facility, currently provision in place for up to 50 per day which is being shared with primary care.</td>
<td></td>
</tr>
<tr>
<td>Availability of hotel accommodation for frontline NHS staff (voluntary)</td>
<td>Ongoing</td>
<td>A number of hotels have offered free accommodation to TRFT. The booking and reimbursement process is instructed by NHSE/I guidance.</td>
<td></td>
</tr>
<tr>
<td>Management of at-risk staff</td>
<td>Ongoing</td>
<td>The Divisions have reviewed a number of risk assessments and made recommendations to support people to remain at work. We have circa 230 staff who are/have been off/ shielding.</td>
<td></td>
</tr>
<tr>
<td>Deployment of at-risk/isolated clinical staff to undertake telephone consultations,</td>
<td>Ongoing</td>
<td>Redeployment of staff to lower risk areas/roles is happening with the Deputy Dir of Nursing leading on this.</td>
<td></td>
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</tbody>
</table>
| video & advice  
i.e. outpatients,  
111, OOH |  |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>All clinicians in non-patient facing to be inducted to return to direct patient facing Duties</td>
<td>Complete</td>
</tr>
<tr>
<td>Complete</td>
<td>In line with national guidance, all appropriate registered Nurses, Midwives and AHP’s currently in non-patient facing roles have been asked to support direct clinical practice, following appropriate local induction, training and support.</td>
</tr>
<tr>
<td>Support the wider population measures</td>
<td>Sustain urgent and routine outpatient &amp; primary care via video, telephone, email &amp; text</td>
</tr>
<tr>
<td>Complete</td>
<td>Video consultation has been trialled and teams are using a combination of telephone and video for outpatients at present. As part of the recovery plans a number of other clinical teams are trailing non-face to face consultation</td>
</tr>
<tr>
<td>Support the wider population measures</td>
<td>Limit visitors to patients</td>
</tr>
<tr>
<td>Complete</td>
<td>From 20.3. the only visitors will be: 1 visitor for births and patients with complex Mental Health issues and visitors for patients on End of Life pathway.</td>
</tr>
<tr>
<td>Stress test operational readiness</td>
<td>All providers to check business continuity plans Trust incident management teams – ability to provide daily sitrep information</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Recording COVID costs</td>
<td>Monthly returns of costs incurred – including extra bed capacity Provide expected costs to end of period</td>
</tr>
<tr>
<td>Planning for Recovery</td>
<td>As the impact of the pandemic wave subsides and it is considered that there is reduced threat of further waves occurring the</td>
</tr>
</tbody>
</table>
UK will move into the recovery phase. The reintroduction of performance targets and normal care standards need to recognise the loss of skilled staff and their experience.

Most staff have been working under acute pressure for prolonged periods and are likely to require rest and continuing support.

Critical physical assets are likely to be in need of backlog maintenance, refurbishment or replacement.

Shields and screens are being erected across all reception outpatient areas.

Patient entrances and exits are being managed via security or lockdown.

Testing of patients pre operation has commenced with a cabin facility outside of the day unit.

Patient letters and communications have been adjusted to explain the latest guidance.
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

Meeting
- Capacity & RTT
- Workforce Group
- Testing
- Outpatients
- Cancer Recovery
- PPE
- Community Pathways
- Bed Base & Winter

Chair
- Louise Tucker
- Steve Nead/Paul Harm
- Helen Dobson
- George Briggs
- George Briggs
- Angela Woods
- Sally Kilgarriff
- Sally Kilgarriff

1st Meeting Frequency
- Tue 9th June, Fortnightly, 10-11
- Fri 5th June, Weekly, 10-10:30
- Wed 27th May, Weekly, 10:15
- Fortnightly
- Fortnightly
- Fortnightly
- Fortnightly

Diary
- Incident Room
- Incident Room
- Incident Room
- Daily
- Daily
- Daily

Minutes
- IE: Action Notes
- IE: Action Notes
- IE: Action Notes

June 2020
Integrated Performance Report – May 2020

Provided by

Business Engagement Team, Health Informatics
# Integrated Performance Report

## PERFORMANCE SUMMARY

<table>
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<tr>
<th>Quality</th>
<th>Operational Delivery</th>
<th>Finance</th>
<th>Workforce</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Planned Patient Care</td>
<td>Financial Position</td>
<td>Workforce Position</td>
<td>Acute</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>Emergency Performance</td>
<td></td>
<td></td>
<td>Community Services</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Cancer Care</td>
<td></td>
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<td>Maternity</td>
<td>Inpatient Care</td>
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<tr>
<td>Patient Feedback</td>
<td>Community Care</td>
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</tr>
</tbody>
</table>

## CQC DOMAINS

<table>
<thead>
<tr>
<th>Responsive</th>
<th>Effective</th>
<th>Safe</th>
<th>Caring</th>
<th>Well Led</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Patient Care</td>
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<td>Community Care</td>
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</tbody>
</table>
Operational Delivery

Urgent & Emergency Care:
Whilst we are not currently reporting the 4-hour standard due to being a Field Test pilot site, the published HES statistics evidence that the Trust’s Mean Total Time in A&E improved to its best level since October 2019 in April’s data. Similarly, the 3 core field test pilot metrics were all comfortably met. This was possible due to strong flow through the organisation, despite the need to cohort Covid-19 patients in appropriate beds. DTOCs were once again close to 0% for the month, and there were no 12 hour trolley waits, with a total of 3 ambulance handovers over 60 minutes (compared to 46 in the same month last year).

Elective Care:
From an inpatient perspective, activity remains very low at the Trust given the anaesthetic rotas required to staff red and green critical care, but activity has been increased in June to ensure we can start dealing with the significant backlogs which have developed. Referral to Treatment performance dropped right down to 67% given the number of long-waters who have not been treated during the pandemic, although the overall size of the waiting list remains low compared to historically.

Cancer:
Cancer care remains a significant concern given the volume of patients now waiting for diagnostics or treatment, but capacity has been significantly increased in June with the revision to the NHS and British Society of Gastroenterologists (BSG) guidance on endoscopy. However, with nearly 300 patients on the PTL waiting for endoscopy procedures, there will be much longer waits than planned for these patients over the next few weeks. Use of the Independent Sector is being maximised wherever possible.

Outpatient care:
The positive trend within the DNA rate will be driven in part by the switch to more non-face-to-face consultation mediums. This positive change is one which the Trust is keen to continue, and teams are already focusing on establishing how to enable fewer face-to-face interactions within our outpatient activity.

Quality Summary

Mortality:
The Trust mortality comparative benchmark figures remain high. The planned change to recording methodologies (to ensure the Trust’s recording is as accurate as possible) will not be visible until we are reviewing April’s data in a month or two’s time. N.B. Covid-19 deaths will be removed from the SHMI until the end of July’s data (pending any further review).

Infection Prevention & Control:
Since late May, the Trust has treated 8 patients whereby their Covid-19 result was confirmed at least 15 days after their admission to hospital, and 9 patients between 8 and 14 days after admission. In line with national guidance, Root Cause Analyses will be carried out on all such infections acquired over 15 days. There have been two instances where asymptomatic staff are likely to have led to increased numbers of cases, but these were both identified and managed very rapidly, with no further action required.

Patient Safety:
The Trust experienced a Never Event in May, which has been communicated to the CCG and CQC. The preliminary investigation has been completed, with the full review to follow within the 60 day timescale. However, total patient harms remained low, in part possibly based on the lower volume of activity being delivered by the Trust. In addition, the proportionate number of complaints remained very low, and care hours per patient day continued to exceed target, at nearly 3 hours per day above the target. The VTE risk assessment completion levels remain well below previous levels, and as things stand, the mandatory field within Meditech has not corrected the previous issues with this metric.

Maternity:
Our midwifery teams continue to deliver an excellent service to expectant parents, with over 95% of antenatal appointments taking place within 90 days despite the current challenges around PPE and social distancing. Breastfeeding initiation has fallen this month, with 79/208 mothers not breastfeeding their newborn babies beyond 6 weeks.

Workforce Summary

Recruitment:
There were 49 WTE starters in the month of May, including 16 Student Nurses, recruited as part of the initiative to retain Student Nurses during the Covid-19 pandemic. The Trust also recruited 17 staff into Additional Clinical Services roles. Although this was a fall from the previous month, it is almost double the number of staff (WTE) recruited in the same month last year.

Retention:
The month of May continued to show positive trends in key recruitment and retention metrics, with turnover at 0.55%. The nursing and midwifery vacancy figure of 116 also does not include a further 48 newly-qualified and aspirant nurses, meaning the overall vacancy figure is 69 WTE.

Sickness:
Sickness absence was also below trend when Covid-19 sickness was excluded, with an in-month net reduction of long-term cases of 19 (14%). This is the first time that sickness absence has been below target for over a year. However, with the inclusion of Covid-19 sickness, the rate rises to 6.5%, and some of this sickness may be replacing what would normally be counted within short-term sickness.

Mandatory and Statutory Training (MAST):
Despite the very busy recent period, MAST training remains above target at 90% in-month, although Fire Safety and Hand Hygiene are below target levels (this is due to the fact the face-to-face training has had to be postponed given Covid-19 and social distancing requirements). Medical and dental compliance is at 77%.

Personal Development Reviews:
PDR compliance is down to 72%, but this is expected due to the pause on PDR completion in order to ensure colleagues had appropriate time to deliver these effectively. The organisation is about to relaunch the PDR season for 2020/21, with a 2-month extension to the usual deadline of June.

Finance Summary

I&E Position:
In line with national guidance, the Trust has set itself a break-even plan for the first four months of the financial year 2020/21. For the two months ending 30th April 2020 the Trust has delivered a £7K deficit position in line with this plan, which is after taking account of :-
- COVID-19 related expenditure of £3,461K;
- which has been offset by additional top-up value payments of £2,179K above the value assumed in the Trust’s emergency plan. However, this is only £545K above the maximum values allowable for reasonable expenditure to break-even and hence, the Trust will expect that this will be reimbursed in full by NHSE/I.

Capital Expenditure:
In May 2020 there was a total of £745K of capital expenditure incurred in month (£1,819K year to date), resulting in a cumulative over-spend of £601K (49%). Within these figures is COVID-19 related expenditure of £894K across Estates, medical equipment and information technology requirements that are expected to be funded nationally via receipt of additional PDC in year.

Cash position:
Cash management guidance issued at the start of the Covid-19 pandemic required provider organisations to have certainty regarding cash inflows during the first four months’ emergency plan phase. To facilitate this, commissioners and NHSE/I central have been required to make block contract and top-up payments to providers a month in advance, as well as reimbursing Covid-19 costs two months in arrears. Against this background the Trust had a closing cash balance at 31st May 2020 of £24,184K.
## Trust Integrated Performance Dashboard - Operations

### KPI Reporting Period Target

<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Target Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 Waiting List Size</td>
<td>May-20</td>
<td>L 12,796</td>
<td>12,796</td>
</tr>
<tr>
<td>P2 Referral to Treatment (RTT) Performance</td>
<td>May-20</td>
<td>N 92%</td>
<td>91.0%</td>
</tr>
<tr>
<td>P3 Overdue Follow-Ups</td>
<td>May-20</td>
<td>L 8,721</td>
<td>10,637</td>
</tr>
<tr>
<td>P4 First to follow-up ratio</td>
<td>May-20</td>
<td>B 2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>P5 Day case rate (%)</td>
<td>May-20</td>
<td>B 80%</td>
<td>80.7%</td>
</tr>
<tr>
<td>P6 Diagnostic Waiting Times (DM01)</td>
<td>May-20</td>
<td>N 1%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### Emergency Performance

<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Target Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1 Number of Ambulance Handovers &gt; 60 mins</td>
<td>May-20</td>
<td>CQC 0</td>
<td>167</td>
</tr>
<tr>
<td>E2 Number of 12 hour trolley waits</td>
<td>May-20</td>
<td>N 0</td>
<td>15</td>
</tr>
<tr>
<td>E3 Conversion rate from A&amp;E (not including Observations)</td>
<td>May-20</td>
<td>-</td>
<td>20.5%</td>
</tr>
<tr>
<td>E4 Proportion of same day emergency care</td>
<td>May-20</td>
<td>L 33%</td>
<td>26.6%</td>
</tr>
</tbody>
</table>

### Cancer Care

<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Target Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ca1 2 Week Wait Breast Symptoms</td>
<td>Apr-20</td>
<td>N 93%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Ca2 2 Week Wait Breast Symptoms</td>
<td>Apr-20</td>
<td>N 93%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Ca3 31 day first treatment</td>
<td>Apr-20</td>
<td>N 96%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Ca4 62 Day Performance</td>
<td>Apr-20</td>
<td>N 85%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Ca5 62 day Patient Tracking List Size</td>
<td>May-20</td>
<td>L 800</td>
<td>602</td>
</tr>
<tr>
<td>Ca6 28 day faster diagnosis standard</td>
<td>Apr-20</td>
<td>N 75%</td>
<td>74.1%</td>
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</table>

### Inpatient Care

<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Target Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1 Mean Length of Stay - Elective</td>
<td>May-20</td>
<td>-</td>
<td>0.5</td>
</tr>
<tr>
<td>I2 Mean Length of Stay - Non-Elective</td>
<td>May-20</td>
<td>-</td>
<td>5.8</td>
</tr>
<tr>
<td>I3 Length of Stay &gt; 7 days (Proportion discharged)</td>
<td>May-20</td>
<td>L 21%</td>
<td>27.1%</td>
</tr>
<tr>
<td>I4 Length of Stay &gt; 21 days (Proportion discharged)</td>
<td>May-20</td>
<td>L 3.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>I5 Length of Stay &gt; 21 days (Snapshot Numbers)</td>
<td>May-20</td>
<td>L 20</td>
<td>55</td>
</tr>
<tr>
<td>I6 Delayed Transfers of Care - Percentage</td>
<td>May-20</td>
<td>N 3.5%</td>
<td>5.6%</td>
</tr>
<tr>
<td>I7 Discharges before midday</td>
<td>May-20</td>
<td>L 20%</td>
<td>11.0%</td>
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### Outpatient Care

<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Target Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>O1 Did Not Attend Rate (OutPatients)</td>
<td>May-20</td>
<td>B 8.0%</td>
<td>9.0%</td>
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<tr>
<td>O2 Appointment Slot Issues</td>
<td>Apr-20</td>
<td>N 4%</td>
<td>24%</td>
</tr>
<tr>
<td>O3 % of missing outcomes</td>
<td>May-20</td>
<td>L 20%</td>
<td>19.1%</td>
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### Community Care

<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Target Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC1 MusculoSkeletal Physio &lt;4 weeks</td>
<td>May-20</td>
<td>L 80%</td>
<td>36%</td>
</tr>
<tr>
<td>CC2 % urgent referrals contacted within 2 working days by specialist nurse (Contin)</td>
<td>May-20</td>
<td>L 95%</td>
<td>81%</td>
</tr>
<tr>
<td>CC3 A&amp;E attendances from Care Homes</td>
<td>May-20</td>
<td>L 133</td>
<td>166</td>
</tr>
<tr>
<td>CC4 Admissions from Care Homes</td>
<td>May-20</td>
<td>L 50</td>
<td>89</td>
</tr>
<tr>
<td>CC6 Patients assessed within 5 working days from referral (Diabetes)</td>
<td>May-20</td>
<td>L 95%</td>
<td>99%</td>
</tr>
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</table>

### Data Quality

<table>
<thead>
<tr>
<th>Trend</th>
<th>Data Quality</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>KPI</th>
<th>Reporting Period</th>
<th>Type of Standard</th>
<th>Target</th>
<th>Previous Month (3)</th>
<th>Previous Month (2)</th>
<th>Previous Month (1)</th>
<th>Current Month</th>
<th>YTD 20/21</th>
<th>Same Month Prev. Yr</th>
<th>Forecast - Year End</th>
<th>Trend</th>
<th>Data Quality</th>
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<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>M1 Mortality index - SHMI</td>
<td>Dec-19</td>
<td>B</td>
<td>100</td>
<td>116.3</td>
<td>118.2</td>
<td>118.8</td>
<td>120.0</td>
<td>120.0</td>
<td>107.2</td>
<td>112</td>
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<tr>
<td>M2 Mortality index - HSMR (Rolling 12 months)</td>
<td>Mar-20</td>
<td>B</td>
<td>100</td>
<td>116.8</td>
<td>114.0</td>
<td>116.9</td>
<td>117.3</td>
<td>117.3</td>
<td>111.4</td>
<td>110</td>
<td></td>
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<tr>
<td>M3 Number of deaths (crude mortality)</td>
<td>May-20</td>
<td>-</td>
<td>-</td>
<td>97</td>
<td>93</td>
<td>171</td>
<td>112</td>
<td>283</td>
<td>73</td>
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<tr>
<td><strong>Infection, Prevention and Control</strong></td>
<td></td>
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<tr>
<td>In1 Clostridium-difficile Infections</td>
<td>May-20</td>
<td>L</td>
<td>TBC</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
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<tr>
<td>In2 MRSA Infections (Methicillin-resistant Staphylococcus Aureus)</td>
<td>May-20</td>
<td>L</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>In3 In-Hospital Mortality - Infectious Diseases</td>
<td>Feb-20</td>
<td>CQC</td>
<td>100</td>
<td>118.8</td>
<td>116.7</td>
<td>117.9</td>
<td>112.7</td>
<td>110.9</td>
<td>N/A</td>
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<tr>
<td><strong>Patient Safety</strong></td>
<td></td>
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<tr>
<td>PS1 Incidents - severe or above</td>
<td>May-20</td>
<td>L</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
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<tr>
<td>PS2 Never Events</td>
<td>May-20</td>
<td>L</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>PS3 Number of Patient Harms</td>
<td>May-20</td>
<td>-</td>
<td>-</td>
<td>665</td>
<td>446</td>
<td>327</td>
<td>327</td>
<td>703</td>
<td>581</td>
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<tr>
<td>PS4 Readmission Rates</td>
<td>Dec-19</td>
<td>B</td>
<td>9.3%</td>
<td>9.0%</td>
<td>8.5%</td>
<td>8.6%</td>
<td>9.3%</td>
<td>9.1%</td>
<td>8.7%</td>
<td></td>
<td></td>
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<tr>
<td>PS5 Venous Thromboembolism (VTE) Risk Assessment</td>
<td>May-20</td>
<td>N</td>
<td>95%</td>
<td>84.7%</td>
<td>81.8%</td>
<td>84.1%</td>
<td>82.6%</td>
<td>79.2%</td>
<td>74%</td>
<td></td>
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<tr>
<td>PS6 Number of complaints per 10,000 patient contacts</td>
<td>May-20</td>
<td>L</td>
<td>8</td>
<td>8.7</td>
<td>10.3</td>
<td>1.7</td>
<td>3.5</td>
<td>2.6</td>
<td>10.4</td>
<td></td>
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<tr>
<td>PS7 Proportion of complaints closed within 30 days</td>
<td>May-20</td>
<td>L</td>
<td>100%</td>
<td>75.0%</td>
<td>87.5%</td>
<td>86.4%</td>
<td>20.0%</td>
<td>59.5%</td>
<td>85.7%</td>
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<tr>
<td>PS8 Care Hours per Patient Day</td>
<td>May-20</td>
<td>B</td>
<td>7.3</td>
<td>6.8</td>
<td>11.0</td>
<td>11.2</td>
<td>10.1</td>
<td>10.7</td>
<td>7.9</td>
<td></td>
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<tr>
<td><strong>Maternity</strong></td>
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<td></td>
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</tr>
<tr>
<td>Ma1 Antenatal appointments within 90 days</td>
<td>May-20</td>
<td>N</td>
<td>90%</td>
<td>92.9%</td>
<td>91.6%</td>
<td>92.2%</td>
<td>95.3%</td>
<td>93.5%</td>
<td>94.7%</td>
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<tr>
<td>Ma2 % of emergency Caesarean-sections</td>
<td>May-20</td>
<td>L</td>
<td>16.5%</td>
<td>16.4%</td>
<td>16.3%</td>
<td>18.5%</td>
<td>18.5%</td>
<td>18.6%</td>
<td>16.3%</td>
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<tr>
<td>Ma3 Breast Feeding Initiation Rate</td>
<td>May-20</td>
<td>N</td>
<td>66%</td>
<td>71.5%</td>
<td>68.1%</td>
<td>72.9%</td>
<td>61.7%</td>
<td>67.1%</td>
<td>64.1%</td>
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<tr>
<td>Ma4 Stillbirths per 1000 live births</td>
<td>May-20</td>
<td>L</td>
<td>0</td>
<td>4.8</td>
<td>0.0</td>
<td>10.4</td>
<td>4.8</td>
<td>7.5</td>
<td>13.4</td>
<td></td>
<td></td>
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<tr>
<td>Ma5 1:1 care in labour</td>
<td>May-20</td>
<td>-</td>
<td>75%</td>
<td>78.7%</td>
<td>79.0%</td>
<td>74.2%</td>
<td>78.6%</td>
<td>76.5%</td>
<td>80.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KPI</td>
<td>Reporting Period</td>
<td>Type of Standard</td>
<td>Target</td>
<td>Previous Month (1)</td>
<td>Previous Month (2)</td>
<td>Previous Month (3)</td>
<td>Current Month</td>
<td>YTD 20/21</td>
<td>Same Month Prev. Yr</td>
<td>Forecast - Year End</td>
<td>Trend</td>
<td>Data Quality</td>
</tr>
<tr>
<td>------------------------------------------</td>
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</tr>
<tr>
<td>Workforce</td>
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<td></td>
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</tr>
<tr>
<td>W1 Whole Time Equivalent against plan - Total</td>
<td>May-20</td>
<td>L</td>
<td>-178</td>
<td>-272</td>
<td>-255</td>
<td>-234</td>
<td>-166</td>
<td>-166</td>
<td>-246</td>
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<tr>
<td>W3 Total Headcount</td>
<td>May-20</td>
<td></td>
<td></td>
<td>4,696</td>
<td>4,711</td>
<td>4,734</td>
<td>4,812</td>
<td>4,812</td>
<td>4,644</td>
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<tr>
<td>W4 Vacancy Rate - TOTAL</td>
<td>May-20</td>
<td>B</td>
<td>4.3%</td>
<td>6.6%</td>
<td>6.2%</td>
<td>5.7%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>6.1%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>W5 Vacancy Rate - Nursing</td>
<td>May-20</td>
<td>B</td>
<td>7.4%</td>
<td>9.8%</td>
<td>9.8%</td>
<td>9.5%</td>
<td>9.2%</td>
<td>9.3%</td>
<td>8.6%</td>
<td></td>
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<tr>
<td>W6 Time to Recruit</td>
<td>May-20</td>
<td>L</td>
<td>34</td>
<td>31</td>
<td>28</td>
<td>36</td>
<td>36</td>
<td>36</td>
<td>41</td>
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<tr>
<td>W7 Sickness Rates (%) - exc COVID related</td>
<td>May-20</td>
<td>L</td>
<td>3.5%</td>
<td>4.8%</td>
<td>6.0%</td>
<td>7.4%</td>
<td>4.6%</td>
<td></td>
<td>4.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W8 Sickness Rates (%) - inc COVID related</td>
<td>May-20</td>
<td>L</td>
<td>0.63%</td>
<td>0.61%</td>
<td>0.77%</td>
<td>0.37%</td>
<td>0.55%</td>
<td>0.46%</td>
<td>0.8%</td>
<td>0.63%</td>
<td></td>
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</tr>
<tr>
<td>W9 Turnover</td>
<td>May-20</td>
<td>L</td>
<td>90%</td>
<td>89.4%</td>
<td>88.7%</td>
<td>80.0%</td>
<td>72.0%</td>
<td>72.0%</td>
<td>70.6%</td>
<td>90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W10 Appraisals complete (%)</td>
<td>May-20</td>
<td>L</td>
<td>85%</td>
<td>92.2%</td>
<td>91.4%</td>
<td>91.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.2%</td>
<td>90%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W11 MAST (% of staff up to date)</td>
<td>May-20</td>
<td>L</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>
**Trust Integrated Performance Dashboard - Finance**

<table>
<thead>
<tr>
<th></th>
<th>In Month Plan £000s</th>
<th>In Month Actual £000s</th>
<th>In Month Variance £000s</th>
<th>YTD Plan £000s</th>
<th>YTD Actual £000s</th>
<th>YTD Variance £000s</th>
<th>Forecast Variance £000s</th>
<th>Prior Month Forecast £000s</th>
<th>Year-end Forecast £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>I&amp;E Performance</td>
<td>0</td>
<td>(7)</td>
<td>(7)</td>
<td>0</td>
<td>(7)</td>
<td>(7)</td>
<td>Forecasts have not yet been completed due to the unique contractual payment system we are currently operating under. A forecast is due to take place in M4, for reporting at the MS Board meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Spend</td>
<td>683</td>
<td>888</td>
<td>(205)</td>
<td>1,366</td>
<td>1,711</td>
<td>(345)</td>
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</tr>
<tr>
<td>Capital Expenditure</td>
<td>1,218</td>
<td>745</td>
<td>472</td>
<td>1,218</td>
<td>1,819</td>
<td>(601)</td>
<td></td>
<td></td>
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<tr>
<td>Cash Balance</td>
<td>0</td>
<td>4,608</td>
<td>4,608</td>
<td>1,357</td>
<td>24,184</td>
<td>22,827</td>
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</tr>
</tbody>
</table>

**Trust Integrated Performance Dashboard - Activity**

- **UECC Attendances**
- **Total Outpatients**
- **Inpatient Admissions (including Observations)**
- **Inpatient Admissions (excluding Observations)**
- **Total Referrals (Acute)**
- **2ww Referrals**
<table>
<thead>
<tr>
<th>Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Handovers - % of handovers &gt; 60 minutes</strong></td>
</tr>
<tr>
<td><strong>Referral to Treatment - % of patients waiting less than 18 weeks for treatment</strong></td>
</tr>
<tr>
<td><strong>12 hour trolley waits - per month</strong></td>
</tr>
<tr>
<td><strong>Delayed Transfers of Care - average % of patients with delayed transfer in month</strong></td>
</tr>
<tr>
<td><strong>Did Not Attends (DNAs) % of appointments</strong></td>
</tr>
<tr>
<td><strong>Length of Stay &gt; 21 days (proportion of patients discharged)</strong></td>
</tr>
</tbody>
</table>

- **Trust became field test pilot site on 23rd May with revised Urgent and Emergency Care standards in place**
- **Zero tolerance communicated**
- **Covid-19 pandemic forced cancellation of significant volumes of activity**
- **Significant increase in proportion of non-face-to-face appointments due to Covid-19 pandemic**
- **Trust became field test pilot site on 23rd May with revised Urgent and Emergency Care standards in place**
- **Zero tolerance communicated**
- **Covid-19 pandemic forced cancellation of significant volumes of activity**
- **Significant increase in proportion of non-face-to-face appointments due to Covid-19 pandemic**
Trust Integrated Performance Dashboard - SPC Charts - Operational Performance (2)

Cancer 2 week wait standard

Cancer 2 week wait breast symptoms standard

Cancer 62 day first treatment standard

Diagnostics - % of breaches over 6 weeks (DM01)

Covid-19 pandemic forced cancellation of significant volumes of activity
Trust Integrated Performance Dashboard - SPC Charts - Quality (1)

**Standardised Hospital Mortality Indicator (SHMI)**

**Hospital Standardised Mortality Ratio (HSMR)**

**Crude Mortality (number of deaths)**

Covid-19 pandemic peaked in Rotherham in April, leading to higher numbers of deaths than otherwise expected.

**Incidents (severe or above)**
Covid-19 pandemic has meant the closure of a number of beds and significantly lower bed occupancy figures, meaning nurse:patient ratios have improved.
Covid-19 pandemic has introduced significant additional short-term (self-isolation) and long-term (shielding) sickness.

Aspirant nurses working at the Trust as part of Covid-19 response included in Trust overall workforce figures.

Decision made to stop face-to-face MAST training and relax expectations for clinicians directly involved in Covid-19 response for a short period.
Patient Feedback Tweets May/June

The Early pregnancy unit and the Chaplaincy team have been outstanding helping me and my husband through this difficult time. The care and compassion the staff gave us even with the restrictions due to covid-19, I couldn't have asked for anything more. thank you so much x

Absolutely amazing staff, I cannot thank the labour ward enough for the delivery of our beautiful little girl, you are all amazing and wonderful at what you do. Thank you all very much

I lost my dad last week to covid19 myself and 2 family members were also tested positive 3 out of the 4 required hospital admission I can’t fault the care my family member who died received from the staff on B5 and the doctor looking after them who rang me at home to discuss the situation the staff are doing a fantastic job in a difficult situation as a member of staff at The Rotherham Nhs Foundation Trust Community Nursing service I am proud to be a staff member

my uncle as passed due to contracting covid on your ward when he was initially admitted with tachycardia he was placed on covid ward where patients was government letter and you put him at risk. He lost his life not long after. His wife is now showing symptoms of covid and you are refusing to test just she as been in contact with someone who tested positive!

Over the last few week my dad has been really poorly I just want to say a massive thank you to a very special lady for everything you have done for my dad you’ve gone above and beyond for him especially at a time like this putting yourself in danger to save others, not only for my dad but thank you for been out there on the frontline THANKYOU

After being in rotherham hospital for nearly 2 weeks my son has bravely fought covid19 thanks to him for fighting this awful virus and thanks to the excellent care he has received from the doctors and nurses on ward A2 and A5 his only complaint was some of the food welcome home mark at least a bit of good news we have had over the last 3 weeks
**Escalation/Assurance Report**

**Metric Requiring Improvement:**
- **Type of Standard:** National Benchmark
- **Assurance Committee:** Quality
- **Latest Data Period:** March 2020

**Mortality index - HSMR (Rolling 12 months)**

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<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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**Target**
- 2019/20: 100
- 2020/21: 100

**Performance:**

**Driver for Underperformance:**
- **Counting:** The Trust has not historically recorded ‘observations’ from A&E (where patients are assessed and treated in an assessment area such as AMU) as non-elective admitted activity. As such, none of these patients count within the Hospital Standardised Mortality Ratio calculation. This is in contrast to most other trusts, where similar patients would be counted within their non-elective admissions figures. This negatively impacts our HSMR all year, with estimates suggesting it could have an 8-12 point impact on our HSMR (full-year impact).

- **Clinical Care:** The Trust continues to outlie in a few specific groups, where deaths are significantly higher than expected. These are being investigated with support from Dr Foster.

**Actions to Deliver Improvement:**
- From 1st April, Inpatient Observation activity is flowing to the activity submission as non-elective admitted activity. This will have a gradual impact from review of the April data onwards, but given the timelag for receipt of data and the required cumulative impact of the change, this is unlikely to be noticeable for a few months.

- The Executive Medical Director is developing more intelligence around Mortality than the Trust has had previously, in order to inform clinical service planning across the organisation.

- The recently-appointed Medical Examiner (ME) is reviewing all deaths with a Stage 1 review, and co-ordinating any Stage 2 reviews which are required. Furthermore, the Executive Medical Director is working with the ME to increase the number of MEs and ME officers with a view to the provision of a 7-day service, and on strengthening the Trust’s Learning from Deaths resource via Clinical Effectiveness.

**Expected Trajectory/forecast:**
- The Improvement Plan target is for an HSMR of less than 110 by the time of the March data 2021. Whilst this is an ambitious target without being able to compute the exact impact of the switch to observations being recorded as non-elective admissions, at this stage there is confidence that this target is deliverable. However, even in achieving this significant reduction, there is unlikely to be noticeable movement on the HSMR until Q3 of 2019/20

**Lead Executive Director:**
Callum Gardner, Executive Medical Director

**Lead Senior Manager:**
Carrie Kelly, Medical Examiner

**Lead Analyst:**
Lisa Fox
**Escalation/Assurance**

<table>
<thead>
<tr>
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<th>Report Period:</th>
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<tr>
<td>Referral to Treatment (RTT) Performance</td>
<td>National Constitutional Standard</td>
<td>FPC</td>
<td>May 2020</td>
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### Performance:

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Target: 92%, 92%, 92%, 92%, 92%, 92%, 92%, 92%, 92%, 92%, 92%, 92%

### Driver for Underperformance:

- **National Covid-19 guidelines:** National and Royal College guidelines have necessitated the cancellation of significant amounts of activity since the Covid-19 pandemic began. This includes a significant reduction in diagnostic activity.

- **Social distancing and IPC requirements:** Due to social distancing and IPC requirements, face-to-face capacity in outpatient clinics has been significantly reduced. Whilst many outpatient appointments can take place virtually, this is much more difficult in surgical specialties.

- **Staff sickness:** In some specialties where staff sickness has led to the cancellation of activity. In smaller specialties in particular, this remains an ongoing challenge.

- **Patient Choice:** Since the Covid-19 pandemic started, some patients have chosen not to come to hospital for any appointments or tests. Even if they are declining these for the foreseeable future, we are not able to remove them from our waiting lists under current guidelines.

### Actions to Deliver Improvement:

- **Increase in elective activity at the Trust:** As Royal College and National guidelines change, we are gradually increasing our activity levels on site in a safe and appropriate way.

- **Reconfiguration of Clinics:** The Outpatient department has a carefully marked waiting area outside, and arrival and departure times for patient appointments are being staggered. Alternative rooms are being utilised on site wherever possible. Rooms have had additional air extraction capacity added where possible (work ongoing).

- **Use of the Independent Sector:** The Trust has been making use of the Independent Sector in Rotherham for several weeks now, under the terms of the national contract. From late June, the Trust is also using the two main Independent Sector providers in Sheffield.

- **Locum consultants:** For critical specialties, where substantive staff are going to be off sick for lengthy periods of time, the Trust has established contracts with locum consultants.

### Expected Trajectory/Forecast:

RTT performance is likely to continue to deteriorate for the next quarter as referral volumes pick up and the Trust continues to have limitations on its capacity. A year-end forecast of 75% has been set at this stage, although this is not built on a detailed bottom-up demand and capacity model at this stage, given the number of unknown assumptions required for such an exercise. This will be reviewed on a monthly basis, and as national guidelines change, this will be factored in as services establish the impact on our capacity.

---

**Lead Executive Director:**
George Briggs, Chief Operating Officer

**Lead Senior Manager:**
Louise Tuckett, Director of Strategy, Planning & Performance

**Lead Analyst:**
Ruth Gallagher
**Escalation/Assurance**

<table>
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**Performance:**

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**Driver for Underperformance:**

The Trust has historically struggled to recruit sufficient numbers of nursing staff, with a mean vacancy rate of over 10% over the last 2 years. This is despite extensive efforts to secure staff from abroad, including a recruitment and interview campaign in January focussing on nurses from India. This is a critical priority for the Trust this year. Note that the data above does not include newly-qualified nurses and midwives awaiting pin numbers, nor Aspirant Nurses. If these staff are included in the figures, the true vacancy rate reduces to 5.5%, which is below the acute trust average in the North East & Yorkshire region (Q4 2019/20).

**Actions to Deliver Improvement:**

- **Aspirant Nurses:** We currently have over 40 Aspirant Nurses working within the Trust, as part of the NHS response to Covid-19. The Trust is putting significant resource into ensuring these nurses have a positive experience with us, and are able to gain a permanent position when they qualify.

- **Ongoing Recruitment:** We continue to advertise for and recruit to nursing positions, with 39 of our Aspirant Nurses accepting a post at the Trust from September 2020 (when they qualify). In addition, we have secured a flight for 7 of the 20 nurses from India who we have recruited, so they will be starting at the Trust at the end of July, after a period of self-isolation.

- **Nurses Returning to Practice:** 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 Computer Based Test (CBT) and Objective Structured Clinical Examination (OSCE) in order to re-register with the Nursing and Midwifery Council (NMC). Recruitment are prioritising the pre-employment checks of those on the temporary NMC register. Three have been successful from a second cohort interviewed on 20 May. Further interviews are planned for 24 June.

**Expected Trajectory/forecast:**

The trajectory for this metric this year is partly dependent on ensuring the Aspirant Nurses who have accepted a position at the Trust from September do take this up, as well as our ability to bring a further 13 nurses from India to start work at the Trust in September or October. At this stage, if all of these individuals were to take up a permanent position and we successfully added the additional 13 nurses from India to our substantive workforce, we should meet the target of 7.4% at the end of the year, and ensure a more stable and substantive workforce for next year.

**Lead Executive Director:**

Angela Wood, Chief Nurse

**Lead Senior Manager:**

Helen Dobson, Deputy Chief Nurse

**Lead Analyst:**

Danielle Hardy
### Escalation/Accurance

<table>
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<td>0.03%</td>
<td>0.12%</td>
<td>0.02%</td>
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#### Target:

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- 1%

#### Driver for Underperformance:

- Covid-19 has led to a significant reduction in diagnostic capacity, for similar reasons to those described in the 18 Weeks Referral to Treatment escalation report. PPE and necessary infection control for COVID have reduced capacity by 25-50% dependent on the examination being carried out. In addition, if a patient is intubated, the air filtration is not of a high enough standard in the CT scanners so the room has to be left for 3 hours in-between appointments which significantly impacts on our capacity. 3 CT staff are shielding, which has reduced opportunities for extended days or additional weekend activity.

- Endoscopy activity had to be reduced to life and limb only for several weeks given national and British Society guidance. This has now changed and activity is ramping up; however, due to social distancing guidelines and physical capacity constraints, we are only able to use 3 out of our 5 possible endoscopy rooms at present.

#### Actions to Deliver Improvement:

- **Mobile MRI**: We have been given a mobile MRI scanner on site at RCHC by mid July, 6 times a month. The hope is that we will be able to increase this, dependent on available funding. This will only be able to do certain procedures but will still make some inroads into reducing the backlog.

- **Temporary CT**: The Trust is expecting delivery of a portable CT scanner, to be located on site, within the next 6 weeks. This will be staffed utilising locums and will be in operation 5 days a week.

- **Independent Sector**: The Trust plans to send up to 10 CT patients a day and 10 MRIs a day to Claremont Hospital in Sheffield (Independent Sector). At least one all-day endoscopy list a week is currently being carried out in the Independent Sector as well. A significant proportion of our colposcopy and hysteroscopy activity is taking place at Kinvara Hospital in Rotherham, and the colposcopy backlog has now been cleared.

- **Shift Patterns**: Shift patterns are being amended to ensure we are utilising all of our staff as effectively as possible, including when staff sickness occurs due to Covid-19.

#### Expected Trajectory/forecast:

- The Ultrasound backlog is expected to be cleared by the end of August (currently at over 1,300 patients). Until the CT and MRI temporary/mobile scanners are in place, we cannot yet be confident of a recovery trajectory for these diagnostic tests. However, there are currently over 750 patients awaiting MRI, 1,000 awaiting CT, and approximately 1,000 awaiting endoscopy, which, given the significant infection prevention and control measures that need to be in place for these specific tests and procedures, the recovery period is expected to extend beyond Q2.

- Currently, the Trust is predicting to be meeting the DM01 standard within the year-end forecast. Once we have the two mobile units on site, and have delivered a number of diagnostic procedures in the Sheffield Independent Sector hospitals, we will be able to produce a more detailed test-level forecast.

---

**Lead Executive Director**: George Briggs, Chief Operating Officer  
**Lead Senior Manager**: Lisa Hickling, Service Manager, Imaging Services  
**Lead Analyst**: Catherine Dixon
The below summary sets out the proposed methodology and colouring we will use at TRFT, noting the different trends that will be shown as special cause variation or out of control.

We will use the following colours to indicate variation:
- **orange** indicates special cause variation of concern and needing action
- **blue** indicates special cause variation where improvement appears to lie
- **grey data** indicates no significant variation
- **red** indicates where the process is out of control (outside control limits)

We will follow the NHS guidance and identify 4 different ways in which a trend will be defined as special cause variation:

1) A single point outside the control limits

![Graph](image1)

2) A run of at least 6 points above or below the mean line

![Graph](image2)

3) Six consecutive points increasing or decreasing

![Graph](image3)

4) A pattern of 2 out of 3 points within the outer thirds

![Graph](image4)

Other SPC methodologies classify a further 4 trends as special cause variation, but these will not be identified by colour coding within our SPC charts, for ease:

5) 14 consecutive points alternating up and down
6) 15 consecutive points in the central third
7) 8 consecutive points with none in the central third
8) 4 out of 5 consecutive points in the middle third

In addition, we will annotate any reasons for special cause variation which we are aware of.
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<th>Agenda item</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Quality Report</td>
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| 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. |
| Appendices | 1. Hospital Acquired Infections  
2. Infection Prevention & Control (IPC) Board Assurance Framework  
3. Nurse Staffing Information |
1.0 Patient Safety

1.1 Harm Free Care – There has been no further update received regarding the replacement national system for monitoring patient safety.

1.2 Hospital Acquired Infection - There have been 3 cases of Clostridium difficile to date for 2020/21, the trajectory has not yet been received. There have been zero cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia to date in 2020/21, and although not formally received, the trajectory will remain as zero. There has been 1 case of E.coli bacteraemia to date for 2020/21, a trajectory was anticipated but has not yet been received. Due to the COVID-19 pandemic and changes in health care provision comparison of data with previous years needs to be viewed with caution.

COVID-19 management is in progress. See appendix 1 for further details. The Trust have received and have completed an NHSI/E Infection Prevention and Control (IPC) Board Assurance Framework (Appendix 2). The framework identifies the practice that should be undertaken by the organisation in relation to the management of Covid 19. It identifies any gaps in assurance with mitigated actions taken. The robust processes and good practice in place across the Trust are identified within the assessment.

1.3 Looked After Children (LAC) - The percentage of Initial Health Assessments (IHA) completed within the statutory 20 working day timeframe was 90% for May 2020. During the month, 20 IHAs required completion, of which 18 were within timescale. Both patients who received assessment outside the 20-day timeframe were due to patient choice. Assessments are currently being undertaken virtually rather than face to face.

1.4 Mortality – The Hospital Standardised Mortality Ratio (HSMR) currently sits at 116 and the Summary Hospital-level Mortality Indicator (SHMI) at 119. These continue to be statistically significantly higher than expected, but on a downward trend. Issues related to quality of care and coding are being considered in detail and reported by the Medical Examiner in conjunction with the detailed mortality report provided by Dr Foster to provide further insight into the themes and trends affecting our data. The Medical Examiner service is currently challenged due to COVID-19 and staff sickness, but the Medical Director is actively trying to expand the number of Medical Examiners and Medical Examiner Officers in post to improve resilience.

2.0 Patient Experience

2.1 Complaints - The Trust received 83 concerns (57 in April) and 6 formal complaints (3 in April) in the month of May. 15 complaints were closed. No local resolutions meetings were held due to social distancing restrictions. Complaints responded to within the agreed timescale were 20% (79% in April). It should be noted that this significant reduction in the key performance indicator was due to closure of the backlog of overdue complaints within the Division of Urgent and Emergency Care. It is therefore anticipated that this metric will improve next month and be maintained. There were 5 complaints re-opened in May, making the total currently being re-investigated 18.

2.2 Friends and Family Test (FFT) – No further information has been provided about the national recommencement of data collection. Communications have been shared throughout the Trust to encourage colleagues to seek feedback from service users through alternative processes.

3.0 Clinical Effectiveness

3.1 Nurse Staffing – In response to the COVID-19 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 safest nurse staffing levels are being maintained are shown in appendix 3.

3.2 CQUIN’s - NHS England and NHS Improvement have confirmed that the 2020/21 Commissioning for quality and innovation (CQUIN) (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 Care Quality Commission (CQC) - A range of activities continued throughout May in preparation for the 2020 CQC inspection, focussing on completion of action plans. Preparations for inspection later in the year continues where appropriate although no confirmation of a restart for inspections has yet been received. It is recognised that some previously completed actions such as mandatory training levels may fall off track due to current pressures but this is being closely monitored to mitigate against adverse consequences.

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 actions are undertaken to resume previously affected services. This includes ensuring that newly identified ways of working as well as recommencement of paused processes ensure high quality care as a fundamental expectation.

Angela Wood    Dr Callum Gardner
Chief Nurse     Medical Director
June 2020
Appendix 1

**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 3 cases to date.

- The 2020/21 TRFT trajectory for Methicillin-resistant Staphylococcus aureus (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 Clinical Commissioning Group’s (CCG’s) only. There have been 1 case to date.

- There have been 2 cases of Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia to date with no trajectory set.

- Influenza: Monitoring for 2019/20 ceased in May. Planning is commencing for the 2020/21 season.

- COVID-19: Phase 2: The Trust continues to work on the management of and first phase of recovery from COVID-19 coronavirus. To date there have been 519 in-patients with a positive result of which 320 have been discharged and sadly 176 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.

Test and Trace by Public Health England (PHE) has commenced across England, this initiative is to rapidly identify contacts of confirmed cases who are then required to self-isolate. Tracing of any staff to staff exposure is being carried out by the Infection Prevention and Control Nurses.

Antibody testing has commenced for Trust staff with increased testing per week based on laboratory capacity. The test will show if someone has had infection not that someone is currently infected and it is not known how long antibodies may last and if they give any immunity against further COVID-19 infection. There is no change to the advice that staff need to follow when they are informed of the result of antibody test, the testing is supporting the research into the virus.

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 availability of Personal Protective Equipment (PPE) has improved and continues 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. The PPE stream continue to meet via teams on a weekly basis as part of the recovery plan.
Following the announcement that all NHS staff must wear surgical face masks (as a minimum) whilst working in any area by 15 June the Trust have launched this in advance of the required date to help further protect our staff whilst working.

The Trust is now preparing for a return to urgent elective procedures where possible and a temporary drive up swabbing area for patients has been started next to day surgery. A group has been convened to look at all options for testing for staff and patient groups as part of the separate streams for recovery.
Infection prevention and control board assurance framework

The Rotherham NHS Foundation Trust
26\textsuperscript{th} June 2020
### Key lines of enquiry

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.

#### Systems and processes are in place to ensure:

- Infection risk is assessed at the front door and this is documented in patient notes.
- Patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission.
- Compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients.
- Patients and staff are protected with PPE, as per the PHE national guidance.
- National IPC PHE guidance is regularly checked for updates and any changes are available on Winpath and ICE.
- Discharge to alternate care providers, emails between the Integrated Discharge Team, Care Homes Team, Community lead Clinician and the IPCN team with results.
- Daily sit rep of PPE. Records of Silver and Gold meetings. PPE operational group.
- Emails: The assistant DIPC and Lead Nurse both receive automated PHE guidance emails. Any changes are identified and acted upon. Communications to all email users.

<table>
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<tr>
<th>Key lines of enquiry</th>
<th>Evidence</th>
<th>Gaps in Assurance</th>
<th>Mitigating Actions</th>
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<tr>
<td>Systems and processes</td>
<td>Available on Winpath and ICE. IPCN maps of amber and red wards and cubicle lists held on the IPC team shared drive.</td>
<td></td>
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<tr>
<td>to ensure:</td>
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<tr>
<td>• Infection risk is assessed at the front door and this is documented in patient notes.</td>
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<tr>
<td>• Patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission.</td>
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<tr>
<td>• Compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients.</td>
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<tr>
<td>• Patients and staff are protected with PPE, as per the PHE national guidance.</td>
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<tr>
<td>• National IPC PHE guidance is regularly checked for updates and any changes are available on Winpath and ICE.</td>
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effectively communicated to staff in a timely way

- changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted
- risks are reflected in risk registers and the Board Assurance Framework where appropriate
- robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens

<table>
<thead>
<tr>
<th>Key lines of enquiry</th>
<th>Evidence</th>
<th>Gaps in Assurance</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems and processes are in place to ensure:</td>
<td>Re-configuration of clinical and ward areas to enable segregation of green/amber/red patients as documented in action logs Silver and Gold Communications and briefing emails.</td>
<td></td>
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<tr>
<td>- teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas</td>
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</table>

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

- TB Updates
- Covid Risk Register
- COVID control room emails.
- Gold and Silver action plans.
- Covid Risk Register
- QAC minutes, CGC minutes, Board of Director minutes.
- CCG Support
- Gold and Silver meeting logs
- QAC minutes
- CGC minutes
- designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.

| Isolation cleaning team for terminal cleaning. Ward and department teams for ward areas, domestic team training records. Face fit testing records held by the H&S lead. Local departmental clinical teams training on disinfectant preparation and use. |  |  |
- decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance

- increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance

- attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas

- cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is appropriate environmental decontamination against coronavirus’s. Alcohol hard surface wipes are used as disinfectant with contact time required specified by the manufacturer.

Emails between the Head of Facilities Services and relevant colleagues. (e.g. Fitzwilliam and Stroke Unit)

These areas are part of frequent cleaning and we also use Hydrogen Peroxide Vapour (HPV) via a managed service with engineers accessing shared areas as often as capacity allows.

The Trust uses Tristel fuse which is appropriate environmental decontamination against coronavirus’s.

Protocols are in place to ensure manufacturers guidance is followed
effective against enveloped viruses

- manufacturers’ guidance and recommended product ‘contact time’ must be followed for all cleaning/disinfectant solutions/products

- as per national guidance:
  - ‘frequently touched’ surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids
  - electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily
  - rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)

with regards to contact time for all products used

These areas have had additional cleaning since the beginning of the pandemic reaching the UK under the Head of Facilities services. Direction has been given to domestic staff and increase in staffing has been identified and deployed to support clinical areas

All staff are advised to decontaminate all frequently touched items of equipment, this includes cleaning of each item after patient contact e.g phone, tablets.

There is not a set time for doffing, this is a staggered procedure based on giving staff time to doff safely and on personal requirement to have break times etc.

Communications and emails between the Head of Facilities Services and Linen hire contract company.
- Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken.

- Single use items are used where possible and according to Single Use Policy.

- Reusable equipment is appropriately decontaminated in line with local and PHE national policy.

- Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission.

| Single Use Policy and practice continues with no deviation, Communications across the organisation regarding single use items undertaken. Instructions regarding visor decontamination. Standing Sterile Services policies. |
| Natural ventilation is encouraged where possible and where weather conditions allow but also bearing in mind heatwave guidance. |
### 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

<table>
<thead>
<tr>
<th>Key lines of enquiry</th>
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<th>Mitigating Actions</th>
</tr>
</thead>
</table>
| Systems and process are in place to ensure:  
  - arrangements around antimicrobial stewardship are maintained  
  - mandatory reporting requirements are adhered to and boards continue to maintain oversight | Consultant Microbiologist completes ward rounds in critical care and liaises with the Haematology consultants on a daily basis.  
  e-prescribing continued.  
  Existing antimicrobial stewardship principles and practice are continuing as prior to COVID.  
  Policy: Antimicrobial policy is available and includes a restricted list which hasn’t changed. Existing policies surrounding HAP/CAP etc are unchanged. [http://www.therotherhamftformulary.nhs.uk/chaptersSub.asp?FormularySectionID=5](http://www.therotherhamftformulary.nhs.uk/chaptersSub.asp?FormularySectionID=5)  
  Micro guide app has been purchased to improve access to the policy and work inputting data into this is going on during COVID.  
  Meetings: Antimicrobial stewardship group | Some policies need updating | Policies are now being reviewed by colleagues who are shielding. |
meetings are taking place via MS teams where possible, although no meeting took place in March or April due to workload and availability of staff. Antimicrobial Pharmacist has weekly MS teams meetings with regional colleagues to share information and experience on working in the current environment. Minutes for May meeting is awaited

Surveillance/Advice
Rx define and Refine is still being used for surveillance purposes. See minutes of May ASG meeting
The EPMA team are looking at a tab within sepia to allow for real time information on all patients on antimicrobials to improve surveillance and allow virtual ward rounds.

Pharmacists still have a presence on wards whether physically or virtually using EPMA to screen prescriptions, be able for advice and challenge inappropriate use of antimicrobials. The antimicrobial pharmacist is still available for advice via teams message/phone call or email despite remote working.
Microbiology are still available for advice.

Antimicrobial stewardship team is small in numbers therefore vulnerable if sickness takes place within the team

Audit work
Some of the team are working from home

Complexity of completing using EPMA system and the workload of pharmacy to collect this data. We are looking at an automatic system to assist with this but this is not available yet. Usage is being reviewed via Rx define and pharmacy colleagues are challenging inappropriate
prescriptions. Sepia and EPMA work is being developed to assist with review of antimicrobials and allow a virtual ward round to take place from microbiology/pharmacy if time allows.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

<table>
<thead>
<tr>
<th>Key lines of enquiry</th>
<th>Evidence</th>
<th>Gaps in Assurance</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems and processes are in place to ensure:</td>
<td>Communications shared widely via letters, social media, local newspapers, website. Notices on all entrances to the buildings. IPC notices and boards provided to all relevant areas. Restricted access to all buildings.</td>
<td>Internet IPC page to be updated in line with changes and communications.</td>
<td>Trust Internet Hub has all up to date information and communication relating to Covid 19. Trust IPC pages are up to date with information and guidance relating to non Covid 19 issues.</td>
</tr>
<tr>
<td>• implementation of national guidance on visiting patients in a care setting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and</td>
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</table>
where appropriate with restricted access

- information and guidance on COVID-19 is available on all Trust websites with easy read versions
- infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved

<table>
<thead>
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<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems and processes are in place to ensure:</td>
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</tr>
<tr>
<td>- front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection</td>
<td>Gold and Silver documentation/Action logs. Flow chart identifying triage and cohorting Executive Team Minutes</td>
<td></td>
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<tr>
<td>- patients with suspected COVID-19 are tested promptly</td>
<td>Algorithm by Dr Jha. Gold and Silver documentation/Action Logs Executive Team Minutes</td>
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</tbody>
</table>
- patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested
- patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately

<table>
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<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems and processes are in place to ensure:</td>
<td>Links to PHE videos and guidance shared via communications. Paper copies distributed to wards PPE updates shared via Silver and Comms. Video explaining to staff from Chief Nurse</td>
<td>Insufficient availability nationally of PPE to train everyone in donning and doffing practice.</td>
<td>Local videos and printed photographs distributed to support verbal information from champions and senior colleagues. Observation by experienced colleagues of new staff undertaking to ensure appropriate use.</td>
</tr>
<tr>
<td>- all staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe</td>
<td>Observational training of donning and doffing provided by Anaesthetists to critical care teams. Video made by Microbiologist to demonstrate donning and doffing with initial available PPE and shared via comms and on the HUB. PPE champions lead role commenced May 2020 to support areas further.</td>
<td></td>
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<tr>
<td>- all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it</td>
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</table>

Algorithm by Dr Jha. Gold and Silver documentation/Action Logs Executive Team Minutes

Screening questions pre-attendance and on arrival. No incidence of this reported to date (29/06/2020)
- A record of staff training is maintained
- Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed
- Any incidents relating to the re-use of PPE are monitored and appropriate action taken
- Adherence to PHE national guidance on the use of PPE is regularly audited
- Staff regularly undertake hand hygiene and observe standard infection control precautions
- Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff training</td>
<td>No records currently available</td>
<td>Donning and doffing training has not been recorded.</td>
</tr>
<tr>
<td>PPE reuse</td>
<td>Single use PPE has not been re-used in the Trust – clearly identified via Communications this is not to occur</td>
<td>We are not formally auditing across the whole Trust</td>
</tr>
<tr>
<td>PPE audit</td>
<td>Audit of Medical wards commenced in May 2020 by the divisions Matrons. PPE champion lead role commenced, information shared with clinical areas.</td>
<td>Audit programme will commence in July 2020</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>Use of PPE demonstrates increase in precautions being followed. Supplies of alcohol hand rub used. Where hand hygiene champions are within date of training they can continue to complete MAST with colleagues but without using the UV light “Glow and Tell”.</td>
<td>Unable to quantify levels of use of alcohol hand rub or had wash due to stock being pushed not pulled and various supplies being received via supply chain as well as donations from company’s and schools.</td>
</tr>
<tr>
<td>Hand dryers</td>
<td>The only electric hand dryers are in the public toilets and there have been visitor restrictions in place so access to any dryers is minimal. Additional paper</td>
<td>A laptop is on order to enable a shielded member of the IPC team to work from home to be able to deliver Microsoft Teams training remotely.</td>
</tr>
</tbody>
</table>
dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance

- guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas
- staff understand the requirements for uniform laundering where this is not provided for on site
- all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms.

Communications have included in these areas.

Communications available in all areas
Communications circulated widely regarding handwashing and drying.

Communications via email and via teams cascade
Silver and Gold Minutes
Chief Nurse Video

Communications circulated widely.
Emails, screensavers, staff huddles
High volume calls recorded via the staff Covid help line. Number of staff and family members swabbed held by IPCNs.
### 7. Provide or secure adequate isolation facilities

<table>
<thead>
<tr>
<th>Key lines of enquiry</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Systems and processes are in place to ensure:</td>
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</tr>
<tr>
<td>- patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate</td>
<td>Gold and Silver documentation. Ward isolation maps on IPCN drive. Site management team coloured bed availability lists. Dedicated ward areas Cubicle management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance</td>
<td>Tristel fuse in use in all in-patients areas and departments. Alcohol hard surface wipes in use in the community.</td>
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<tr>
<td>- patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement</td>
<td>Continue to be isolated in single rooms where appropriate.</td>
<td>New critical care capacity surge area has no single rooms.</td>
<td>Patients cared for in individual bays where resistant alert identified in the critical care surge area</td>
</tr>
</tbody>
</table>

### 8. Secure adequate access to laboratory support as appropriate

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<tr>
<th>Key lines of enquiry</th>
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<th>Gaps in Assurance</th>
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</thead>
</table>
There are systems and processes in place to ensure:

- testing is undertaken by competent and trained individuals
- patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance
- screening for other potential infections takes place

Demonstration to each new swabbing team staff member by staff already doing swabbing. OSCE written by the H@N lead nurse. Communications on appropriate bagging and sending of samples to the lab. Pictorial guide provided to areas and teams commencing swabbing.

Monitoring for IPC alerts maintained by IPCNs, lists held on IPC drive.

9. Have and adhere to policies designed for the individual’s care and provider organisations that will help to prevent and control infections

<table>
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<tr>
<th>Key lines of enquiry</th>
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</thead>
<tbody>
<tr>
<td>Systems and processes are in place to ensure that:</td>
<td>Alert organism flags monitored by IPCNs on a daily basis to ensure patients are appropriately screened, isolated, treated. IPC drive.</td>
<td>Communications. Silver and Gold minutes Updating policy and guidelines</td>
<td>Trust waste manager records and emails.</td>
</tr>
</tbody>
</table>

- staff are supported in adhering to all IPC policies, including those for other alert organisms
- any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff
- all clinical waste related to confirmed or suspected
COVID-19 cases is handled, stored and managed in accordance with current PHE [national guidance](#).

- PPE stock is appropriately stored and accessible to staff who require it

Communications sent out to all areas. Change of working hours to provide 7 day stores cover. Stock dashboard in place. PPE Meeting

### 10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

<table>
<thead>
<tr>
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<th>Gaps in Assurance</th>
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</thead>
<tbody>
<tr>
<td>Appropriate systems and processes are in place to ensure:</td>
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<tr>
<td>- staff in ‘at-risk’ groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported</td>
<td>HR systems recording those that are shielding. Communications sent advising staff of access to support systems.</td>
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<tr>
<td>- staff required to wear FFP reusable respirators undergo training that is compliant with PHE <a href="#">national guidance</a> and a record of this training is maintained</td>
<td>Records held by the H&amp;S lead.</td>
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<tr>
<td>- consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between</td>
<td></td>
<td>This is followed where possible but has restrictions when staff are unwell at short notice and safe staffing levels have to be met. Where indicated staff will change uniform/scrubs between different areas of care.</td>
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<tr>
<td>planned and elective care pathways and urgent and emergency care pathways, as per national guidance</td>
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<tr>
<td>• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas</td>
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<tr>
<td>• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas</td>
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<tr>
<td>• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing</td>
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<tr>
<th>Wearing of surgical masks for all clinical areas commenced 28th March above national guidance</th>
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<tbody>
<tr>
<td>Wearing of surgical masks for all staff commenced 8th June in advance of the national guidance of 15th June. All staff are required to socially distance wherever possible and MUST do so at break times when masks are removed for eating and drinking.</td>
</tr>
<tr>
<td>This is being followed in all areas and communications have been circulated with this advice. Matrons and Heads of Nursing reviewed all areas to identify appropriate break areas and timing of breaks</td>
</tr>
</tbody>
</table>

| HR records. Manager support and communication COVID staff help-line Staff drive through testing area. Positive results phoned by IPCNs with advice provided. Negative results phoned by Senior nurse in the help line area. |
- Staff that test positive have adequate information and support to aid their recovery and return to work.

<table>
<thead>
<tr>
<th>Manager support and communication</th>
<th>COVID staff help-line</th>
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<tbody>
<tr>
<td>IPC contact</td>
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</table>
Nurse Staffing

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

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 May the CHpPD for Registered staff was 5.75 and 4.35 for non-registered staff, resulting in an overall reduced actual CHpPD of 10.1.

The principle of ensuring the safest staffing has been considered and aligned to operational planning processes so that care can be provided during the pandemic. Nurse staffing has been temporarily increased in some wards and departments to safely manage the increase in acuity and patient numbers in those areas. Colleagues have been redeployed from temporarily closed wards to support those with increased acuity and/or capacity.

Critical care remains in the temporary location of wards A3 & A4 with an increased number of ventilators, in anticipation of potentially increased demand. Consequently planned staffing has temporarily increased to support this. Wards have been flexed to care for patients that are COVID-19 positive, negative or awaiting results depending upon requirements.

Adaptations to skill mix have been considered and implemented during this period. The Staffing Hub was established to manage the movement of staff to support the wards throughout the period of the pandemic and has enabled a Care Assistant role to be created to provide additional presence in clinical areas. The Staffing Hub has supported the redeployment of both Registered Nurses and Support Workers to patient facing clinical roles following refresher training although many of these colleagues have now returned to their substantive roles following the gradual reopening of substantive services.

Forty four 3rd year student nurses opted-in to move into clinical practice at the Trust and are currently moving into their third month in these roles. Likewise, forty one 2nd year adult student nurses opted-in to undertake a 9 week paid placement at the Trust. A rotational placement has been implemented for the majority of these students. This will broaden their experience, whilst providing additional support to key teams such as Safeguarding, Patient Experience and Discharge Co-ordination. Smaller numbers of 2nd and 3rd year 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, the majority of whom are within the students on paid placement establishment.

International nurse recruitment was placed on hold due to the restrictions on travel during the pandemic. The Trust continues to liaise with NHS Professionals (NHSP) International and will resume the recruitment process as soon as possible. Currently it is hoped that this will occur during July although it is anticipated that a quarantine period will be required.

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 Computer Based Test (CBT) and Objective Structured Clinical Examination (OSCE) to re-register with the Nursing and Midwifery Council (NMC). 9 candidates have accepted posts at TRFT from the first cohort. Recruitment are prioritising the pre-employment
checks of those on the temporary NMC register. Three have been successful from a second cohort interviewed on 20 May. Further interviews have taken place on 24 June.

In the Community there were 0 day shifts during May that were not staffed to plan, which is the same position as compared to last month. There were 12 nights shifts staffed below plan which equates to 19.4% of District Nursing night shifts being below plan, which is an improved position as compared to April 2020.

An appropriate escalation process remains in place for when staffing falls short of quality and safety outcomes. 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 commence roll out in July.
### Agenda item
228/20(b)

### Report
Operational Report

### Executive Lead
George Briggs, Chief Operating Officer

### Link with the BAF
B1, B2

### Purpose
<table>
<thead>
<tr>
<th>Decision</th>
<th>To note</th>
<th>Approval</th>
<th>For information</th>
</tr>
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<td>✓</td>
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</table>

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

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

It includes a summary of latest positions against:

- **Urgent & Emergency care standards**
  - Initial Assessment (Local agreed standard 15 minutes) 13 minutes last period similar to previous position
  - Time to be seen by a Clinician (Local agreed standard 60 minutes) 43 minutes last period
  - Mean time (National standard 200 minutes) 136 minutes has shown a marked improvement
  - Improved performance against 12 hour waits 0 patients in the last month

18 week Referal to Treatment (RTT) incomplete pathway – validated position for May 2020 is at 67.1% (77.1% April):

- **67.1% overall performance for incompletes**
- Total incomplete patient tracking list (PTL) size 12796 (14591 March, 12727 April)

Diagnostics Waiting Times (DMO1) – the validated position for DMO1 for May 2020 is 70.4%. 3367 breaches as can be seen this is across all specialties

National Cancer Standards un-validated Q1:

- 62 days 71.3% –against 85% target
- 2 week waits – 86.7% against 93% target
- 31 days 1st treatment is 99.1% against the 96% target
- Faster diagnosis standard 58.2% target not agreed but we believe 70%

### Recommendations
It is recommended that the Board note the information.

### Appendices
1. Operational Report
1.0 Introduction

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

The healthcare landscape in the UK continues to operate in a restricted 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 Commissioning Group teams is obviously that our performance will deteriorate significantly across all elective care standards given the response we’ve had to provide to Covid-19 patients.

1.2 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.

2.0 Operational Performance

2.1 The charts and graph shows attendances across the north have increased considerably in the last few weeks.

<table>
<thead>
<tr>
<th>Attends (all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Week</td>
</tr>
<tr>
<td>89632</td>
</tr>
</tbody>
</table>

2.2 Accident & Emergency attendance for North - all Trusts

<table>
<thead>
<tr>
<th>Proportion of Stranded Patients (21 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Week</td>
</tr>
<tr>
<td>13.82%</td>
</tr>
</tbody>
</table>

2.3 % of beds occupied by patients at 21 days or more (North Region)

The Rotherham NHS Foundation Trust 21day Occupancy as of week ending 4 June 202 is 5.12%
2.4 As can be seen all attendances are increasing in the North Region.

3.0 **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 has asked us to continue during the pandemic period.

Due to the reduction in attendances and release of capacity throughout the hospital, this has led to good flow out of the Emergency Department on a daily basis.

3.2 **May 2020**

<table>
<thead>
<tr>
<th></th>
<th>Rolling</th>
<th>Time to Initial Assessment (Mins)</th>
<th>Time to be seen by a Clinician (Mins)</th>
<th>Mean Total Wait (Mins)</th>
<th>12hrs in Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>15</td>
<td>60</td>
<td>200</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pre-Field Test (6weeks)</td>
<td>15</td>
<td>93</td>
<td>189</td>
<td>3 (per day)</td>
<td></td>
</tr>
<tr>
<td>Fri</td>
<td>22/05/2020</td>
<td>13</td>
<td>33</td>
<td>117</td>
<td>0</td>
</tr>
<tr>
<td>Sat</td>
<td>23/05/2020</td>
<td>14</td>
<td>54</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>Sun</td>
<td>24/05/2020</td>
<td>11</td>
<td>33</td>
<td>129</td>
<td>0</td>
</tr>
<tr>
<td>Mon</td>
<td>25/05/2020</td>
<td>10</td>
<td>43</td>
<td>125</td>
<td>0</td>
</tr>
<tr>
<td>Tue</td>
<td>26/05/2020</td>
<td>19</td>
<td>47</td>
<td>124</td>
<td>0</td>
</tr>
<tr>
<td>Wed</td>
<td>27/05/2020</td>
<td>13</td>
<td>56</td>
<td>151</td>
<td>0</td>
</tr>
<tr>
<td>Thu</td>
<td>28/05/2020</td>
<td>7</td>
<td>27</td>
<td>108</td>
<td>0</td>
</tr>
<tr>
<td><strong>Rolling 7 Days</strong></td>
<td><strong>13</strong></td>
<td><strong>43</strong></td>
<td><strong>136</strong></td>
<td><strong>0 (0 per day)</strong></td>
<td></td>
</tr>
<tr>
<td>Field Test Start to Date</td>
<td>16</td>
<td>96</td>
<td>217</td>
<td>6 (per day)</td>
<td></td>
</tr>
</tbody>
</table>
3.3 Initial assessment is showing continued improvement compared to previous reports and improvement in overall wait times in this period. The figures are considerably different than pre pandemic.

3.4 As can be seen, attendances have started to rise again as have ambulances and ambulance admissions.
4.0 Waiting List 18 Weeks RTT Incomplete

4.1 All services are breaching 18 weeks.

The number of 18-week long waiters has increased by more than 3,700 patients since the middle of March, with 26+ week waiters increasing by over 2,000 in that time.

Elective activity has had to be reduced significantly to manage Covid-19 demand and all current infection prevention and control measures.

4.2 Please find the Rotherham NHS Foundation Trust's position:

- 67.1% overall performance for incompletes (77.1% April)
- Total incomplete PTL size 12796 (12727 April)
<table>
<thead>
<tr>
<th>Trust Total</th>
<th>&lt;18Wks</th>
<th>18Wks+</th>
<th>% &lt;18Wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td>990</td>
<td>478</td>
<td>67.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>470</td>
<td>164</td>
<td>74.1%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>774</td>
<td>659</td>
<td>54.0%</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>616</td>
<td>587</td>
<td>51.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1083</td>
<td>633</td>
<td>63.1%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>24</td>
<td>38</td>
<td>38.7%</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>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>General Medicine</td>
<td>120</td>
<td>22</td>
<td>84.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>463</td>
<td>70</td>
<td>86.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>568</td>
<td>164</td>
<td>77.6%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>382</td>
<td>64</td>
<td>85.7%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>419</td>
<td>242</td>
<td>63.4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>295</td>
<td>48</td>
<td>86.0%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>121</td>
<td>19</td>
<td>86.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1001</td>
<td>427</td>
<td>70.1%</td>
</tr>
<tr>
<td>Other</td>
<td>1260</td>
<td>595</td>
<td>67.9%</td>
</tr>
<tr>
<td>Total</td>
<td>8586</td>
<td>4210</td>
<td>67.1%</td>
</tr>
</tbody>
</table>

5.0 Cancelled Operations

No elective operations were cancelled on the day in May, we only planned urgent and emergency patients with electives not commencing until June 2020.

6.0 Diagnostics

The validated position for DMO1 for May 2020 is 70.38% (73.6% April). 3367 (3636 April) breaches as can be seen this is across all specialties.

7.0 Cancer Performance

<table>
<thead>
<tr>
<th>Q1 2020/21 SUMMARY</th>
<th>Expected achievement (%) - includes treated and confirmed cancers with a planned treatment date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>APR 2020 Validation Provisional figures</td>
</tr>
<tr>
<td></td>
<td>Data capture 100% complete (estimate)</td>
</tr>
<tr>
<td>2ww</td>
<td>68.8</td>
</tr>
<tr>
<td>2ww Breast Symptoms</td>
<td>80.5</td>
</tr>
<tr>
<td>62 Day from GP</td>
<td>81.2</td>
</tr>
<tr>
<td>62 Day Consultant Upgrade</td>
<td>81.5</td>
</tr>
<tr>
<td>62 Day from Screening</td>
<td>85.7</td>
</tr>
<tr>
<td>31 Day First Treatment</td>
<td>100</td>
</tr>
</tbody>
</table>
7.1 April’s figures are now validated the main indicator of 62-day treatment shows 81.2% against the 85% target with as predicted a large drop in May and June (not validated). Other targets are showing a positive position but this is due to reduced numbers and limited referrals.

7.2 Numbers of patients on the waiting list over 62 days has increased which, once they are treated, will deteriorate our position further.

7.3 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. The process was implemented for all new referrals, although we are now restarting full assessments and diagnostics

7.4 We are now also restarting non-urgent diagnostics for cancer patients, in order to confirm the original clinical triage decision of low or medium risk, and also to ensure timely diagnosis for the emotional wellbeing of our patients.

8.0 Discharge Information

8.1 Covid-19 has led us to replace our ward-by-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 2 April 2020 we had 0 DTOCs, and they remained at 2 or below for the months of April and May.
8.2 Please see below the status update for 17th June 2020.

<table>
<thead>
<tr>
<th>Total Number of patients</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Internal Patients</td>
<td>20</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>Clifton</td>
<td>7</td>
</tr>
<tr>
<td>Athorpe</td>
<td>8</td>
</tr>
<tr>
<td>Ackroyd</td>
<td>10</td>
</tr>
<tr>
<td>IMC</td>
<td>10</td>
</tr>
<tr>
<td>Number of Definite Discharges</td>
<td>9</td>
</tr>
<tr>
<td>Number of Potential Discharges</td>
<td>7</td>
</tr>
</tbody>
</table>

8.3 We are no longer seeing DTOCs and medically fit patients have continued to be significantly lower than the 50-80 pre pandemic.

8.4 As a Trust, our focus is on implementing our ‘recovery’ plans, which need to involve an increase in our elective activity, to ensure we minimise the indirect impact of Covid-19 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
June 20
### Executive Lead
Steven Ned, Director of Workforce

### Purpose
- Turnover during May 2020 was 0.55% (99.45% retention) which is a 0.21% reduction against May 2019.
- The Trust’s sickness absence for May 2020 was 3.61% (excluding Covid-19 absence) which is a 0.52% improvement compared to April 2020.
- Sickness rate including Covid-19 is 6.46% May 2020, a decrease of 0.96% compared to previous month.
- The Trust’s core Mandatory and Statutory Training (MaST) compliance for May 2020 has decreased slightly to 90%.
- The 12 month rolling Personal Development Review (PDR) compliance is currently 72.07% against a 90% target.
- NHS Virtual Pride – Trust actively involved via social media and flying the flag for the first time. Close working with regional Equality and Diversity (EDI) network
- Three Trust Apprentices have won awards at Rotherham North Notts (RNN) College for their outstanding efforts.
- Black, Minority and Ethnic (BAME) risk assessments letters/emails were sent to every member of staff employed by the Trust who has identified themselves as BAME on our electronic staff record system highlighting the new risk assessment framework.

### 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 May 2020 was 0.55% (99.45% retention) which is a 0.21% reduction against May 2019.

1.2. Further analysis shows of the 27 leavers who left voluntarily in May 2020, 8 (6.73 Whole Time Equivalent (WTE)) had the leaving reason of 'Relocation' followed by 'Promotion' 5 (5 WTE).

1.3. Time to clear through the recruitment process in May is at 36 days, slightly above the target of 34. During May there were further groups of students and return to practice nurses moving through the recruitment process plus the impact of Covid-19 restrictions.

1.4. On 25 May the Trust welcomed 6 2nd year midwifery students with 9 3rd year midwifery students due to come on a placement on 22 June 2020.

2.0 Sickness Absence

2.1. The Trust’s sickness absence for May 2020 was 3.61% (excluding Covid-19 absence) which is a 0.52% improvement compared to April 2020.

2.2. Sickness rate including Covid-19 is 6.46% May 2020, a decrease of 0.96% compared to previous month. Medicine Division has seen the largest increase in sickness absence relating to Covid-19 (1.32%), compared to previous month.

2.3. The absence rate has decreased by 0.52% to 3.61% and has fallen below target by 0.34%. Clinical Support Services, Corporate Services, Emergency and Family Health divisions are below the sickness absence target of 3.95%.

2.4. The 12 month rolling sickness absence for May 2020 was 4.69% and represents a 0.11% improvement from the previous month (4.80%).
3.0 **Mandatory and Statutory Training (MaST)**

3.1 The Trust’s overall core MaST compliance for May 2020 has decreased slightly to 90%; the Medical & Dental staff group compliance is currently at 76.69%. 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>86%</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>89%</td>
</tr>
<tr>
<td>Emergency</td>
<td>90%</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>

3.2 Face to face training has stopped, however, Learning and Development continue to deliver a comprehensive development programmes, induction, and Personal Development Review support – all available via the Hub/TEAMS/or Bespoke.

4.0 **Personal Development Review**

4.1 The 12 month rolling Personal Development Review (PDR) compliance is currently 72.07% against a 90% target. The data below is the position at 08 June 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>872</td>
<td>624</td>
<td>72%</td>
</tr>
<tr>
<td>Corporate Operations</td>
<td>496</td>
<td>327</td>
<td>66%</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>267</td>
<td>172</td>
<td>64%</td>
</tr>
<tr>
<td>Emergency</td>
<td>167</td>
<td>131</td>
<td>78%</td>
</tr>
<tr>
<td>Family Health</td>
<td>609</td>
<td>422</td>
<td>69%</td>
</tr>
<tr>
<td>Medicine</td>
<td>778</td>
<td>579</td>
<td>74%</td>
</tr>
<tr>
<td>Surgery</td>
<td>731</td>
<td>570</td>
<td>78%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3,920</td>
<td>2,825</td>
<td>72%</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 Planning is underway for the 2021/22 new appraisal process as part of Our People Strategy commitment; and alignment with Our Talent Management implementation - with a soft launch planned for Autumn 2020. This launch will include consultations with staff on re-designed career conversations paperwork, development of support and action learning sets that focus upon and discuss different parts of the new appraisal process.
5.2 Learning and Development team have made welfare calls, contacting 30 colleagues that are shielding at home. Outcomes and requests have been collated and shared back with HR colleagues and managers for action.

5.3 “Our People Pack” which centralises tools, guidance and links to support self, managers and teams as part of the Rotherham response to this pandemic and beyond is currently being branded.

5.4 A training needs analysis for clinical Continuous Professional Development has been completed with colleagues across the Trust. This has been shared with Health Education England to ensure the Trust receives appropriate funding support. So far, the Trust has been successful in securing funding for 53 Non-Medical Prescribing places and 12 Advanced Physical Assessment and Consultation Skills (APACS) places. More details are expected to be confirmed over the coming weeks. Universities are offering remote delivery approaches to ensure the safety of those enrolled on courses.

5.5 Three Trust Apprentices have won awards at RNN College for their outstanding efforts. Wendy Jarvis (Assistant Practitioner), Shane Atkins (Assistant Practitioner) and Colette Ashforth (Senior Healthcare Support Worker) won the “Principal’s Award”, the “Above and Beyond” and “Amazing Attitude” awards respectively.

5.6 The planning of the next cohort of Trainee Nursing Associates (TNA) is underway with a University start date of 26 October planned. We currently have 42 TNA’s at various stages of their apprenticeship journey.

6.0 **Equality, Diversity & Inclusion**

6.1 NHS Virtual Pride – Trust actively involved via social media and flying the flag for the first time. Close working with regional Equality Diversity and Inclusion (EDI) network

6.2 Launch of the EDI blogspace happened in June and has been well received; hoping that this will encourage other network members to participate in raising awareness of different challenges/views.

6.3 Black, Asian and minority Ethnic (BAME) risk assessments letters/emails were sent to every member of staff employed by the Trust who has identified themselves as BAME on our electronic staff record system highlighting the new risk assessment framework and inviting them to make an appointment with their line manager for a risk assessment if they had not already had one

6.4 Understanding Privilege and Becoming Anti-Racist – training piloting via Teams will commence towards the end of June.

7.0 **Bank & Agency / NHS Professionals**

7.1 NHSP rapid recruitment process is working well and allows workers to be recruited with on-boarding within 24 hours. 167 additional nursing shifts were filled as a result.

7.2 In May demand for both registered and unregistered staff groups has reduced; 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 agency cascade was tightened and JS3 agency has now been removed which should result in further savings going forward. Further discussions about other agency usage are taking place.

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 ongoing improvement work and review of the owed hours metric has seen a continued decrease in the total hours owed. The e-roster steering group established last month will monitor this metric along with the suite of measures associated with best practice roster efficiency.

<table>
<thead>
<tr>
<th>Period</th>
<th>Hours Owed</th>
</tr>
</thead>
<tbody>
<tr>
<td>December</td>
<td>53,061</td>
</tr>
<tr>
<td>January</td>
<td>51,224</td>
</tr>
<tr>
<td>February</td>
<td>34,364</td>
</tr>
<tr>
<td>March</td>
<td>31,418</td>
</tr>
<tr>
<td>April</td>
<td>31,286</td>
</tr>
<tr>
<td>May</td>
<td>24,050</td>
</tr>
</tbody>
</table>

8.3 The terms of reference for the e-roster internal audit were agreed; aim is to complete the work by August factoring in the current restrictions in relation to Covid-19.

8.4 Following the successful electronic payslips project; the Trust is exploring how we can implement Electronic Staff Record (ESR) Employee Self Service (ESS) & Manager Self Service (MSS) over the next year. The Trust and Barnsley hospital are considering a joint approach and project management of this exercise as both organisations are also working with the central ESR team who can potentially support us with roll-out.

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-19 related wellbeing support and extended service offerings.

9.2 A key priority for the Trust is to ensure there are optimal referral pathways into occupational health to ensure managers/employees access services in the most cost effective manner. A work stream is being set up to review this and the Immunisation & Vaccination process. The team review all late cancellation/did not attend (DNAs) of appointments and are working with divisions to eliminate this problem which has averaged around £4k - £5k cost each month. During May we saw the lowest cost associated to these cancelled appointments at £ 2,262.

**Steven Ned**  
**Director of Workforce**  
**June 2020**
# Board of Directors’ Meeting
7 July 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>228/20(d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Finance Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Steve Hackett, Interim Director of Finance</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B8 and B9: This report provides assurance regarding the financial out-turn results for the two-months period ending 31st May 2020 against the Trust’s requirement to deliver a break-even position in line with national guidance.</td>
</tr>
</tbody>
</table>

**Purpose**

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

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

The report provides details of:

- Sections 1 to 4 – Financial Performance 2020/21

  This includes details of financial results for the two months ending 31st May 2020 in terms of:

  - Income and expenditure account:
    - £7K deficit position as at 31st May 2020, as required by NHSE/I;
    - After accounting for £3,461K COVID-19 expenditure; and
    - Additional Top-Up income of £6,438K.
  
  - Capital expenditure:
    - £745K incurred in month and £1,819K year to date, which is £601K above plan;
    - This includes £894K of COVID-19 related expenditure year to date, which the Trust expects to be reimbursed for nationally.
  
  - Cash
    - A closing cash position at 31st May 2020 of £24,184K as a consequence of the revised arrangements to compliment the emergency 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 2 2020/21 (May 2020)
2. COVID-19 Expenditure Subjective Summary for Month 2 2020/21 (May 2020)
3. Capital Expenditure Summary for Month 2 2020/21 (May 2020)
1. **Key Financial Headlines**

1.1 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.

<table>
<thead>
<tr>
<th></th>
<th>In Month</th>
<th>In Month</th>
<th>In Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>I&amp;E Performance</td>
<td>0</td>
<td>(7)</td>
<td>(7)</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>1,218</td>
<td>745</td>
<td>473</td>
</tr>
<tr>
<td>Cash Balance</td>
<td>1,357</td>
<td>24,184</td>
<td>22,827</td>
</tr>
</tbody>
</table>

2. **Income & Expenditure Account**

2.1 In line with national guidance, the Trust has set itself a break-even plan for the first four months of the financial year 2020/21.

2.2 For the two months ending 31st April 2020 The Trust has delivered a £7K deficit position in line with this plan, which is after taking account of COVID-19 related expenditure of £3,461K. This has been offset by Additional Top-Up value payments of £2,179K above the value assumed in the Trust’s emergency plan. The Trust will expect that this level of Top-Up payments will be fully reimbursed by NHSE/I.

2.3 The deficit of £7K relates to depreciation on donated asset which does not count against the NHS funding control total and hence, when excluded the Trust is showing the break-even position required by NHSE/I.

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

   (a) NHS clinical income is above plan in month by £532K and £1,624K year to date, as the Trust is requesting £2,179K additional Top-Up payments to help fund the additional costs of COVID-19. This is made up of £1,634K not initially required as part of the Trust's initial emergency financial plan (excluding COVID-19) together with a further £545K to enable the Trust to break-even in accordance with national requirements and expectations. Total Top-Up payments expected up to 31st May 2020 total £6,438K, with April’s Top-Up payment of £3,548K having being paid in full during June 2020.

   (b) These Top-Up values are being offset by £601K 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 (£92K).

   (c) Other operating income is behind plan both in month by £110K and year to date by £229K. This 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.

(d) Pay costs are over-spending both in month by £762K and year to date by £1,189K. This is primarily 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) This month non-pay costs are under-spending by £293K but over-spending by £298K year to date, The Trust incurred significant costs on personal protective equipment and other medical equipment in April 2020, which have significantly reduced during May 2020, with under-sPENDs on other non-pay costs continuing 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.

2.5 Details of COVID-19 related expenditure is similarly shown 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. reported in April 2020. These costs are no longer to be separately identified for NHSE/I and hence, this value has been reversed in the May 2020 numbers and explains why the pay costs shown in month are so low both actually and in comparison to the year to date position.

(d) Non-pay costs include c. £1,299K 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.

3. **Capital Expenditure**

3.1 Details of capital expenditure incurred in April and May 2020 is shown in Appendix 3 – a total of £745K in month and £1,819K year to date, resulting in a cumulative over-spend of £601K (49%).

3.2 Within these figures is COVID-19 related expenditure of £894K across Estates, medical equipment and information technology requirements that are expected to be approved and funded nationally via receipt of additional PDC in year.

4. **Cash**

4.1 At the same time as new financial planning guidance was issued nationally in March 2020, 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 plan phase.
4.2 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 Block Contract and Top-Up payments.

4.3 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.

4.3 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 31\textsuperscript{st} May 2020 of £24,184K.

4.4 The Trust's cash balance has remained this high whilst reducing its trade and other payables (creditors) by £8,945K as it has received the cash payment for the non-recurrent financial support monies due from quarter 4 of 2019/20 financial year totalling £10,139K.

Steve Hackett  
Interim Director of Finance  
26\textsuperscript{th} June 2020
## Appendix 1 – Income & Expenditure Account Summary for Month 2 2020/21 (May 2020)

<table>
<thead>
<tr>
<th>Summary Income and Expenditure Position</th>
<th>Monthly Position (May - Month 2)</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>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>0</td>
<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>
<td>721</td>
<td>721</td>
</tr>
<tr>
<td>Excluded Drugs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Clinical Income</td>
<td>21,817</td>
<td>22,349</td>
</tr>
<tr>
<td><strong>Total NHS Clinical Income</strong></td>
<td>22,538</td>
<td>23,070</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>1,653</td>
<td>1,543</td>
</tr>
<tr>
<td>Provider Sustainability Fund (PSF)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>24,191</td>
<td>24,613</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Costs - Agency</td>
<td>(683)</td>
<td>(888)</td>
</tr>
<tr>
<td><strong>Total Pay Costs</strong></td>
<td>(16,482)</td>
<td>(17,244)</td>
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<tr>
<td>Total Non-Pay Costs</td>
<td>(6,692)</td>
<td>(6,400)</td>
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<tr>
<td>Total Operating Costs</td>
<td>(23,174)</td>
<td>(23,643)</td>
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<tr>
<td>EBITDA</td>
<td>1,016</td>
<td>970</td>
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<tr>
<td>Non-Operating Costs</td>
<td>(1,016)</td>
<td>(976)</td>
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<tr>
<td>RETAINED SURPLUS / (DEFICIT)</td>
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<td>(7)</td>
</tr>
</tbody>
</table>
## Appendix 2 – COVID-19 Expenditure Subjective Summary for Month 2 2020/21 (May 2020)

### Summary Income and Expenditure Position

<table>
<thead>
<tr>
<th>Income</th>
<th>Monthly Position (May - Month 2)</th>
<th>Year to Date Position</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Plan £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>0</td>
<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>
</tr>
<tr>
<td>Community Services Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Excluded Drugs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Clinical Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total NHS Clinical Income</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provider Sustainability Fund (PSF)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

### EXPENDITURE

<table>
<thead>
<tr>
<th>EXPENDITURE</th>
<th>Monthly Position (May - Month 2)</th>
<th>Year to Date Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan £000s</td>
<td>Actual £000s</td>
</tr>
<tr>
<td>Pay Costs [Excluding Agency]</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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<tr>
<td>Total Non-Pay Costs</td>
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<tr>
<td>Total Operating Costs</td>
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<tr>
<td>EBITDA</td>
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<td>(642)</td>
</tr>
<tr>
<td>Non-Operating Costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>RETAINED SURPLUS / (DEFICIT)</strong></td>
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<td>(642)</td>
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## Appendix 3 – Capital Expenditure Analysis for Month 2 2020/21 (May 2020)

<table>
<thead>
<tr>
<th>In Month</th>
<th>(Above)</th>
<th>Description</th>
<th>Annual Plan</th>
<th>Year To Date</th>
<th>(Above)</th>
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<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
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<td>144</td>
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<td>Relocation of Greenoaks Services</td>
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<td>Endoscopy Decontamination</td>
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<td>0</td>
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<td>Window Replacement Programme</td>
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<td>5</td>
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<td>260</td>
<td>6</td>
<td>255</td>
<td>Air Conditioning Initiatives</td>
<td>260</td>
<td>260</td>
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<tr>
<td>1</td>
<td>8</td>
<td>(7)</td>
<td>Disability Discrimination Act</td>
<td>10</td>
<td>1</td>
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<tr>
<td>1</td>
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<td>1</td>
<td>Replace Electrical Distribution Boards</td>
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<td>Internal &amp; External Signage</td>
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<td>31</td>
<td>(24)</td>
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<td>Maintaining Environmental Standards</td>
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<td>31</td>
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<td>35</td>
<td>(25)</td>
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<td>9</td>
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<td>Fire Safety</td>
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<td>5</td>
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<td>Legionella Controls</td>
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<td>34</td>
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<td>10</td>
<td>0</td>
<td>10</td>
<td>Electrical Infrastructure</td>
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<td>10</td>
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<td>36</td>
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<td>36</td>
<td>Theatre Maintenance &amp; Repairs</td>
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<td>36</td>
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<td>52</td>
<td>5</td>
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<td>Substation Upgrade</td>
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<td>446</td>
<td>30</td>
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<td>0</td>
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<td>EPR</td>
<td>115</td>
<td>12</td>
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<td>0</td>
<td>0</td>
<td>Switchboard Upgrade</td>
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<tr>
<td>22</td>
<td>1</td>
<td>22</td>
<td>End User Device Refresh</td>
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<td>15</td>
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<td>15</td>
<td>0</td>
<td>15</td>
<td>Business Intelligence Project</td>
<td>150</td>
<td>15</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>10</td>
<td>Patient Flow &amp; Hospital at Night</td>
<td>100</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>5</td>
<td>UPS Replacement</td>
<td>50</td>
<td>5</td>
</tr>
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<td>38</td>
<td>0</td>
<td>38</td>
<td>Replace Core Network Infrastructure</td>
<td>370</td>
<td>38</td>
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<td>23</td>
<td>3</td>
<td>20</td>
<td>Clinical Noting</td>
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<tr>
<td>10</td>
<td>39</td>
<td>(29)</td>
<td>Digital Aspirant</td>
<td>10</td>
<td>10</td>
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<td>152</td>
<td>43</td>
<td>109</td>
<td>Total Information Technology</td>
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<td>152</td>
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<td>306</td>
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<td>Medical Equipment</td>
<td>1,792</td>
<td>306</td>
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<tr>
<td>2</td>
<td>0</td>
<td>2</td>
<td>Other Equipment</td>
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<td>2</td>
</tr>
<tr>
<td>308</td>
<td>(11)</td>
<td>319</td>
<td>Total Medical &amp; Other Equipment</td>
<td>1,812</td>
<td>308</td>
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<tr>
<td>0</td>
<td>195</td>
<td>(195)</td>
<td>Estates COVID 19</td>
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<tr>
<td>0</td>
<td>206</td>
<td>(206)</td>
<td>Medical &amp; Other Equipment COVID 19</td>
<td>0</td>
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<td>41</td>
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<td>Contingency Buildings</td>
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<td>22</td>
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<td>22</td>
<td>Contingency IT</td>
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<tr>
<td>0</td>
<td>128</td>
<td>(128)</td>
<td>IT COVID 19</td>
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<td>0</td>
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<tr>
<td>63</td>
<td>529</td>
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<td>Total Other</td>
<td>609</td>
<td>63</td>
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<tr>
<td>1,218</td>
<td>745</td>
<td>472</td>
<td>Total Capital Expenditure Programme</td>
<td>7,092</td>
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</tr>
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<td>Agenda item</td>
<td>229/20</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td>Quality Priorities for 2020/21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Author            | Dr Callum Gardner, Medical Director  
Angela Wood, Chief Nurse |
| Link with the BAF | B1, B2, B4      |
| Purpose           | Decision ☐  
To note ☐  
Approval ☑  
For information ☐ |

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

It is a legislative requirement to develop the Quality Improvement Priorities for the Trust, which will be included in the Trust’s 2019/20 Quality Account.

The proposed Quality Improvement Priorities for 2020/21 have been developed in conjunction with a number of key stakeholders and have been through the Clinical Governance Committee, Quality Committee and a Board of Directors’ seminar session, prior to being submitted to the Board of Directors for approval.

### Recommendations

It is recommended that the Board of Directors approve the Quality Improvement Priorities for 2020/21.

### Appendices

- Appendix A – Proposed Quality Priorities for 2020/21
- Appendix B – Details of the Proposed Quality Priorities
Appendix A – Proposed Quality Priorities for 2020/21

Patient Safety

• Learning from incidents
• Introduce Schwartz Rounds Within the Organisation
• Roll-Out Medical Examiner Office

Clinical Effectiveness

• Utilisation of Trust Wide Audit to Facilitate Improvement in 2 Key Areas:
  o Sepsis Management
  o Medicines Management (incorporating compliance with anti-coagulation and Insulin Script modules)
• Reduce HSMR and improve Learning from Deaths
• Ensure staff have the knowledge and training to give excellent care to Patients with a Learning Disability (PLD) and Autism

Patient Experience

• 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’
• 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, and that any such learning is sustained.</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 has sustained improved 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 ensure that key learning/actions are added to the Forward Audit Plan for spot audits to ensure they are sustained.                                                                                                                                 |
| **How will progress be monitored and reported?** | Progress will be reported and monitored by the Patient Safety Group, Clinical Governance Committee and Quality Committee.                                                                                                                                                                                                                               |
The Quality Priority will focus on improving colleagues wellbeing within the organisation by introducing Schwartz Rounds. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. Listening to colleagues describe the challenges of their work helps to normalise emotions, which are part and parcel of working in healthcare but are often kept under the surface.

Evidence shows that Schwartz Rounds reduce professional hierarchies and improve communication between colleagues. Staff who regularly attend Schwartz Rounds also feel less stressed and isolated at work, with increased insight and appreciation for each other’s roles, and help staff feel more supported in their jobs. The underlying premise for Schwartz Rounds is that the compassion shown by staff can make all the difference to a patient’s experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work. As such, there is a direct correlation between organisations with Schwartz Rounds and those with ‘Good’ or ‘Outstanding’ CQC ratings.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Introduce Schwartz Rounds Within The Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current position and why is it important?</td>
<td>The Quality Priority will focus on improving colleagues wellbeing within the organisation by introducing Schwartz Rounds. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. Listening to colleagues describe the challenges of their work helps to normalise emotions, which are part and parcel of working in healthcare but are often kept under the surface. Evidence shows that Schwartz Rounds reduce professional hierarchies and improve communication between colleagues. Staff who regularly attend Schwartz Rounds also feel less stressed and isolated at work, with increased insight and appreciation for each other’s roles, and help staff feel more supported in their jobs. The underlying premise for Schwartz Rounds is that the compassion shown by staff can make all the difference to a patient’s experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work. As such, there is a direct correlation between organisations with Schwartz Rounds and those with ‘Good’ or ‘Outstanding’ CQC ratings.</td>
</tr>
</tbody>
</table>
| The aim and objective(s) (including the measures/metrics) | • Introduce Schwartz Rounds to the Trust.  
  o Metric 1 - Appoint Clinical Lead and link with POF Q2.  
  o Metric 2 - Rounds arranged/communication plan in-situ Q3.  
  o Metric 3 - At least 4 Schwartz Rounds within Trust by end Q4. |
| The planned activity to achieve this | • Re-introduction of Schwartz Rounds to the Trust. |
| How will progress be monitored and reported? | • Number of, and attendance at, Trust Schwartz Rounds.  
  • Audit feedback on use of Schwartz rounds.  
  • Quarterly 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>
<thead>
<tr>
<th>Priority</th>
<th>Roll-Out Medical Examiner Office</th>
</tr>
</thead>
</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.  

By the end of Q4, at least 95% of all deaths within the Trust will have a first-stage mortality review within 1 month of the death (50% end of Q2; 75% end of Q3) and at least 75% of all deaths deemed to require a second-stage review (SJR) will have the SJR completed within 2 months of the death within each division (25% end of Q2; 50% end of Q3).  

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; this role will ultimately sit with the Clinical Effectiveness Department. 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. |
| Priority | Utilisation of Trust Wide Audit to Facilitate Improvement in 2 Key Areas:  
|-----------------|------------------------------------------------------------------------------------------------------------------|
|                 | • Sepsis Management  
|                 | • Medicines Management (incorporating compliance with anti-coagulation and Insulin Script modules) |
| 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 2 key areas chosen for Trust-wide audit remain ongoing areas of challenge; both are common themes in adverse incidents, inquests and/or complaints, and sepsis is an intermittent mortality alerts. |
| The aim and objective(s) (including the measures/metrics) | Sepsis  
| | The aim will be to undertake an audit, including around the use of sepsis bundles (adult, paediatric and maternity), and then 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 (by end of Q2).  

Sepsis eLearning will also be introduced for relevant clinical staff:  
| | • Q2 – identification of those in scope which are then added to ESR and communicated to those staff  
| | • Q3 - 20% compliance with sepsis mandatory training modules by end of the quarter  
| | • Q4 - 40% compliance with sepsis mandatory training modules by end of the quarter  
| Medicines Management – compliance with anti-coagulation and Insulin Script modules mandatory training for identified medical staff and relevant non-medical prescribers:  
| | • Q2 – identification of those in scope which are then added to ESR and communicated to those staff  
| | • Q3 - 20% compliance with those two mandatory training modules by end of the quarter  
| | • Q4 - 35% compliance with those two mandatory training modules by end of the quarter |
| The planned activity to achieve this | • Agreement and refinement of areas of focus for first key area in Quarter 2, 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 |

<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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current position and why is it important?</strong></td>
<td>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, focusing on the ‘3 C’s’ (quality of Care; Case mix; Coding).</td>
</tr>
</tbody>
</table>
| **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 110 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 2 key areas to improve quality of care, identified through recurrent mortality alerts:  
  - Community-acquired Pneumonia (CAP)  
    - Reinroduce the Trust’s CAP care bundle and improve achieve utilisation in 30% of all cases by end of Q3 and 50% of all cases by end of Q4  
    - Ensure that the CAP risk-stratification CURB65 tool is routinely documented and improve achieve utilisation in 50% of all cases by end of Q3 and 70% 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 Q4 (subject to Business Case approval for medical palliative care support)  
    - 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.

<p>| How will progress be monitored and reported? | Progress will be monitored and reported monthly by the Trust Mortality Group, Clinical Effectiveness and Research 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. |</p>
<table>
<thead>
<tr>
<th>Priority</th>
<th>Ensure staff have the knowledge and training to give excellent care to Patients with a Learning Disability (PLD) and Autism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current position and why is it important?</strong></td>
<td>Currently there is no systematic training provided for all Trust staff around Learning Disabilities (LD). The law has recently changed and there will be mandatory training provided to all health and social care staff in the near future around learning disabilities and autism. However, in the interim it would help to improve the standard of care we give to people with learning disabilities at TRFT, in line with the standards outlined in the Learning Disability improvement standards for NHS Trusts by NHSI, focusing upon the 3 standards for acute Trusts, respecting and protecting rights, inclusion and engagement and workforce. This recognises that if we get it right for people with a learning disability we get it right for everyone.</td>
</tr>
<tr>
<td><strong>The aim and objective(s) (including the measures/metrics)</strong></td>
<td>To increase awareness around the needs of people with learning disabilities for TRFT staff to enable support to people with LD in the most frequented areas of the Trust in the first instance. Audit the current staff knowledge with a questionnaire, to gauge the current level of knowledge and then undertake a follow up questionnaire to assess whether the training has improved their knowledge level; First Quarter (Dependent on commencement date)– Baseline of knowledge obtained Second and Third Quarters – Training sessions held End of Third Quarter – Re audit of knowledge to aim for an improved position by 30%</td>
</tr>
</tbody>
</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  
- 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.  
- 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  
- To undertake patient and carer satisfaction surveys |

Monitored through Clinical Governance Committee and Quality Committee.
<table>
<thead>
<tr>
<th>Priority</th>
<th>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'</th>
</tr>
</thead>
</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?**  

*FFT is currently suspended nationally, therefore this objective will commence when the national programme restarts.* |
| 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.
### Priority

<table>
<thead>
<tr>
<th><strong>Current position and why is it important?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<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.</td>
</tr>
</tbody>
</table>

- 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. |

### 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.
<table>
<thead>
<tr>
<th>Priority</th>
<th>Maximising the potential of volunteering - recognise, recruit, embed and celebrate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current position and why is it important?</td>
<td>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</td>
</tr>
<tr>
<td>The aim and objective(s) (including the measures/metrics)</td>
<td>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.</td>
</tr>
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</table>

*N.B Post Covid 19 changes with regard to the access and utilisation of volunteers across the Trust will be reviewed and all appropriate processes and safety mechanisms put in place for our volunteers, patients and staff to enable the volunteer service to continue an grow in line with this objective.*
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:

- 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

<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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• Identify targeted audiences to promote volunteering, to ensure that our volunteers reflect the diverse local population and a representative patient demographic</td>
</tr>
<tr>
<td></td>
<td>• Champion an organisational culture that welcomes and celebrates volunteers as an integral part of our Trust teams.</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
</tbody>
</table>
- 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.

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.

| 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. |
### Board of Directors’ Meeting
7 July 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>231/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Governance Report</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>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)
- NICE (The National Institute for Health and Care Excellence) began to publish non-COVID guidance at the end of June following the pause caused by the pandemic;
- the Parliamentary and Health Service Ombudsman (HMSO) have now restarted their work;
- The CQC has issued details of its intentions to consider, and regulate against closed cultures, in which stakeholders may receive a poor care;
- Changes are being proposed by Government which will impact on the Insolvency Act 1986, the Companies Act 2006, and the Cooperative and Community Benefit Societies Act 2014;
- Details of the Trust's up and coming Governor elections are provided.

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

#### Appendices
None
1.0 Introduction

1.1 This report provides an update since the last board meeting on 2 June 2020.

2.0 Complaints - PHSO now re-opened

2.1 Since pausing their work on NHS complaints on 26 March 2020 to support the NHS focus resources on talking the pandemic, the Parliamentary and Health Service Ombudsman (HMSO) have now restarted their work, with effect from 1 July 2020.

2.2 New complaints are being accepted, as well as existing ones now being processed although the majority of PHSO staff continue to work remotely.

2.3 The PHSO is also now seeking clarity on government’s plans for an inquiry into the overall response to the pandemic.

3.0 NICE Guidance – move to begin publishing again

3.1 Moving on from the pause caused by the COVID19 pandemic and resulting diversion of healthcare resources, NICE began a phased restart of publishing its non-COVID19 guidance, and have also indicated a timetable for future guidance and quality standards to be published.

3.2 Matters described as ‘non-critical’ will be deferred until later in the year or the start of 2021. However, colleagues may wish to consider the work being undertaken with regard to ‘Behaviour change: digital and mobile health interventions’ in response to the pandemic, which is due to be published on 7 October 2020.

4.0 CQC – ‘closed cultures’

4.1 The CQC have advised that their inspectors will be trained throughout summer 2020 on issues affecting closed cultures, these being defined as cultures likely to develop in services where

- people are removed from their communities
- there is weak leadership
- staff lack the right skills, training or experience to support people
- there is a lack of positive and open engagement between staff and with people using services and their families.

4.2 The regulator advises that the work will shape their next strategy, and will improve the way that they inspect services in the future.

5.0 Proposal for sweeping changes to Company and Insolvency Laws

5.1 The Government introduced the draft Corporate Insolvency and Governance Bill 2019-21, which introduces changes to Company and Insolvency laws directed at easing the burden on businesses during the COVID-19 crisis and giving them flexibility to enable them to continue to trade, and promote their chances of survival.
5.2 There are three main measures to be implemented by the Bill, by way of amendments to the Insolvency Act 1986, the Companies Act 2006, and the Co-operative and Community Benefit Societies Act 2014:

- The introduction of a statutory insolvency moratorium, to help companies maximise their chances of survival by giving them the breathing space to look at options for rescue while supplies are protected;
- The temporary and retrospective suspension of the wrongful trading provisions in the Insolvency Act, to protect companies from aggressive creditor action and to support directors to continue to trade without the fear and threat of personal liability; and
- The temporary relaxation of filing requirements and the ability to hold virtual general meetings.

5.3 The third reading of the Bill was due in the House Lords early this week.

5.4 The Trust will not be directly affected by the Bill, if introduced. However, should a complex structure be used by the Trust in the near future which includes a limited liability company or limited liability partnership, the taking of legal advice would be recommended.

6.0 Governor Elections 2020

6.1 A new election process will begin at the end of July 2020, with work currently being undertaken by Governors, in conjunction with support being provided by our Communications team, to increase stakeholder engagement.

<table>
<thead>
<tr>
<th>ELECTION STAGE</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of Election / nomination open</td>
<td>Thursday, 30 Jul 2020</td>
</tr>
<tr>
<td>Nominations deadline</td>
<td>Friday, 14 Aug 2020</td>
</tr>
<tr>
<td>Summary of valid nominated candidates published</td>
<td>Monday, 17 Aug 2020</td>
</tr>
<tr>
<td>Final date for candidate withdrawal</td>
<td>Wednesday, 19 Aug 2020</td>
</tr>
<tr>
<td>Electoral data to be provided by Trust</td>
<td>Friday, 21 Aug 2020</td>
</tr>
<tr>
<td>Notice of Poll published</td>
<td>Thursday, 3 Sep 2020</td>
</tr>
<tr>
<td>Voting packs dispatched</td>
<td>Friday, 4 Sep 2020</td>
</tr>
<tr>
<td>Close of election</td>
<td>Thursday, 24 Sep 2020</td>
</tr>
<tr>
<td>Declaration of results</td>
<td>Friday, 25 Sep 2020</td>
</tr>
</tbody>
</table>

6.2 The seats to be contested will be:

- Rother Valley South (1 seat)
- Rother Valley West (1 seat)
- Rotherham North (2 seats)
- Wentworth North (2 seats)
- Wentworth South (1 seat)
- Wentworth Valley (2 seats)
- Rest of England (2 seats)

Anna Milanec
Director of Corporate Affairs / Company Secretary,
June 2020
### Agenda item

| 232/20 |

### Report

**Annual Review of Risk Management and Appetite**

### Executive Lead

Angela Wood, Chief Nurse

### Link with the BAF

All Board Assurance Framework Risks

### Purpose

| Decision | To note | Approval | For information |

### Executive Summary

This report provides an update on the review of risk management processes in the Trust that occurred in June 2019, progress on the subsequent action plan and reports on outcome of the annual review of risk appetite that was undertaken with the Trust Board on 5 June 2020.

### Recommendations

The Board are asked to support the changes that are being proposed to the risk appetite for the next 12 months.

### Appendices

- Appendix 1 - Findings from the CQC Inspection and Well Led Review
- Appendix 2 – Risk Management Action Plan
- Appendix 3 – Risk Management Action Plan from 2019/20 Internal Audit Review
- Appendix 4 -TRFT Risk Appetite
1. Introduction

1.1 This report provides an update on implementation of the new Risk Management processes agreed by the Trust Board in June 2019 and the recommendations for changes to the risk appetite following annual review by the Board of Directors.

2. Review of Findings – Areas to Improve

2.1 In March 2019 the Trust Board received a paper detailing and proposing new arrangements for risk management within the Trust. A review had been undertaken using feedback from staff involved in risk management, learning from other organisations, and the findings from the CQC Inspection and Well Led Review (See Appendix 1)

2.2 It was therefore recognised that in the following areas improvements were required:

- The Risk Management Strategy and Appetite
- The Risk Analysis Group function
- Datix functionality and visibility
- Reporting arrangements and escalation
- Engagement and ownership
- Guidance and process

2.3 The Trust Board of Directors supported the changes proposed and the new strategy, policy and guidelines were approved to be implemented. It was agreed that significant actions would be undertaken, to address the areas for improvement identified above (these are included as an action plan in Appendix 2).

2.4 The action plan is now complete and work continues to embed the new processes and procedures across the organisation.

2.5 In May 2020, the final report from the 360 Assurance Internal Audit Review of Governance and Risk Management was published. Limited Assurance was given to risk management, with the statement “There has been significant work to ensure risk management processes are defined, however we found they could work more effectively. Reporting routes have been established but again could work more effectively. There is also variability in how risk management arrangements are operating at a divisional level. We raised a number of medium risk issues.”. This led to the development of the action plan which is located in Appendix 3. A significant amount of work has already occurred to address the actions.

3. Risk Appetite Review

3.1 The risk appetite of the organisation needs to reviewed on an annual basis to ensure it reflects the organisations risk strategy and the current challenges the organisation is facing.

3.2 A Board development session was held on 5 June, to review the current risk appetite and ensure it was still appropriate with challenges and risk levels in the Trust. A workshop format allowed board members to review current appetite and categories, debating the current levels and making suggestions to modify content and scores as appropriate.
3.3 Discussions held are reflected in the changes proposed to the appetite in Appendix 4. The Risk Management Committee and Risk Analysis Group have not yet seen the proposed changes, and so these will be communicated to the members in their July 2020 meetings.

4. Conclusion

4.1 The Board are asked to note the progress made in relation to implementing the Risk Management Action Plan and support the changes suggested to the risk appetite following debate at the Board Seminar.

Angela Wood
Chief Nurse
June 2020
## Must and Should do actions from CQC Inspection

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Action Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trustwide</strong></td>
<td>Must</td>
<td>The trust must ensure there are robust governance arrangements in place to identify risk at core service level, and ensure the reporting arrangements for board committees provides effective oversight of the overall system of internal control.</td>
</tr>
<tr>
<td><strong>Trustwide</strong></td>
<td>Must</td>
<td>The trust must conclude the streamlining of operational risk management processes to ensure there are embedded arrangements for escalating and de-escalating risk from ward to board.</td>
</tr>
<tr>
<td><strong>Urgent &amp; Emergency Care</strong></td>
<td>Must</td>
<td>The trust must ensure the departmental risk register fully reflects the risks faced by the department and has appropriate actions to mitigate the risks.</td>
</tr>
<tr>
<td><strong>Medical Care</strong></td>
<td>Must</td>
<td>The Trust must ensure that all risks on the divisional risk register are regularly reviewed and updated to ensure they are managed and mitigated effectively.</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Must</td>
<td>The trust must ensure all identified risks affecting the service in line with trust policy are escalated to the risk register.</td>
</tr>
</tbody>
</table>

## Findings from Well Led Inspection

KLOE 5 – Managing Risk and Performance – suggested action
Develop a standard approach across all divisions for monitoring, managing and reporting risks and performance issues
## Appendix 2 – Action Plan

<table>
<thead>
<tr>
<th>Overall Action</th>
<th>Actions</th>
<th>Date to be Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the organisation’s risk appetite and relaunch a revised policy</td>
<td>Review the appetite statement for appropriateness and developing clear risk appetite statements for each of the Trust’s strategic aims and objectives across categories including risks to patients, organisational risk, reputational risk and opportunistic risk.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Review the appetite statement on an annual basis as part of the business planning process.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Raise awareness of risk appetite and ensuring that all risks scoring 15 or above are assessed based on their risk appetite.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>The Risk Management Strategy will be reviewed and updated to become a Policy and then awareness raised of the content, along with the Risk Management Guidance.</td>
<td>Completed</td>
</tr>
<tr>
<td>Ensure a single and comprehensive risk management process (improving the quality of risk assessments).</td>
<td>Risk Analysis Group membership has been reviewed and updated, with quoracy of two Executive Directors. At each meeting a division will be requested to present their current risks to discuss in detail.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>The Risk Analysis Group Sub Group has been established to undertake work looking at the risks for addition and removal, enabling the Risk Analysis Group to focus on the current approved risks.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Review the functionality of Datix, ensuring it captures the controls and assurance. Launch a 15 or above risk reporting template (Appendix 3).</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Recruit a Compliance and Risk Officer.</td>
<td>Completed</td>
</tr>
<tr>
<td>Increase the coverage and utilisation of appropriate risk assessments throughout the Trust.</td>
<td>Each department will continue to carry out risk assessments which feed into the divisional/corporate Risk Registers.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>The incident reporting process will identify where risk assessments have not been completed and remedial actions identified from the failures from each individual adverse event will be addressed by the relevant manager.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Each Division/Corporate Function will continue to maintain a comprehensive risk register, which will be formally reviewed through the Divisional Governance Meetings or equivalent Corporate Function Meeting. At these meetings the Divisions/Corporate Function will be expected to report on their risk register, highlight any new or emerging risks to service delivery and present action plans for minimising and managing those risks.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>The divisional governance meetings equivalent Corporate Function Meeting and underpinning structure will be used to monitor gaps in risk assessment, using the monthly divisional governance reports and attendance at Risk Analysis Group and Sub Group.</td>
<td>Completed</td>
</tr>
<tr>
<td>Overall Action</td>
<td>Actions</td>
<td>Date to be Implemented</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>provide the relevant assurance.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Review the Governance and Performance Management arrangements in place for Risk Management</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Increase the use of Trust wide data to inform the risk management process</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Topic expert groups to review the risks for their area, such as Information Governance, on a regular basis, to identify any themes or trends.</td>
<td>Completed</td>
</tr>
<tr>
<td>Improve the culture of the organisation through enhancing the knowledge and skills base of staff in risk management across the Trust, thereby also further encouraging an open and transparent reporting culture and increasing engagement</td>
<td>Review the existing Risk Management training programme, training materials and provide general communications regarding risk and incidents to ensure appropriate knowledge and skills in risk management at different levels of the organisation.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Along with continuing to provide the Risk Management Training, a risk assessor’s course will be established to improve the quality of the risk assessments undertaken.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>In addition, how awareness with regards to all staffs responsibility for risk identification can be increased will be reviewed, looking at attendance at possibly Induction, Clinical Leadership Programme, LEAD course etc</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Further develop the mechanism for gaining feedback from those responsible for managing risk to ensure that lessons are fed back to those involved in adverse events. This will be achieved by increased collaboration with the governance leads within the divisions.</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Engagement will be improved through the Safe and Sound Framework, primarily through the Governance, Risk and Safety Safe and Sound Group.</td>
<td>Completed</td>
</tr>
<tr>
<td>Strengthen the system of assurance regarding risk reporting</td>
<td>Review the risk reporting template for risks scoring 15 or above</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Expand the detail of information provided to the Assurance Committees</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Revise the reporting paper to the Board of Directors and Trust Management Committee</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Monitor the risk review dates</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Increase the scrutiny of risk assessments and quality of risk ratings</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Clear risk action plans competed and actions addressed</td>
<td>Completed</td>
</tr>
</tbody>
</table>
### Appendix 3 - Risk Management Action Plan from 2019/20 Internal Audit Review

<table>
<thead>
<tr>
<th>Title</th>
<th>Finding</th>
<th>Risk</th>
<th>Risk Score</th>
<th>Action</th>
<th>Responsible Officer</th>
<th>Implementation Date</th>
<th>Management Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Risk owner responsibilities</td>
<td>The role and responsibilities of a risk owner is not explicitly defined in the strategy or guidelines.</td>
<td>If the role and responsibilities of an individual risk owner are not clearly defined, then risks may not be managed in accordance with the Trust-wide strategic approach.</td>
<td>Low 3x2</td>
<td>The Strategy and/or Guidelines should be amended to define the role of a risk owner clearly.</td>
<td>Anne Rolfe, Quality Governance, Compliance and Risk Manager</td>
<td>30-Sep-20</td>
<td>Agreed</td>
</tr>
</tbody>
</table>
| 8 Risk Management Committee responsibilities | a. There is some duplication of work between RAG and RMC around review of risk scores and descriptors.  
b. RMC could focus more on ensuring that the approach adopted to risk management is effective and proactive by challenging actions in place to manage risks to target levels.  
c. We noted issues with attendance at RMC, including cases of cancelled meetings, lack | Review RMC Terms of Reference to clarify the need to challenge how risks are being actively managed towards target. | Medium 3x4 | Review RMC Terms of Reference to clarify the need to challenge how risks are being actively managed towards target. | Anne Rolfe, Quality Governance, Compliance and Risk Manager | 31-Aug-20 | Agreed |
of representatives from particular divisions, and not meeting quorum.

| 9 Recording and reporting actions against risks | a. The Trust does not currently use Datix to track individual actions against risks; meaning that information on ownership and timescales of actions is not explicitly clear from the risk register downloads. b. RMC receives risk reports in a template that is manually compiled; all of the information could be compiled automatically through use of the Datix action planning module. | If actions are not clearly identified in the Datix system, this makes reporting less effective and there is a lack of oversight of actions in place for each risk. If separate templates, outside the Datix system, are used for risk reporting, this duplicates effort. | Medium 4x3 | Review the functionality of Datix to explore if actions can be more clearly logged, enabling an automated report format which includes information about when each risk was last reviewed, planned mitigating actions, and target dates. | Anne Rolfe, Quality Governance, Compliance and Risk Manager | 30-Sep-20 | Agreed |

| 10 Escalation and reporting | a. Seven different groups receive the 15+ risk register (or their relevant sections of this), without sufficient clarity on what their respective responsibilities are. b. Cover sheets and information reported should be revised to provide more direction | If reports to Board and board committees are not clear on their purpose, then the Board may not get sufficient assurance that risks are being managed. | Medium 4x3 | Cover sheets and the detail of information reported have been revised for all board committees; the new format was agreed at Audit Committee in May 2020. This will provide more direction and relevant | Anne Rolfe, Quality Governance, Compliance and Risk Manager | Implemented | Risk Management is a standing agenda item at Exec team and any issues to highlight are raised as appropriate, for example updates from RMC and RAG. |
and relevant information for groups receiving risk management information.

c. During the course of this review, the Trust has implemented additional monthly reporting to RMC which provides an improved snapshot of the Trust-wide risk management picture.

d. There may be a lack of oversight of risks below a score of 15. This will be addressed through

e. Action 4 in our recent review of Divisional Quality Governance “Obtain feedback from divisions about use of their quality governance agendas and develop a revised standard agenda with an associated work plan. The work plan should be clear on the

| and relevant information for groups receiving risk management information. | information for groups receiving risk management information. |  |  |  |
discussions that should be held on each item.” The Trust asks divisions to review risks at quality governance meetings.

11 **Invalid “Manager” field on Datix**

| 24.1% of risks are not assigned a valid Manager; the DatixWeb instructions define the manager as the person who is responsible for the risks, i.e. operationally. | If risks are not assigned to a manager, then they may not be reviewed and managed in accordance with the Trust-wide Strategy and Guidelines. | Review the risk register and rectify any invalid “Manager” fields. Dashboards set up through Datix to review mandatory fields which will be subject to review. This will be fed back in to Risk Management Committee. | Anne Rolfe, Quality Governance, Compliance and Risk Manager | 30-Jun-20 | Dashboards will be set up to highlight any blank fields. |

12 **Divisional/CSU Quality Governance documents**

| Although the Governance documents do align to Trust-wide strategy (insofar as they stipulate that they will adhere to it) the documents we reviewed have several gaps which may indicate that their risk management arrangements are not sufficiently outlined, as follows: | If divisions/CSUs do not have clearly defined responsibilities around risk management per their governance documents, then they may not exercise robust and efficient risk management processes. | See finding and action 4 in the Divisional Quality Governance audit (1920/RFT/09): Obtain feedback from divisions about use of their agendas and develop a revised standard agenda with an associated work plan. The work plan should be clear on the | | | |
UECC’s Terms of Reference does not make any reference to their responsibilities for risk managements.

None of the Terms of Reference stipulate which risk levels the divisions/CSUs are responsible for.

None of the divisions/CSUs have a work planner (Sexual Health’s Terms of Reference explicitly states that they will produce one).

None of the governance documents for the divisions/CSUs we tested stipulate that they should be managing action plans around risks.

The standard agenda for Quality Governance meetings outlined by the Clinical Governance Committee does not give any context on what action should be taken with the risk register at different divisional forums.

discussions that should be held on each item.
<table>
<thead>
<tr>
<th></th>
<th>Divisional/CSU risk management arrangements</th>
<th>If divisions do not have clearly defined roles and responsibilities with regards to risk management, then risks may not be managed effectively.</th>
<th>Medium 3x3</th>
<th>See finding and action 4 in the Divisional Quality Governance audit (1920/RFT/09): Obtain feedback from divisions about use of their agendas and develop a revised standard agenda with an associated work plan. The work plan should be clear on the discussions that should be held on each item.</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Although all divisions/CSUs are demonstrating some continuous maintenance of their risk registers, we identified the following issues:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. The majority of documented risk management discussion at divisional/CSU level is reactive (risk scores and descriptors) rather than proactive (challenge of action plans).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. divisions/CSUs should be reviewing – while most focus on 12-15 (as stipulated in the Strategy) there are some inconsistencies and this could result in duplicated effort with other groups.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Risks are not being consistently reviewed at the frequency stipulated in the guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 - 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 2019/20</th>
<th>Risk Appetite Score 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Innovation</td>
<td>TRFT has a <strong>MEDIUM</strong> risk appetite for Clinical Innovation that does not compromise quality of care. <strong>Removal of ‘that does not compromise quality of care.’ and reduce appetite</strong></td>
<td>12-16</td>
<td>6-10</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 <strong>Increase appetite</strong></td>
<td>6-10</td>
<td>12-15*</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. <strong>Stays the same</strong></td>
<td>6-10</td>
<td>6-10</td>
</tr>
<tr>
<td>Financial/Value for money (VFM)</td>
<td>TRFT has a <strong>MEDIUM</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. <strong>Removal of VFM identified and reduce appetite</strong></td>
<td>12-16</td>
<td>6-10</td>
</tr>
<tr>
<td>Partnerships</td>
<td>TRFT has a <strong>MEDIUM</strong> risk appetite for partnerships which may support and benefit the people we serve. <strong>Stays the same</strong></td>
<td>12-16</td>
<td>12-15*</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Risk Appetite</td>
<td>Risk Appetite</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>---------------</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>
<td>1-5</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>
<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>
<td>1-5</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>
<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. <strong>Remove ‘that does not compromise quality of care’ Appetite stays the same.</strong></td>
<td>12-16</td>
<td>12-15*</td>
</tr>
<tr>
<td>Environment</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Environment that does not compromise quality of care. <strong>Remove ‘that does not compromise quality of care’ Appetite stays the same</strong></td>
<td>6-10</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. <strong>Change to an Estates category, remove ensuring that it does not compromise quality of care and reduce appetite</strong></td>
<td>12-16</td>
<td>1-5</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. <strong>Split into 2 categories and reduce both to 6-10</strong></td>
<td>12-16</td>
<td>6-10</td>
</tr>
<tr>
<td>Fire Safety / General Security</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Fire Safety/General Security <strong>Reduce appetite</strong></td>
<td>6-10</td>
<td>1-5</td>
</tr>
<tr>
<td>Business / Service Interruption</td>
<td>TRFT has a <strong>LOW</strong> risk appetite for Business/Service Interruption. <strong>Stays the same</strong></td>
<td>6-10</td>
<td>6-10</td>
</tr>
</tbody>
</table>

*Suggestion that risk appetite should not be above 15 overall*
### Board of Directors’ Meeting
**7 July 2020**

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>233/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Policy for Management of Concerns and Complaints</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Angela Wood, Chief Nurse</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1 (Standards and quality of care do not deliver the required patient safety, experience and clinical outcomes that meet regulatory requirements)</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 Trust’s concerns and complaints policy was previously revised in line with best practice and benchmarked against other Trust policies where they have been rated outstanding by the CQC.

The policy describes the roles and responsibilities of all staff in ensuring concerns are handled as quickly as possible and formal complaints in line with appropriate National guidance. The policy applies to all hospital services, sites departments and areas within the organisation, buildings or the environment and to all permanent and temporary staff working within the Trust.

Due to the recruitment of the Assistant Chief Nurse for Patient Experience the policy has been updated to reflect this role of accountability within the structure and a flow chart has been added to the staff appendices which provides a step by step guide of a formal investigation in working days.

**Recommendations**

It is recommended that the Board approve the policy.

**Appendices**

1. Step by step guide
2. Guidance on conducting an Investigation into a complaint
3. Guidelines for staff on the preparation of statements
4. Guidance on preparing a complaint response letter
5. Guidance notes for meetings a with complainants
POLICY FOR THE MANAGEMENT OF CONCERNS AND COMPLAINTS

SECTION 1
PROCEDURAL INFORMATION

<table>
<thead>
<tr>
<th>Version:</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratified by:</td>
<td>Trust Document Ratification Group</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>May 2020</td>
</tr>
<tr>
<td>Title of author:</td>
<td>Head of Patient Experience</td>
</tr>
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Copyright © 2020 The Rotherham NHS Foundation Trust
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1. INTRODUCTION

The Rotherham NHS Foundation Trust (TRFT) is committed to responding to all issues of concern by a patient, relative, carer or advocate and learning from the issues raised. The Trust will provide an accessible and impartial service, which is accountable, confidential and effective. All issues raised will be handled not only with the seriousness they deserve, but also in a way that provides answers to service users which are full, frank, honest and timely.

The Trust will ensure that services change occurs, as a result of the lessons learned from the issues raised and will meet the standards laid down in the NHS (Complaints) Regulations 2009 SI (2009) No. 309. Under these Regulations, the Trust should be providing a patient-focussed complaints service. We must be:

- **Listening** to what the complainants are saying
- **Responding** to the issues they raise and
- **Improving** Trust services subsequent to the lessons learnt from Trust investigations into their concerns.

The Trust will ensure that the principles of the Human Rights Act 1998 and the European Convention of Human Rights are maintained at all times.

The Trust will also deliver a complaints service which complies with Parliamentary and Health Service Ombudsman (PHSO) best practice. The six principles of best practice are; Getting it right; Being 1 customer focused; Being open and accountable; Acting fairly and proportionately; Putting things right and Seeking continuous improvement.

Towards the end of 2014, the PHSO started its ‘My expectations’ project in partnership with the Local Government Ombudsman and Health Watch England to review people’s expectations for good complaints handling. The following ‘My expectations’ model which resulted from this piece of work has been adopted by the Care Quality Commission for their inspections. The PHSO ‘My expectations’ model will also be adhered to by TRFT;

1 In the context of healthcare, we mean patients.
This Trust recognises and accepts its responsibilities outlined by the Care Quality Commission’s Fundamental Standard; Regulation 16.

Receiving and acting on complaints ‘Guidance for providers on meeting the regulations’ or Key Line of Enquiry (KLOE) Responsive 4 The intention of this regulation is to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A). To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service.

The systems and processes must also assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. Providers must continually evaluate and seek to improve their governance and auditing practice.

The recommendations following the final report into the Mid Staffordshire NHS Foundation Trust inquiry by Robert Francis QC and the review of the NHS Hospitals Complaints system ‘Putting Patients back in the Picture’, Clwyd and Hart 2013 and the Assurance of Good Complaints Handling for Acute and Community Care – A toolkit for commissioners has been considered in the development of this policy.

This policy supersedes and replaces The Management of Concerns and Complaints Policy Ref No: 221 and the previous version of the policy for the management of Compliments, Comments, Concerns and Complaints

2. PURPOSE & SCOPE

The policy deals with the handling of concerns and complaints regarding Trust services, buildings or the environment. Concerns and complaints may be received from patients, patient relatives, carers, visitors and other service users. Concerns and complaints excluded from the scope of this policy are identified in section 4.6. The policy applies to all hospital services/sites, departments and areas within the organisation and applies to all permanent and temporary staff working within the Trust.

2.1 Purpose

The policy aims to promote early, local and prompt resolution, and involving the complainant in deciding how their concerns are handled. Likewise, good complaint handling and continuous learning is endorsed throughout the policy, promoting improvements in the quality and safety of services at TRFT and facilitating positive patient experiences.

Aims:

1) To listen, to acknowledge mistakes, explain what has happened and to consider prompt appropriate and proportionate remedies to put things right, if necessary.
2) To provide a consistent approach to the timely and efficient handling of all concerns and complaints, establishing an agreed complaints plan with the complainant, with an emphasis on early resolution.
3) Ensure organisational openness and an approach that is appeasing and fair to people both using and delivering services.
4) Respect the individual’s right to confidentially and treat all users of this policy with respect and courtesy.
5) Learn from concerns and complaints and use them to improve the quality of services and to prevent mistakes happening again.
6) The Trust will actively seek the views and the comments of its users and encourage a culture of openness.
7) Complaints will not be seen in isolation, but as part of the overall service that the Trust provides. Complaints handling will be seen as an integral part of everyone’s role.
8) Information on complaints trends will be captured, analysed and reported across the organisation to effect improvements in how services and care are provided.
9) Staff will be suitably trained and empowered to deal with complaints.
10) Expressions of dissatisfaction will, where possible and appropriately, be resolved immediately by the person receiving them.
11) The Trust will communicate with its patients and service users using language that is easily understood.

Outcomes:
1) The policy and procedure will, as far as is reasonably practical, be easy to understand, accessible, publicised in ways that will reach all service users and include information about support and advocacy services.
2) All staff will receive an appropriate level of training to enable them to respond positively to concerns and complaints, and to endeavour to resolve issues quickly.
3) The Trust will ensure that service users and carers can raise a concern or complaint without their care, treatment or relationship with staff being compromised.
4) All concerns and complaints will be acknowledged within three working days. Where possible the complaint issues will be clarified, investigation timescale agreed with the complainant, and the best way to reach a satisfactory outcome discussed.
5) Investigations will be thorough, responsive and appropriate to the seriousness of the complaint, conducted within the timescales where possible agreed with the complainant.
6) The format of the response to the concern/complaint will be agreed with the complainant, this may be verbal (by telephone or at a meeting), by email or written letter.
Concerns will often be resolved with a verbal response. Complaints will require a written response or if a meeting was agreed a copy of the digital recording taken during the meeting.

The response will explain how the complaint has been investigated, acknowledging shortcomings and apologising where appropriate, explain the outcome of the investigation, what actions have been or will be taken and what the next steps are for the complainant if they remain dissatisfied with the response.

7) The Trust will strive to resolve all complaints locally, whilst reminding people of their right to take the matter to the PHSO if they are not satisfied.

8) Within Divisions local leadership and accountability will support early resolution and ensure concerns and complaints are responded to promptly and used to initiate actions for service improvement/opportunities for staff improvement.

9) Trust governance structures will be used to ensure organisational learning from complaints and the sharing of best practice.

10) To ensure that staff are aware of their responsibilities and are sympathetic and responsive to any concerns expressed.

11) All complainants will be kept informed of the progress and outcome of their complaint investigation as far as is reasonably practicable and that timely apologies are given, where appropriate.

12) That the reasons for the complaint are identified and the appropriate action is implemented. Where it is specifically requested and felt appropriate the lessons learnt should be communicated to the complainant and shared Trust-wide to inform best practice.

13) That staff are supported by an organisation that advocates an open and fair culture.

14) Confidentiality, respecting the confidentiality of both the staff and complainants.

15) Concerns and complaints are reviewed and monitored to ensure fairness and effectiveness.

16) Compliant and concern processes will be honest, thorough and with the prime purpose of satisfying the concerns of the complainant whilst also being fair to the staff.

2.2 Scope

The policy applies to all departments and areas within the organisation; and applies to all staff working within the Trust.

The policy deals with the handling of concerns and complaints regarding Trust services, buildings or the environment received from patients; patient relatives, carers or visitors; other service users and members of the public.

The complaints excluded from the scope of this policy are;
3. ROLES & RESPONSIBILITIES

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<td>Board of Directors</td>
<td>The Board of Directors is ultimately accountable for ensuring the concerns and complaints policy is in place and has effective controls to support the policy’s purpose and aims.</td>
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<td>The Board will ensure that there is appropriate expertise and the necessary resources available to enable the policy to be effectively discharged.</td>
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<td>Provide scrutiny of complaints via the Non-Executive Directors; Directors will review a random sample of closed complaints files on a quarterly basis.</td>
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<td>Chief Executive (CEO)</td>
<td>The CEO is the ‘responsible person’ for ensuring compliance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and that action is taken if necessary in light of the outcome of the complaint.</td>
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<tr>
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<td>The CEO or nominated deputy in his/her absence will read and review all complaints and the responses and will provide a signed cover letter to accompany this.</td>
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<tr>
<td>Chief Nurse (CN)</td>
<td>The CN or nominated deputy in his/her absence is responsible for providing the Board with a monthly report regarding complaints activity, the actions taken and an evaluation of the effectiveness of these actions.</td>
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<td>Deputy Chief Nurse (DCN)</td>
<td>The DCN is responsible for ensuring detailed procedures are developed, agreed, implemented and monitored.</td>
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<tr>
<td>Roles</td>
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<td>Ensuring Key Performance Indicators (KPIs) are monitored and reported to Divisions, Patient Experience Group, Quality Assurance Committee, Clinical Governance Committee and Trust Board.</td>
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**Assistant Chief Nurse (Patient Experience) (ACN)**
- The ACN or nominated deputy in his/her absence will read all complaints and provide a written acknowledgement of the complaint.
- The ACN or his/her nominated deputy in their absence will quality assure all complaints responses for those complaints which are risk rated at red of amber levels.
- The ACN or their nominated deputy in his/her absence will consider and approve requests for an extension to a complaint response timeframe where it is deemed appropriate to do so.

**The Head of Patient Experience**
- The Head of Patient Experience is responsible for:
  - Day to day management and provision of a patient advice and support service in relation to concerns and complaints.
  - Managing the procedures for handling and considering complaints under the complaints regulations.
  - Interpretation of NHS Complaints Procedure and developing and reviewing associated local policy and procedures.
  - Executing his/her duties as described in the associated procedural documents.
  - Providing quality assurance of complaint responses for complaints risk rated yellow or green.
  - Managing the administrative process for PHSO investigations.
  - Providing training in relation to the management of complaints.
  - Monitoring concerns and complaints’ KPIs, analysing complaints information and provide data and information for divisions, Patient Experience Group, Quality Assurance Committee, Clinical Governance Committee, Rotherham Clinical Commissioning Group and Trust Board reports and KO41a quarterly return submission to NHS Digital.
  - Escalating as appropriate issues to the Assistant Chief Nurse (Patient Experience).
  - Informing the Communications Manager of Potential Media interest.

**The Complaints Manager and Patient Advisors**
- The Complaints Manager and Patient Advisors will provide day to day advice and support to services users and their representations in relation to concerns and complaints.
- Execute their duties as described in the associated procedural documents. Monitor concerns and complaints,
<table>
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<td>KPIs and analyses complaints information and provides data and information as required by the Head of Patient Experience. Ensure the Head of Patient Experience is kept apprised of any complaint investigations that are not going to meet the timescales within the complaints procedure.</td>
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<tr>
<td>Divisional Governance and Quality Leads (Heads of Nursing/Heads of Midwifery/Heads of Clinical Professions)</td>
<td>Are accountable for the management of complaints within their Division in liaison with the Head of Nursing, Service Manager, General Manager and Clinical Director as required. Ensure that this policy and associated procedures are implemented within his/her Division. Allocate an Investigating Officer to each complaint investigation within their Division and inform the Patient Experience Team of the named lead. Ensure complaints investigations are undertaken within the required timeframes. Quality assure all complaint responses and ensure all aspects of the complaint have been addressed and the response has been written in line with the guidance on writing response letters at Appendix 3. Make a judgement regarding whether the complaint is upheld, partially upheld or not upheld and is included within the complaint response. Disseminate complaints information as appropriate to frontline staff within the Division. Ensure that individual complaints and also trend data are considered at the Divisional or speciality governance groups. Inform the Division’s governance group who is responsible for the achievement of the KPI performance in relation to these areas in the management of complaints. Ensure that complaint action plans are monitored at Divisional or speciality governance groups and ensure that all identified learning and improvements are implemented and disseminated across the division and the Trust. Provide the Complaints Manager with monthly updates on the progress of all action plans and lessons learned.</td>
</tr>
<tr>
<td>Directors of Clinical Services</td>
<td>The Directors of Clinical Services are responsible for investigating complaints relating to or involving a senior member of his/her medical team/Division. Each Director of Clinical Services will account to the Medical Director for performance within their area of responsibility.</td>
</tr>
<tr>
<td>General and Service Managers</td>
<td>Inform the Head of Patient Experience of any changes to services which may have a potential impact upon patient experience, or the potential to raise concerns or complaints.</td>
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<tr>
<td>Roles</td>
<td>Responsibilities</td>
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| Investigating Officer                     | Ensure a full investigation of each aspect of the complaint (in line with the Trust’s Incident and Serious Incident Management Policy) and provide the Patient Experience Team with the information required as set out in the policy and complaints 7 step guide within 20 working days of receipt of the letter of complaint.  
Conduct a complaints investigation following the guidance at Appendix 1.  
Ensure that any clinician involved in the person’s care, directly named or identified as a part of the investigation, is notified of the complaint and provided with a copy for their information.  
Discuss any delays or complications encountered during the investigation with the Divisional lead for complaints. If the final response will not be available within the agreed timescale, an extension request can be submitted for consideration by the Assistant Chief Nurse (Patient Experience) or nominated deputy in their absence.  
Provide the Patient Experience Team with the completed investigation file for storage, to ensure that all information is held in one location. |
| Matrons / Lead Nurses / Ward or Departmental Managers | Ensure every effort is made to informally resolve concerns/complaints which arise locally. Provide advice to their staff teams on the principles of ‘first line resolution’ wherever possible.  
Provide advice to patients regarding the process for making a complaint is local resolution cannot be achieved. Act as an investigator or assist with a full investigation of the concern or complaint and provide the investigating officer with the information required electronically and within the timescale requested.  
Ensure feedback to the staff involved in complaints and ensure that the learning is disseminated widely. Assist with the development of improvement strategies and their implementation. |
<p>| Communications Manager                   | The Communications Manager will ensure that media interest is managed appropriately, if they are alerted to its potential by the Patient Experience Team. S/he will decide in collaboration with the designated Executive, whether any information will be disclosed to the press, the content of any press statement, who will answer press enquiries and whether media access to the area will be given. |</p>
<table>
<thead>
<tr>
<th>Roles</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Affairs Manager</td>
<td>Will review complaints responses in cases where there is a possible or pending claim for negligence.</td>
</tr>
<tr>
<td>Assistant Chief Nurse (Patient Safety)</td>
<td>Will review complaints responses for cases subject to an inquest, or where a Serious Incident/potential harm may have occurred.</td>
</tr>
<tr>
<td>Corporate Secretariat</td>
<td>Responsible for opening and date stamping all written complaints received by the Chief Executive’s Office. All complaints received must be electronically scanned and emailed directly to the Patient Experience Team email in-box at <a href="mailto:your.experience@nhs.net">your.experience@nhs.net</a> upon receipt. The original can then await review by the appropriate Executive Director/ addressee.</td>
</tr>
<tr>
<td>All Staff</td>
<td>Every staff member is responsible for supporting people who wish to provide feedback or raise concerns, every effort will be made by our staff to act upon feedback at the time that it is given, to try to resolve the concerns of patients, relatives and carers promptly. The Patient Experience Team provides a comprehensive service incorporating complaints and concerns. Team members will support patients, relatives and carers throughout, regardless of whether their feedback is handled as a complaint or as a concern. All staff will ensure that information gained is acted upon to improve, plan, develop and evaluate the services delivered. All staff must make every effort to deal with concerns as they arise, informally and promptly and inform senior staff of any issues raised. Where local resolution of a concern has failed and/or the individual wishes to make a complaint, then staff should ensure that they are given the appropriate information about how to do this and the Patient Experience Team be advised of the complaint immediately. An incident report should be completed, where appropriate. All staff must ensure that any associated correspondence is not kept or copied and filed in the patient’s clinical record. No reference to the complaint should be documented in the patient’s clinical record. All staff requested to do so, must comply with any complaint investigation, including providing a statement within the defined timeframe.</td>
</tr>
</tbody>
</table>
4. **PROCEDURAL INFORMATION**

In addition to the information contained within this section; procedures and guidance that support the implementation of this policy are listed below:

- Appendix 1 The 7 step guide to the formal complaints management process on working days
- Appendix 2 Guidance on conducting an investigation into a complaint
- Appendix 3 Guidance for staff on preparing statements
- Appendix 4 Guidance on preparing a complaints response letter
- Appendix 5 Guidance for meetings with complainants

4.1 **Methods of providing feedback to the Trust**

Feedback can be made in a number of ways, so that the individual can choose the most convenient way for them.

Patients and their representatives can raise concerns and complaints via a number of methods;

- Verbally in person, or via the telephone to staff on duty, or the Patient Experience Team
- In writing via a letter
- In writing via an email
- In writing via the links on the Trust Internet portal
- Via the NHS Opinion or Patient Choice websites
- Via a third party such Absolute Advocacy (Cloverleaf) or another advocacy service.

The Trust will raise awareness of all these methods through promoting this via the use of leaflets, posters and the Trust internet.

4.2 **Handling and management of feedback**

Making a complaint can be a daunting experience and the evidence suggests that many people who might wish to complain do not do so, because they do not know how to, or they find the process too intimidating. The Trust therefore can lose valuable feedback from its patients.

The Patient Experience Team will offer assistance to facilitate the raising of concerns and will respond to individuals with specific needs, e.g. for interpreting services, in order to enable everyone who wishes to give feedback to be able to do so.

The Patient Experience Team will offer support to complainants throughout the complaints process and will also provide details of Absolute Advocacy (Cloverleaf) who can assist and advocate for them. Complainants must not be led to believe either directly or indirectly, that they may be disadvantaged because they have raised a concern or complaint.

Patients and their representatives must be asked how they wish issues they raise to be dealt with, in line with the Patients Association’s Person Friendly Charter for handling complaints with a human touch.
However, any feedback received which suggests a cause for concern, must be investigated and responded to whether or not the informant has indicated that they wish to have the matter dealt with.

4.3 Information about raising a concern or making a complaint

Written information regarding how the Trust deals with concerns and complaints will be made available in all departments, reception areas, the Trust website, the local CCG, Absolute Advocacy and through external agencies and partners.

Patients, Service users and the public who require assistance to make a complaint will be directed to local complaint advocacy services and will receive as far as is practical, assistance from the Trust to enable them to understand the procedure and receive advice as to where to obtain assistance.

Concerns and complaints may be made verbally (in person or via telephone) or in writing (letter or electronically). A concern or complaint may be raised with any member of Trust staff, the Patient Experience Team, or the Chief Executive. Alternatively, the complainant may choose to address their concerns to the local commissioner for Trust services, NHS England, a Member of Parliament or another third party such as Absolute Advocacy (Cloverleaf).

If an issue is received via one of these external agencies, upon receipt it will be managed in line with any other concern or complaint received by the Trust.

4.4 Who may raise a concern or make a complaint

A complaint can be made by any person who receives or has received services from an NHS organisation, a primary care provider or independent contractor/provider or by a person who is affected, or likely to be affected by the action, omission or decision of the responsible body which is the subject of the complaint. This includes an MP or other bodies such as the CCG or NHS England.

A complaint can also be made by a representative acting on behalf of a person who receives or has received services from the above or who:

- Is a child (an individual who has not attained the age of 18). The Trust must be satisfied that there are reasonable grounds for the complaint being made by a representative instead of by the child e.g. the capacity of the child.

- Is unable to make the complaint themselves because of physical incapacity or lack of capacity within the meaning of the Mental Capacity Act 2005;

- The person has died; or

- has requested the representative to act on their behalf.

If the Trust is satisfied that a representative is not conducting the complaint in the best interests of a child or a person that lacks capacity, then the Trust
must not consider the complaint and will inform the representative of the reason for this decision.

4.5 Consent if the complainant is not the patient/ third party

If a complaint is made on behalf of an individual then the Trust will need to seek consent from that individual, so that an investigation can be legitimately carried out.

If an individual is unable to provide consent for a person making the complaint on their behalf (for example, they are incapable by reason of physical or mental incapacity, or they are a child), then their legal guardian or parent or other verified appropriate representative will be accepted to act on their behalf.

Where a complaint has been made on behalf of a patient by a Member of Parliament (MP) it will be assumed that implied consent has been given by that patient. If however the complaint relates to a third party, consent will need to be obtained from the patient prior to the release of personal information.

If a patient is deceased, the relationship of the complainant to the deceased patient must be clarified and confirmed as the next of kin, or the Executor of their Estate.

In the event that consent or sufficient evidence cannot be made available confirming the relationship between the complainant and the patient, or the complainant cannot demonstrate sufficient legitimacy in the person’s welfare, the Trust will notify the complainant in writing confirming that they will not progress the matter and the complainant will not receive any details relating to the patient, or any information obtained via their health records.

In circumstances where a complaint is made by a third party when the patient has not authorised the complainant to act on their behalf, this does not preclude the Trust from undertaking a full and thorough investigation into the concerns raised. Specifically, if the complaint raises concerns about patient safety or the conduct of staff, the relevant Trust policies will be invoked.

A response to the third party will be limited, to include any matters of a non-personal or non-clinical nature only, and this will not include the outcome of any Human Resource (HR) investigation. The response to the complainant will explain why this restriction is in place.

4.6 Concerns and complaints excluded from the scope of this policy

The Trust is not required to consider the complaint in the following circumstances - however, the Trust will consider each case individually and as soon as reasonably practicable, notifying the complainant in writing of its decision and the reason for that decision.

a) A complaint made by a responsible body (Local Authority, NHS body, primary care provider or independent provider) who provides care under arrangements made with an NHS body.

b) A complaint by an employee relating to their employment. These must be raised as a concern or a grievance using the appropriate HR policies.
c) A complaint, the subject matter of which has been investigated previously, or has/is being investigated by the PHSO.

d) A complaint arising out of the alleged failure to comply with a request for information under the Data Protection Act 2018 (GDPR) or a request for information under the Freedom of Information Act (2000). These should be directed to the Information Commissioner.

e) Lost property claims, which are investigated and handled under the Security Policy which deals with patient property.

4.7 **Specific considerations when dealing with concerns and complaints**

The Patient Experience Team and the Investigating Officer have a responsibility to ensure that the complainant is fully informed of any relevant considerations that may alter a complaint investigation or a response timeframe.

In any case where the complaints procedure is being brought to an end, the complainant and any persons identified in the complaint must be notified.

4.7.1 **Concerns or complaints involving vulnerable adult or child protection**

Where it is known that the complaint involves a vulnerable adult or child, the Safeguarding Lead must be informed and the most appropriate route of investigation agreed, this may not necessarily be by using the complaints procedure.

4.7.2 **Concerns or complaints that include a Never Event (NE) or Serious Incident (SI).**

If a complaint is received that has already been subject to the completion of a Red Incident, a Never Event (NE) or Serious Incident investigation (SI investigation) but this has not been shared with the patient, their relatives, or Next of Kin (NoK), then the Patient Experience Team must liaise with the Patient Safety Team to determine if the report covers the issues raised as a part of the complaint. If this is the case it may be appropriate that this report is provided in response to the complaint, with an explanation of the process undertaken for investigation, along with an apology that this report was not shared with them at the time. If further issues have arisen and they require investigation, this must be completed in line with the process for investigating new complaints.

If the complaint received triggers a red incident, NE or SI investigation, or is part of one of these processes, this investigation must take precedence and will occur first. The Patient Experience Team must explain this process to the complainant and the timeframes agreed must be in line with the red incident, NE or SI Investigation timeframes agreed.

The Patient Experience Team will duly close a complaint file when a matter is formally passed this level of investigation. However, the Patient Experience Team must put in place a process to ensure that a response is provided before archiving the complaint file for assurance purposes.

If the issues raised within the complaint are not within the remit of the NE or SI investigation, it is expected that the allocated NE or SI Investigating Officer
will also complete the investigation into these issues. However, should they require support to do this, the Patient Experience Team will ask for an Investigating Officer from the Clinical Service Unit (CSU) which the incident relates to support the NE/SI Investigating Officer.

Once the NE or SI investigation is complete and has been through its ratification then this must be shared with the complainant as part of their complaint response. Unless there are circumstances such as a Serious Case Review and criminal proceedings.

4.7.3 **Clinical negligence, personal injury or other claim**

In circumstances where the complainant indicates a clear intention to bring legal action for clinical negligence, personal injury or other claim, the use of the complaints procedure is not necessarily prohibited.

The Patient Experience Team must discuss the nature of the complaint with the Legal Affairs Team to determine whether progressing the complaint might prejudice subsequent legal or judicial action.

If there is no legal reason why the complaint should not be investigated, it will continue in accordance with Trust policy.

If there may be issues which could prejudice subsequent legal action the Patient Experience Team must work closely with the Legal Affairs Team to ensure the complaint response is provided appropriately.

4.7.4 **Disciplinary or professional investigation or investigation of a criminal offence**

Cases regarding professional conduct where a complaint is found to be justified, may require an internal disciplinary investigation to be undertaken. Such an investigation may result in the involvement of one of the professional regulatory bodies, the Police, Trust Security & Emergency Resilience Service depending of the nature of the allegation.

Appropriate action will be taken in accordance with the Trust Disciplinary Procedure. In such circumstances, the complainant must be informed that a disciplinary investigation will be undertaken but that they have no right to be informed of the outcome of the investigation.

Any other issues raised in the complaint which do not form part of the disciplinary or criminal investigation may continue to be dealt with under this policy. The Medical Director, Chief Nurse, Chief Operating Officer and Director of Operations will be informed as appropriate.

4.7.5 **Coroner's Inquest**

In complaints involving a death that is referred to the Coroner, this will be identified by the Patient Experience Team at the point of registration. The Patient Experience Team will liaise with the Legal Affairs Team about this for any specific consideration that may be required and confirmation of what statements and information they may have already.

The Legal Affairs Team must be provided with a copy of the complaint and asked to confirm if they are happy for the investigation to continue.
The allocated Investigating Officer will be made aware that the complaint is also subject to a Coroner’s Inquest and that any information already received will be shared. The Investigating Officer will be asked to liaise with the Legal Affairs Team as appropriate.

4.7.6 Allegations of fraud or corruption
Any complaint concerning possible allegations of fraud, bribery or corruption being discovered or suspected, must immediately be reported directly to the NHS Counter Fraud Authority, the Trust Director of Finance, in line with the Counter Fraud, Bribery and Corruption Policy.

4.7.7 Media Interest
In cases where a complainant has expressed their intention to contact the media, the Communications Team must be informed and will take appropriate action regarding Trust communication and media management.

4.8 Time limit for making a complaint
Normally a complaint should be made within twelve months of the date on which the matter occurred, or within twelve months of the date on which the matter came to notice of the complainant.

Where a complaint is made after this time, the complaint may be investigated if the complainant had good reasons for not making the complaint within the above time limits and given the time lapse it will still be possible to investigate the complaint effectively and efficiently. For example, if circumstances prevented the complainant expressing their dissatisfaction any earlier (i.e. ongoing treatment) or the complainant was previously unaware that there was a cause for complaint.

In circumstances when a complaint is not being investigated on the basis of being time expired, the complainant must be informed of the reason for that decision and informed that they may still ask the Parliamentary and Heath Service Ombudsman to consider their complaint.

Complaints will not be investigated if the time lapsed prevents the Trust from conducting a full and factual investigation. A decision not to extend the twelve-month period will be made by the Assistant Chief Nurse (Patient Experience) in discussion with the Head of Patient Experience and confirmed in writing to the complainant providing them with a concise explanation.

4.9 Handling of joint complaints between organisations
Where a complaint involves a second provider, in health, or social services the Complaints Manager will inform the second provider. The relevant managers will:

- Determine how the complaint can be handled jointly and which provider will be responsible for sending the joint response.
- Advise the complainant accordingly and inform other contacts as necessary.
In circumstances where TRFT has taken the lead on a complaint involving more than one provider and our reply is available, but the other organisation has not supplied their information within the prescribed time limits, The Rotherham NHS Foundation Trust will provide its information to the complainant within the timescale agreed and a reminder will be sent to the Complaints Officer of the other organisation. In the event that information is still not received, the Chief Executive of the other organisation will be advised. In the event that this still does not elicit a response we will close our files.

The complainant will be advised that as the only matter that remains outstanding relates to the other organisation, the matter has been transferred to them for completion.

Named contact details will be provided to the complainant. The second organisation will be advised that our files are closed and that they now have sole responsibility.

In circumstances where the Trust has taken the lead on a shared complaint and the complainant is dissatisfied with the response; but this relates wholly to the other organisation, the further management of this complaint will be handed over to the other organisation. The complainant will be advised of this action and also the rationale. They will be provided with named contact details.

If a complaint is received that relates wholly to another NHS organisation, the complaint will be referred to the appropriate organisation by the Patient Experience Team once consent has been received from the complainant to do so, the complainant will be advised accordingly, including the provision of a contact name and address.

4.10 Support in providing feedback/making a complaint

Making a complaint can be daunting and evidence confirms that many people who might wish to complain do not because they do not know how to do so or they find the process too intimidating. The Trust therefore loses valuable feedback from its patients.

The Patient Experience Team will offer assistance to those individuals with specific needs, e.g. literacy, interpreting services, to enable everyone who wishes to give feedback to be able to do so.

The Patient Experience Team will offer support to complainants throughout the complaints process and will provide details of Absolute Advocacy (Cloverleaf).

Complainants must not be led to believe either directly or indirectly that they may be disadvantaged because they have raised a concern or complaint.

4.11 Listening and responding to concerns of patients, their relatives and carers (early local resolution)

4.11.1 Early local resolution

When something has gone wrong, patients and relatives are encouraged to raise concerns or make a complaint as soon as possible and directly to the staff involved. This is often front line staff in wards, departments, clinics or
reception areas. All Trust staff, as a means of improving service provision, should welcome receiving the complainant’s concerns or complaint positively.

In most circumstances the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise, or as soon as possible after this (early local resolution). Usually this is best undertaken as close to the point of care or service delivery as possible.

If the staff member approached is unable to deal with the issue, they must refer the matter to a more senior member of staff on duty at the time e.g. nurse in charge, Lead Nurse, Matron, Service Manager, Head of the Department. A complainant may simply require an explanation and apology and therefore should not be automatically referred to the Patient Experience Team unless local resolution cannot be achieved or they request this.

If the concern or complaint requires further investigation or if the complainant wishes to address their concerns to somebody not involved, the complaint will be referred to the Patient Experience Team.

The team will provide the complainant with the appropriate information to help them understand the possible options for pursuing a concern or complaint. As far as possible, the complainant will be involved in decisions about how their concern or complaint is handled.

4.11.2 **Stage 1 Local Resolution**
Local resolution is the first line of investigation and response to a complaint and is undertaken within the Trust. Local resolution enables the Trust to provide the quickest opportunity for a full and thorough investigation and response; acknowledge failures and apologise for them; quickly put things right when they have gone wrong and to use the opportunity to improve services.

All concerns and complaints will be dealt with in an open, honest and conciliatory way. The Trust will adopt a flexible approach to resolution with the emphasis on a positive outcome and not on the process.

4.12 **Listening and responding to complaints of patients, their relatives and carers (Complaint Investigation)**

4.12.1 **Local Resolution**
Complaint assessment and acknowledgement

On receipt of a complaint, the first responsibility is to ensure that the patient’s immediate health needs are being met.

If the concern or complaint has been received at the point of service delivery but early local resolution has been attempted but not achieved, the concern or complaint will be passed to the Patient Experience Team.

Other concerns or complaints received in the Trust e.g. by Chief Executive’s Office will also be forwarded to the Patient Experience Team, ideally within 24 hours of receipt.

In cases where a complaint that is being investigated under the NHS Complaints Regulations is received verbally, the complainant will be provided
with a transcript of their concerns or questions to be investigated and this will be sent to the complainant for agreement, prior to the start of the investigation if requested or required.

Alternatively, the complainant may wish to seek the support of an advocate; contact details will be provided or a referral on their behalf can be made to the service if required.

The nature, complexity and seriousness of the complaint are assessed and graded by the Patient Experience Team using the Risk Matrix complaint assessment tool in line with the Trust Risk Management Strategy. Using the National Patient Safety Agency (NPSA) risk rating matrix guidance is a systematic and effective method of identifying risks and it is an essential part of any risk management programme. It also encompasses the processes of risk analysis and risk evaluation with colour rated scoring, green being minor through to red being major. As part of this triage, complaints that highlight potentially serious (red rated) incidents or have Care Quality Commission (CQC) involvement are discussed with the Chief Nurse upon receipt. Any immediate action required is undertaken.

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Unlikely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Likely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Almost certain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

All complaints will be acknowledged within three working days. This is a verbal acknowledgement which then allows the Patient Experience Team to engage with the complainant, to agree their complaint issues and to commence resolution. This verbal acknowledgement will be followed up by a letter of acknowledgment from the Patient Experience Team.

If verbal contact is unable to be made then a letter of acknowledgement will be sent, confirming the registration of their complaint and inviting the complainant to make contact if they wish to discuss anything further. If it is felt that the investigation cannot be completed without having this dialogue with the complainant, a letter of acknowledgement will explain this and ask that they make contact to enable their complaint to be progressed.

4.12.2 Complaint Investigation

Complaints will be thoroughly investigated in a manner appropriate to resolving the issues speedily and efficiently and within the agreed timeframe.

This also provides practical support to the Investigating Officer about the ways in which investigations can be completed and guidance on identifying actions.

Staff directly involved in the complaint will not be nominated as Investigating Officer.
Staff involved or named in a complaint will be notified of the complaint via the Governance Matron, Investigating Officer or their line manager.

Support will be provided to the member of staff by their line manager or the Patient Experience Team. Copies of the complaint will be made available to named persons by the line manager.

The Investigating Officer, Divisional Governance Lead and Patient Experience Team will oversee the quality and timeliness of the investigation, and validate the conclusions, outcome and actions agreed for inclusion in the complaint response. The Investigating Officer is also responsible for the drafting of the response on behalf of the Chief Executive.

On completion of the investigation and draft response the Divisional Head of Nursing (HoN) will be responsible for reviewing the complaint investigation to ensure that it has been thorough and addresses all of the issues raised by the complainant and that appropriate action and lessons to be learnt have been identified. When satisfied that all of these areas have been met the HoN will sign off the response letter. All statements or interviews undertaken as a part of the investigation process must be provided to the Patient Experience Team to form part of the Complaint file.

If a complaint relates to a Corporate Team and sits outside of the clinical divisional structure the signing of the complaint response will be the responsibility of the appropriate Director for that area.

4.12.3 Remedy

If a complaint is upheld or partially upheld, the Trust will decide whether any mal-administration or service failure has caused an injustice (Health Service Ombudsman’s Principles of Remedy). The Trust should as far as is possible, put the individual status back into the position that they would have been if the mal-administration or service failure had not occurred. If that is not possible, the Trust should consider whether it is appropriate to compensate appropriately.

The Trust will consider suitable and proportionate financial and non-financial remedies for the complainant and where appropriate, for others who have suffered the same injustice. An appropriate “remedy” may be an apology, and an explanation or by taking remedial action. Financial compensation will not be appropriate in every case, but should be considered.

Appropriate and proportionate financial remedy will be considered using the principle of ex gratia payments to compensate complainants in exceptional cases. If an ex gratia payment is considered for this purpose, the appropriate governance arrangements are applied to the consideration of each ex gratia payment request and in line with the Trust Standing Financial Instructions (SFI’s).

This policy does not relate to medico-legal claims for compensation which will be dealt with through the Legal Affairs Department in conjunction with the NHS Litigation Authority.
4.12.4 **Complaint Response**

All complainants will receive a fair and honest response. The complainant may prefer to receive this via a letter, at a meeting or in a telephone call. The latter will be followed up in writing. The response will address all issues raised, provide a full explanation, an apology as appropriate, any decisions regarding remedy and actions that have, or are planned to be undertaken to put the matter right. Where possible the response will be in a format suitable for the complainant, e.g. the use of large font.

The Investigating Officer is responsible for producing a draft response which will be initially agreed by the Divisional Governance Lead and Head of Nursing. It will then have a further review by the Assistant Chief Nurse (Patient Experience) or the Head of Patient Experience, the Deputy Chief Nurse, or the Chief Nurse as deemed appropriate in relation to the risk rating given and lastly be signed by the Chief Executive or nominated deputy.

4.12.5 **Meetings**

Face to face meetings with Trust staff are offered as a part of the investigation process. Complainants will be informed of the potential benefits of a face to face meeting with relevant staff in order to clarify issues, determine what outcome they expect and how they wish to be kept updated throughout the investigative process. This meeting will be offered by the investigating officer and if the complainant is in agreement will be arranged swiftly.

If the complainant does not wish to meet at this point, the above details will be discussed during this telephone conversation. The complainant will be informed that there is further opportunity to meet later in the process if they wish. Meetings may be arranged at any point in the process when it is felt to be the most beneficial to the complainant.

Any meetings held are digitally recorded so that a copy of the recording can be provided to the complainant. This enables all parties to be able to refer to this at a later date, to clarify any issues discussed and the specific details.

The digital recording will be issued within 14 working days of the meeting being held. If a recording cannot be taken, meeting notes will be made and sent to the complainant for their review and agreement followed by a final and approved response letter.

4.12.6 **Re-investigation of a Complaint**

In cases where the complainant is not satisfied with the Trust response, the complaint will be re-opened.

This may be because the complainant considers the initial investigation to be inadequate, incomplete or unsatisfactory; or the complainant believes that their issues have not been addressed or fully understood. The complainant may ask further questions at this stage based upon the response that they have received.

The complaint will be reassessed by a member of the Patient Experience Team; the issues that remain unresolved for the complainant will need to be clarified and a new complaints plan agreed, the same procedure will be followed.
Independent advice or a second opinion may be considered, on the element of the complaint that has been re-opened for investigation.

Meeting with the complainant is encouraged, to aid resolution of the complaint. In some circumstances and in agreement with all parties, conciliation or mediation could also be considered.

If local resolution has been completely exhausted and the complainant still remains dissatisfied, the complainant will be reminded of their right to go to the PHSO.

4.12.7 Stage 2: Parliamentary and Health Service Ombudsman (PHSO)
In cases where the Trust has been unable to resolve a complaint (which has been managed in line with the formal complaints regulations) to the complainant’s satisfaction, the complainant has the right to refer their complaint to the PHSO for independent review.

The PHSO is independent of the NHS and the government and will undertake an independent investigation into complaints where it is considered that the Trust has not acted properly or fairly or provided a poor service.

The Trust will fully comply with all PHSO requests for information, the Chief Executive, Chief Nurse, Medical Director and Divisional Management teams will be notified, as appropriate, of any complaint (and any persons named) that is being investigated by the PHSO.

If the complaint is upheld by the PHSO, the above staff will also be notified. The Complaints Manager will work with the relevant division to complete the actions required. This will be reported at Board level, divisional governance meetings and to any other outside agencies as requested by the PHSO for example the appropriate Clinical Commissioning Group (CCG) and NHS Improvement.

4.12.8 Confidentiality
Individuals should be assured that concerns and complaints will be handled in the strictest of confidence. Disclosure of information collected as part of an investigation or contained within an investigation report or written response which identifies individuals must be confined to those with a justifiable and demonstrable need to know.

Disclosure of information from health records to persons involved with an investigation will be handled in accordance with the requirements of the Data Protection Act 2018 and the General Data Protection Regulations (GDPR).

Correspondence about complaints must not be included in patient’s records and no reference to the complaint must be entered in the patient’s clinical record.

Information about complaints and all the people involved is strictly confidential, in accordance with the Caldicott principles. Information is only disclosed to those with a demonstrable need to know or a legal right to access those records under the Data Protection Act 2018 GDPR.

All data will be processed in accordance with Trust’s Data Protection Policy.
Complaints must not affect the patient’s or complainant’s treatment and the complainant must not be discriminated against. Any identified discrimination by a member of staff will be reported to the Human Resources team and managed as per Trust policies.

4.12.9 **Record Keeping**

A complete documentary record will be maintained for each concern or complaint. This will include all written or verbal contacts with the complainant, staff involved in the investigative process, statements and all actions taken in investigating the complaint.

The complaint file is a confidential record and as such will be stored securely and easily retrieved and understood in the event of any further enquiry.

In accordance with the NHS Records Management Policy (2010) Complaints files are kept and disposed of confidentially in accordance with the Trust’s Records Management Policy. Currently, complaints files are retained for 10 years.

4.13 **Support for Complainant and Staff**

Dealing with a complaint can be stressful for both the complainant and the staff involved.

4.13.1 **Complainant**

Guidance and support on how to raise concerns can be obtained from the Patient Experience Team, on the Trust’s website and via local advocacy services. Local advocacy services can assist and support people making a complaint, including preparing, presenting or writing a complaint.

The local advocacy information and advocacy support is noted within the Trust’s Complaints leaflet and which is provided to all complainants with their letter of acknowledgement. The complainant will also be provided with the contact details for the Patient Experience Team.

4.13.2 **Staff**

Receiving and investigating complaints can be stressful for staff to deal with. On receipt of a complaint the staff involved will be notified of the support available to them by the Investigating Officer, e.g. from their line manager, the Patient Experience Team, and relevant trade union.

4.14 **Harassment & Vexatious/Unreasonably Persistent and Intractable Complaints**

4.14.1 **Harassment**

Violence, racial, sexual or verbal harassment will not be tolerated, neither will language that is of a personal, abusive or threatening nature. If staff do encounter this behaviour, they should seek support from their line manager and complete an incident form via Datix. This will also require escalation to the Head of Patient Experience. Where appropriate the complainant will be informed in writing that their behaviour is unacceptable.
In the event that the complainant has harassed or threatened staff dealing with their complaint, all personal contact with the complainant will be discontinued. The complaint thereafter can only be pursued through written communication.

These decisions will be made by the Chief Nurse in conjunction with the Head of Patient Experience and the Trust will manage the individual using the Management of Violence and Aggression Policy.

4.14.2 Management of Vexatious/unreasonably persistent

Vexatious and unreasonably persistent complainants are those that raise the same or similar issues repeatedly, despite having received a full response to all the issues they have previously raised.

Each circumstance must be considered carefully. It is emphasised that it is expected that this guidance will only be used as a last resort and when all reasonable measures have been taken. See Standard Operating Procedure for the Management of Concerns and Complaints.

Examples would include complainants that:

- Display unreasonable demands or expectations and fail to accept that these may be unreasonable e.g. timeframes for response, direct access to the staff involved etc.

- Have excessive contact or inappropriate contact with the Trust, placing unreasonable demands on its staff.

- Persist in pursuing a complaint where the Trust’s complaints procedure has been fully and properly implemented and exhausted.

- Are unwilling to accept documented evidence of treatment given as being factual, deny receipt of an adequate response, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of the Trust staff, or another body to try and assist them to specify their concerns, or where the concerns identified are not within the remit of the Trust to investigate.

- Change the substance of a complaint, continually raise new issues, and seek to prolong contact by continually raising further concerns or questions upon receipt of a response. Care must be taken not to disregard new issues which are significantly different from the original complaint. Any new matter must be considered on its merits.

- Fail to engage with staff in a manner which is deemed appropriate: e.g. repeatedly using unacceptable language; refusing to adhere to previously agreed communication plans, or behaving in an otherwise threatening or abusive manner on more than one occasion, having been warned about this. Where complainants are violent or aggressive, staff should refer to the Trust’s Violence and Aggression Policy.
The Head of Patient Experience in agreement with the Chief Nurse will determine the point at which a complainant is considered to be unreasonably persistent and will decide what course of action to take.

Below are some possible courses of action that may help to manage complainants who have been designated as persistent or unreasonable.

- Requiring their contact to be made with a named member of staff.
- Requiring contact to be made through a third person, such as an advocate.
- Limiting the complainant to one mode of contact e.g. in writing only.
- Requiring any personal contact to take place in the presence of a witness.
- Advising that the organisation does not deal with correspondence that is abusive or contains allegations that lack substantive evidence. Request that the complainant provide an acceptable version of the correspondence or make contact through a third person to continue communication with the organisation.

Notify the complainant in writing that the Trust has responded fully to the points raised and considers that all methods of resolving the complaint have been exhausted and either there is nothing more to add, or continuing contact on the matter will serve no useful purpose. Further, explaining that correspondence is at an end and that any further communications on the specific or a closely related matter that are received will be read and placed on file, but not acknowledged and no further action will be taken.

Once a course of action has been determined the Chief Nurse or Head of Patient Experience will draft a letter informing the complainant of the decision and the reasons for this. The letter will be reviewed and signed by the Chief Executive.

4.14.3 Persistent/ Habitual Complainants

We expect our staff to deal with individuals in a respectful and professional manner at all times and to follow appropriate procedures, however there may be instances when nothing more can reasonably be done to rectify a real or perceived problem. Alternatively, there may be some complainants who because of their frequency of contact with the Trust, hinder progress of its day to day business. At this stage it is important to ensure that complaints procedures have been followed correctly and that all elements of the complaint have been adequately addressed. We need to ensure an equitable approach; this is crucial as habitual or vexatious complainants will usually have issues which contain some genuine substance.

Should such situations occur, we will consider whether it is appropriate to flag the complainant as vexatious. It is emphasised that applying a vexatious status should only be used as a last resort and after all reasonable measures have been taken to try to resolve complaints following the NHS Complaints process.
Procedure, through local resolution, or involvement of an appropriate advocacy support agency.

If at any time an individual’s behaviour becomes offensive or unacceptable (as above) we will manage those individuals in accordance with the Management of Violence and Aggression Policy.

4.14.4 Intractable complainants
Dealing with a complaint is usually a straightforward process but in a minority of cases, people pursue their complaints in a way that can either impede the investigation, or can have a significant resource issue for the Trust.

The difficulty in handling such complaints places a strain on time and resources and can cause undue stress for staff. Staff should respond with patience and sympathy to the needs of all complainants, but there are times when there is nothing further that can reasonably be done to assist them to rectify a real or perceived problem.

If an Investigating Officer or member of the Patient Experience Team feels this is the case, then this will be escalated to the Head of Patient Experience. The Head of Patient Experience and Complaints Manager will review the evidence to support this and in conjunction with the Chief Nurse make a decision on how further contact from the complainant will be managed. It may also be appropriate to seek the views of the Trust’s Legal Affairs Team or Trust Solicitor.

4.15 Reference to External Agencies
If the review of a complaint reveals a possible case of criminal activity or another serious matter, the Head of Patient Experience should ensure the Assistant Chief Nurse (Patient Experience) is notified.

In such cases it will be necessary to refer the matter(s) raised to one or more external agency e.g. the Police, NHS Improvement & NHS England, Her Majesty’s Coroner etc. In such cases the Chief Nurse will be responsible for making such a referral.

4.16 Complaints Analysis, Learning and Reporting
Information from concerns and complaints will be used to improve the quality of care, treatment, services and facilities provided by the Trust and to reduce risk.

Analysis will include;
- Performance achieved against the Key Performance Indicators (KPIs)
- Number of complaints, subject of complaints, location of complaints and risk grading
- Identification of themes or trends
- Complainant satisfaction
On a weekly basis the Complaints Manager will provide each of the Division’s Heads of Nursing and Governance Leads with a report on the target dates for complaints investigations and responses, and a status update on all open complaints within their Division.

On a monthly basis the Head of Patient Experience will provide a report to the Business Engagement Team to show performance against the KPIs and data in relation to concerns, complaints and PHSO investigations.

Complaints information will be reported monthly to the Board via the Chief Nurse, quarterly to the Clinical Governance Committee, Quality Assurance Committee and Clinical Commissioning Group and annually via the annual complaints report. The Head of Patient Experience will report monthly to the Chief Nurse and bi-monthly to the Patient Experience Group, with any supplementary reports as required.

Complaints provide us with valuable information and the Trust aims to have the learning points from these agreed where appropriate, prior to the response being sent to the complainant. An action plan will be produced for those complaints where corrective actions are identified as being necessary and this will be sent out with the complaint response.

Lessons must be learned from individual complaints. This learning needs to translate into improvement strategies that are developed and monitored through divisional governance arrangements from wards and departments through to Board level.

A sample of complaints files will be reviewed by a Non-Executive Director on a quarterly basis.

Trust wide systematic analysis of incidents, complaints and claims will take place on a monthly basis as described in the Incident and Serious Incident Management Policy.

4.17 Complainant Satisfaction

Understanding the experience of the complainant during and after a complaint investigation is considered good practice by the Trust.

Currently the PHSO and NHS England are working together to develop a model survey to enable providers across health and social care to measure service-user satisfaction. In the meantime, complaints handling satisfaction questionnaires are sent with all response letters to obtain feedback on the handling of the complaint by the Patient Experience Team and the Division.

4.18 Comments and Feedback

Outside of concerns and complaints the Trust acknowledges that there are many patients and visitors to the organisation who wish to offer general feedback on their experience or offer suggestions on how we can improve our services. Such comments can be made:

- Verbally in person, via the telephone to staff on duty, or via the Patient Experience Team
- In writing via letter
In writing via email
In writing via the links on the Trust Internet
By using NHS UK or Care Opinion

The Patient Experience Team will acknowledge these comments, send to the relevant departments and where changes are made as a result of a comment, these will be fed back to individual.

5 DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

For the purpose of this policy the following definitions apply (NB it is important to note that it is sometimes difficult to clearly differentiate between a concern and a complaint, and for this reason they should be viewed on a continuum).

5.1.1 Concern: A concern can be defined as “a matter of interest, importance, inquiry or anxiety”. These are often issues where more immediate action is required, where things are ‘going wrong’ or general help and support is required.

Concerns are received throughout the organisation and through the Patient Experience Team, the aim is to resolve the concern to the individual’s satisfaction as promptly as possible and within a reasonable timescale. If this is not possible then the individual raising the concern, can decide to await a satisfactory outcome through local resolution or can ask that their concern be investigated as a complaint under the NHS Complaint Regulations (2009).

5.1.2 Complaint: The Trust defines a complaint as “an expression of dissatisfaction”, or a perceived grievance or injustice which requires a formal response”.

Complaints and concerns can be received in written format (letter, email, on-line contact form) or via face to face or telephone communication.

All concerns and complaints will be recorded and reported via the DATIX system and a wider analysis of trends and themes will be shared through the Trust’s governance structures.

5.1.3 Comment: General feedback not requiring investigation but highlighted to service for possible service improvements

5.1.4 Compliment: Message of appreciation to be disseminated to relevant staff. Please refer to Appendix 5a and 5b.

5.1.5 Independent Review: The Trust will arrange appropriate independent review of complaints and will on occasion’s commission an external body to carry out a review of the care given. This includes the provision of medical records and complaint details to the third party.

5.1.6 Local Resolution: Is the first stage of the NHS complaints procedure. Ideally, it will start after all attempts to resolve a complainant’s concerns have been
explored by clinicians and managers at a local or service level as soon as they arise. On occasions complainants may prefer to bypass clinicians and managers at a local level and contact the Patient Experience Team or Chief Executive personally.

A complainant will be contacted where possible to agree how their issue will be resolved and given a timeframe within which it is felt reasonable to expect this to be completed.

5.1.7 **Never Event:** a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'.

5.1.8 **Serious Incident:** are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or the Trust are so significant, that they warrant using additional resources to mount a comprehensive response. They can extend beyond incidents that affect patients directly and include incidents that may indirectly impact on patient safety or the Trust's ability to deliver on-going healthcare.

5.1.9 **Red Incident:** If following review of an incident the Serious Incident panel do not consider this meets the Serious Incident National Framework SI criteria; but consider this requires a more detailed investigation and report they may ask for an internal or Red Incident level of investigation to be undertaken. These reports are all recorded by the Patient Safety team but must be monitored by the Divisional governance team to ensure all the actions and learning is completed.

5.1.10 **Parliamentary & Health Service Ombudsman:** Is responsible for the second stage of the complaints procedure and a complainant may wish to contact them if the Trust has exhausted attempts to resolve their complaint and they remain unhappy. The Ombudsman is responsible for reviewing complaints and making recommendations where necessary on how the complaint was handled and what more can be done.

### Abbreviations

- **CEO**: Chief Executive Officer
- **CFS**: Counter Fraud Service
- **CN**: Chief Nurse
- **COO**: Chief Operating Officer
- **CQC**: Care Quality Commission
- **CSU**: Clinical Service Unit
- **DCN**: Deputy Chief Nurse
- **ACN**: Assistant Chief Nurse
- **EIA**: Equality Impact Assessment
- **GDPR**: General Data Protection Regulation
- **HoN**: Head of Nursing
- **NoK**: Next of Kin
- **MD**: Medical Director
NE  Never Event
PHSO  Parliamentary and Health Service Ombudsman
RCA  Route Cause Analysis
SI  Serious Incident
SOP  Standing Operating Procedure
TRFT  The Rotherham NHS Foundation Trust

6  REFERENCES

•  Good practice standards for NHS Complaints Handling, (Patients Association 2013)
•  Listening, Responding, Improving – a guide to better customer care (Department of Health 2009)
•  Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
•  Principles of Good Complaint Handling (Parliamentary & Health Service Ombudsman 2008)
•  Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, (Francis Report 2013)
•  Care Quality Commission
•  NHS England, Assurance of Good Complaints Handling for Acute Care 2015

7  ASSOCIATED DOCUMENTATION AND REFERENCES

•  The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
•  NHS Constitution DOH 2009
•  Parliamentary and Health Service Ombudsman Vision for Good Complaint Handling (PHSO 2009)
•  NHS England, Assurance of Good Complaints Handling for Acute Care 2015
•  Patient’s Association – Good practice standards for NHS complaints handling September 2013
•  Care Quality Commission – Complaints Matter 2014
•  Francis Report February 2013
•  Clwyd and Hart Reports October 2013
•  My expectations for raising concerns and complaints report 2014
•  TRFT Patient Experience Strategy (under revision)
•  TRFT Records Management Policy
• TRFT Being Open and Duty of Candour Policy
• TRFT Supporting Staff involved in an incident, Claim or Complaint policy
• TRFT Claims Handling Policy
• TRFT Risk Management Strategy
• TRFT Incident and Serious Incident Management Policy
• TRFT Security Policy (Patient Property)
• TRFT Violence and Aggression Policy
• TRFT Data Protection (GDPR) Policy
• TRFT Information Governance Policy
### 7 Step Guide to the Formal Complaint Management Process in Working Days

#### Day 1
Complaint received by Patient Experience Team (PET)
PET undertakes a risk assessment. Chief Nurse to review risk assessment.
PET Contact with patient made to agree concerns to be investigated, resolution and timescale.
Complaint Management Plan commenced.

#### Day 1-3
Personalised acknowledgement letter signed by the Chief Nurse sent to complainant by PET (requesting consent if required).
Copy of complaint, CMP1, CPM2, CMP3 and action plan sent to the Appropriate Head of Nursing and Divisional Lead for complaints

#### Day 1-3
Appropriate Head of Nursing or Divisional Lead to identify Lead Investigator.
Lead Investigator contacts complainant if appropriate to clarify issues or arranges a meeting with complainant if required or requested. Lead Investigator commences investigation by contacting relevant staff.

#### Days 5-15
Investigation completed and response and action plan drafted covering all aspects of concerns raised by complainant.
If the investigation identifies a complexity (e.g. staff absence) and the final response will not be available within the agreed timescale, the lead investigator is to agree the requirement for an extension with Head of Nursing or Divisional Lead, inform PET of the reasons for this request. PET to contact Chief Nurse for consideration of extension and then informs lead investigator of the outcome). Where extension is agreed PET will contact the complainant to agree the new timeframe and confirms this in writing if required. Prior to sending the final response to PET ensure relevant staff involved in the complaint have all had the opportunity to review the draft response and action plan devised. Draft response will be quality assured by the appropriate Head of Nursing

#### Day 16-18
PET in receipt of final response letter, action plan and completed complaint management plan. Green and yellow complaints to be quality assured by the PET. Amber complaints will be quality assured by the Assistant Chief Nurse and red complaints by the Chief Nurse. PET to complete any amendments required or return to the Lead Investigator for further information or investigation if required.
If further information/investigation is required which will impact upon the response time the lead investigator must agree the requirement for extension as above.

#### Day 20-25
The final response letter and cover letter presented to Chief Executive. If further information/investigation is required PET team to inform Investigating Lead. If this will impact upon the response time PET will contact the complainant to agree the new timeframe and if necessary will confirm this in writing.

#### Days 28-30
If no changes are required and the response is signed by Chief Executive (or nominated deputy), PET will post final letter to complainant and complete Datix entry. If a signed copy of final response is required a copy can be provided to Appropriate Head of Nursing/ Directorate Lead.
Divisions receive weekly update of complaints status via PET.
Appendix 2

Guidance on conducting an Investigation into a Complaint

A comprehensive investigation should be carried out in accordance with the process detailed within the Trust’s reporting, investigation, management and analysis of Incidents, complaints, concerns and claims documented within the Incident and Serious Incident Management Policy.

Note; Independent investigation will be initiated where any one of the following apply;

- A complaint amounts to an allegation of a serious incident.
- Clinically related issues cannot be resolved without an expert clinical opinion.
- A complaint raises issues of professional misconduct or the performance of senior managers.
- A complaint involves issues about the nature and extent of the services commissioned.

The timeframes for an investigation as detailed in the Standard Operating Procedure for the Management of Concerns and Complaints must be adhered to.

It is important that one person is responsible for the conduct of the investigation – “the investigating officer”.

- Before starting the investigation, it is important to understand all the elements of the complaint and to clarify what the complainant’s expectations are. The Patient Experience Team will have contacted the complainant and documented this information on the Complaints Management Plan (CMP1).

- Understanding all the elements of the complaint is essential in developing an investigation action plan. Throughout the investigation, the investigating officer must keep in mind what the complainant is looking for and what is a reasonable, achievable outcome.

- It may be appropriate to construct a timeline of events to help in the development of the investigation, particularly if the complaint is complex.

- In order for the investigation to be efficient, the investigator needs to decide;
  - what needs to be done and what questions need to be answered
  - consider what information is required to establish the facts this could include;
    - Health records
    - Booking systems
    - Lab results
    - Reference to local and national policies and guidance
    - Site visits
  - who needs to be approached for information/statements on each issue for example any named individual or clinician complained against, line management or witnesses. It is good practice, where possible, to have
clinical responses verified by senior clinicians not involved in the care that is the subject matter of the complaint.

- gather sufficient clinical, factual and other information to identify what has occurred and what action, if any, is required.

- In some circumstances it may be necessary to conduct an interview. This may be a serious complaint where conflicting accounts have been provided by staff and 3rd party witnesses. Interview notes must include, date, time, venue, duration of interview, name of the interviewee and job title/role to complainant and the name and job title of the interviewer or a digital recording may be taken.

- Where the complaint relates to serious harm or death, opinions from outside of the Trust are likely to be required. This should be discussed and agreed with the Chief Nurse.

- Other people beside organisation staff may be useful witnesses who can be interviewed or provide statements e.g. friend, relative, carer. The investigator should seek permission from the complainant for 3rd party witnesses to be contacted. The Patient Experience Team can help with this.

- When asking for responses from anyone involved make sure your request is clear about the issues to which you want a response. It is not sufficient to merely ask for comment – you need to pose specific questions which will help build a complete understanding of what happened. You should advise people to refer to the guidance for staff on the preparation of statements at appendix 2.

- Emphasise that all responses, be they correspondence, emails statements or interview notes may be disclosable under Data Protection (GDPR) and Freedom of Information legislation and must include; responses must address all the issues and be factual and be dated and signed.

- Staff providing statement should be made aware that documentary evidence, including statements, obtained in the course of an investigation may be used as evidence in any resulting disciplinary proceeding.

- Any contact made with the complaint, staff or anyone else during the investigation must be logged on the Complaints Management Plan 2 (CMP2). If an investigating officer has been unable to obtain a statement or information from a key member of staff, the reasons why must be recorded. Contact with ex-employees may be appropriate if they are a crucial witness, this must be discussed and agreed with the directorate complaints lead.

Evaluation of findings

- After information has been gathered, the investigating officer must analyse all relevant facts and opinions.

- The investigating officer must identify points of agreement, difference of opinion e.g. differing views from clinicians on the appropriateness of patient treatment and any dispute of facts e.g. where there are different accounts of events.
Where a difference of opinion has been found during the investigation, the investigating officer must highlight any evidence which suggests one opinion to be more reasonable; this may include highlighting key aspects of best practice guidance or independent opinion if obtained and the credibility of witnesses.

Where there is a dispute of facts, the investigating officer must identify any evidence which indicates the more likely version of events; this may include highlighting relevant aspects of the health record, corroborating parts of statements or interviews, highlighting the credibility of witnesses.

The investigating officer should then indicate their preliminary conclusions they have reached for each aspect of the complaint.

Reaching a judgement

Ideally the investigating officer and decision maker should not be the same person.

The investigating officer should write a succinct and comprehensive report/draft response that summarises the investigation, the evidence gathered and the preliminary conclusions reached. The purpose of this report is to enable the divisional Governance Lead to make a decision regarding each aspect of the complaint without needing to go back through the entire investigation in detail.

The report/ draft response letter and a draft action plan (where required) should be sent to the divisional Governance Lead who will review the findings of the investigation and the preliminary conclusions and decide whether a complaint is justified (upheld) or not (not upheld) and whether there are aspects where no conclusion could be made e.g. there is a conflict of accounts about what was said during a consultation and there is no clear evidence to be able to establish fact. They must detail why they have reached their view on the Complaints Management Plan 3 (CMP3).

The Divisional Head of Nursing will then quality assure the response letter and action plan. Evidence that this part of the process has been completed is required by the Patient Experience Team prior to the next stage of the quality assurance process commencing.

All investigation documentation must be sent to the Patient Experience Team as detailed in the procedure for the management of concerns and complaints.
Appendix 3

Guidelines for staff on preparation of statements

This guidance will help you to write a full and thorough statement. Statements may include accounts of events but also opinions on the appropriateness of treatment or the conduct of an individual.

You may take advice from your manager, or the Patient Experience Team.

Although the majority of statements stay within the Trust, your statement is disclosable and may be released to the complainant, their family, the Parliamentary and Health Service Ombudsman, the Coroner, or be used as evidence in defending a legal claim.

Do's

• Make initial notes based on your first reading of the complaint
• Start the statement with your full name, job title, main professional qualifications, the date acquired and the years of experience you have undertaken in your post and profession
• Describe events in their chronological order.
• Note all the points complained of and give a response to each point.
• If the complainant has used a number for each item, please use the same so your response is clear to see for each item.
• If you do not have a response to each item, please say this and why that is the case e.g. I was off duty on the date of this patient’s admission
• Be factual, honest and objective.
• If you recall the patient do say this, make clear what part of your statement is from your memory, what part of your response you have used the records to respond to and finally what part is based upon recollection of your standard practice at that time i.e. ‘it would be my normal practice to ….’.
• If you don’t recall any particular details and there is no written account, say that you do not recall this event, or this patient and there are no records of your contact with them.
• All statements must be signed, your name must also be printed and give the date that the statement was written. If it is later typed, then the date of typing should also be added, but do not remove the date of writing.
• You should give enough information about clinical terms or issues so that it can be understood by someone who is a lay person...
• Try to avoid any abbreviations but if you do need to use one, you must explain it immediately after the first time you use it and then it is acceptable to continue to use the full abbreviation thereafter.
• Do respond on any allegations made in the complaint concerning your involvement with the patient or the issues raised. Please try to be objective and not defensive, by stating the facts of what occurred.

• Point out any factual inaccuracies within the allegations in the complaint and explain how you know they are not correct.

• If you wish to state that you support the reasons for a decision that was made, or an action taken, please try to support this with a reference to the relevant policies, procedure, or guidelines in use at the time of the event. If the current guideline was not followed please explain the reasons for deviating from that if this occurred.

• Identify other staff involved, give their names and job titles.

• Please use simple and clear language and avoid ambiguous statements.

• Provide as much detail as possible, giving dates, times, locations and amounts if appropriate e.g. drug dosage etc.

Don’ts

• Do not simply re-write your entries from the notes. The investigator will already have access to this information.

• Avoid speculating on what others were doing or possibly thinking in any situation unless they told you this or you know something as a fact.

• Give opinions on the care given or actions taken by any other staff or blame other staff or departments for any issues.

• Attempt to write the statement without access to all the clinical records. However, if you recall the patient or events, do commence some initial notes and questions that you will want to have further information for – this will help you to check the notes and write a thorough statement.

• Never be hostile, rude or take a defensive position in your response to the complainant, please remember that complainants or their solicitors if a legal claim is pursued may request sight of your statement. The Trust is obliged to release all documents relating to the complaint and this includes emails between colleagues working on the response.

• Don’t be subjective, try to be clear, succinct and objective, get help with your draft statement if this is a concern to you.

• Keep strictly to what you know, saw, heard or did, never relate conversations that you were told by someone else. This may be inaccurate or exaggerated information.

• Don’t anticipate the evidence of another witness or questions which may arise later, just keep a focus on what is being asked.

• Use abbreviations, see guidance above.

• Comment on the aftermath of the care given, or the patient’s longer term position, rather than the incident itself.
What you will need
A copy of the complaint
Clinical notes

Personal Information
The statement should include:
The reference number of the case
- Your full name, job title and department
- Your professional qualifications and the date you gained these.
- The post held at the time of the incident and it has changed since, what role you are in now. How long you have held your post can also be included.

Your statement should conclude with the phrase:
- “The contents of this statement are true to the best of my knowledge and belief”. 

Print, sign and date the end of your statement with the date of writing and if it typed later add that date also, but keep the original date also.

You should retain a copy of your statement for your own information

Please do not be daunted by the request to provide a statement when a complaint has been received.

There are many and complex reasons why patients or their families make a complaint, your response statement is an opportunity to say what happened from your perspective and for you to ensure that your own actions or conversations are accurately recorded in the complaint response.

Help with your statement is also available from your line manager, governance lead or matron.
Guidance on preparing a complaints response letter

It’s important to appreciate that all letters of complaint that we receive are feedback and represent the patient or their family’s personal experience of the service they have received. Whether a person is justified in complaining or their viewpoint appears unreasonable; all complaints give us an insight into how patients receive the care we offer, what our patients are thinking and they also provide an opportunity to consider service change if something is not working, or to provide appropriate information to explain care or treatment decisions, or change public perceptions of a service, if that is the problem.

Many complaints can be resolved through the provision of an explanation, detailed information and an apology where needed. Responses should be thorough, clear, honest and open, and should include what has been changed or any planned changes in relation to the complaint. The complainant should not then have to ask further questions, in order to be satisfied that the response is comprehensive.

If the letter needs to be in an alternative language or format to meet the needs of the recipient, advice can be sought from the Patient Experience Team on this can be achieved.

This section provides guidance regarding the content of all response letters, however you should always bear in mind that each complaint is unique. A template letter can be found in the Standard Operating Procedure for the Management of Concerns and Complaints.

Content

1. Complaints Regulations state that “complainants are treated with respect and courtesy”. The letter should demonstrate sincerity and where appropriate compassion. The letter should never contain rude or dismissive comments and the tone should match the seriousness of the complaint.

2. The style and language of the response letter should be appropriate. The letter should be written in a style that is easily understood, avoiding jargon and abbreviations. The language used should not be overly formal or overly casual and should show some consideration of the style and the language used by the complainant. Ideally do not use bullet points, numbered points or subtitles through the document, unless the complainant has numbered their concerns. The letter should be personal and not read like a report. The exception to this rule is if the complainant has used this style and it would be beneficial to respond likewise.
3. Follow the principles of plain English. Technical language must be explained so that a lay person can understand it and terminology used by the Trust e.g. winter pressures, discharge plan should be avoided or explained.

4. Confirm that the investigation has now been completed. Explaining the steps taken to investigate the complaint and stating what evidence you have taken into account, including:

- the complainant’s account of events;
- the account of events by the person(s) complained about (if relevant);
- relevant documentation, including medical records;
- relevant law, policy, guidance and procedures (quote the title of the policy when appropriate); and
- any independent clinical or professional advice taken.

5. Summarise what the complaint was about. Include a summary or statement of the complaint that mirrors the complainant’s original complaint letter. Do not go into great detail but the complainant must be confident that we have understood the essence and context of their complaint. E.g. “Further to my letter of 15 July 2009, I am now able to respond to your complaint about the delay in your surgery following your admission to ward X on the (insert date).

6. If the date of the response is outside the timescale that was originally agreed with the complainant, include a specific apology for the delay in the reply, e.g. "I am sorry for the delay in responding to you”.

7. After the introduction, offer an apology or an acknowledgment of how the complainant is feeling. This acknowledgement is important and helps to set the tone of the letter. Even if the Trust has acted entirely appropriately it is clear that the complainant did not see it that way at the time. Possible responses could be something like –

   "I would like to apologise for the distress which this incident has caused you.”

   “I am very sorry that you were dissatisfied with your experience when you attended day surgery”.

   “I was saddened to hear that your mother has died and I do appreciate that this must be a very difficult time for you. Please accept my condolences”.

8. Respond to each part of the complaint and explain the findings of the investigation. This can be complex so it is advisable to break it down into smaller sections. Dealing with the issues chronologically is the best approach, it will also help to make sure for example, that each stage of the care pathway is clear. If the complainant has used a particular format for summarising their concerns, use this as a guide to compiling your response.
9. Avoid telling the complainant something that they already know and have experienced. Rather than saying “On Monday 5 May 2009 you were admitted for your hysterectomy”, it is better to say, “I understand that you were admitted for your hysterectomy on Monday 5 May 2009”.

10. If the complainant has used the actual names of members of staff, use them yourself. Include the job title when you refer to a member of staff by name for the first time.

11. Use active, direct but personal language. Use “I”, “you”, “we” as much as possible. Rather than passive “It was considered…” say “We, the doctor, or Sister Smith considered…”

12. Double check that you have covered every point made in the complaint, no matter how trivial. Answers should be forthcoming and not skirt around the issues. There should be no unsatisfactory events or findings uncovered by the investigation that are deliberately not shared with the complainant. The explanation of the findings should be in a level of detail that the complainant wanted.

13. Where the findings of an investigation have led to disciplinary proceedings, the complainant will not be given explicit information regarding the proceedings or the outcome.

14. State your conclusions based on the evidence. Address any conflicting evidence or lack of evidence. Make sure that the decision is clear. Take into account any discrepancies or omissions that cannot be reconciled and be honest about these in your response.

15. Acknowledge when a mistake has been made, apologise for it and explain what we are doing to prevent it happening again, or that we do not accept the complaint and give the reason why it is not being upheld. Avoid apologising indirectly. Try and avoid phrases like “we are sorry that you felt the organisation or an individual did something wrong”. This can feel patronising to the complainant and that we have not taken their concerns seriously. Apologise for it going wrong instead.

16. Refer to national guidance or Trust Policies when claiming that our care was appropriate. If the patient did not receive current evidence based practice, or a firm conclusion could not be drawn about some or all of the issues raised in the complaint, an explanation of the reason why must be given.

17. One of the Principles of Good Complaint Handling published by the PHSO advises that the Trust should be looking favourably at any request for reimbursement for a financial loss incurred due to an error by the Trust. The Patient Experience Team will provide advice with regard to this.
PHSO six principles of good complaint handling means:

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

18. Be thorough and honest about what the Trust can or cannot do to prevent the same thing happening again. If we need to take remedial action, state when this will be completed and how we will monitor the improvements. The more specific, personalised and timed the plans for improvement are, then the more credible they will be to the complainant.

19. All complaint response letters include information that the complainant can contact the Patient Experience Team, if they are unhappy with the response or wish to discuss the response. However, the investigator may also wish to provide their contact details to discuss the outcome, or it can be helpful to offer a meeting with the complainant. This is particularly the case when there has been bereavement, or if there are a lot of clinical issues involved.

20. Face to face meetings, where complex issues can be discussed openly and sensitively and in language which is understandable, can often resolve issues and is time well spent. The Patient Experience Team will arrange meetings. Please refer to the Guidance for meetings with complainants.

21. Always get the latest information about the patient. It is professional to demonstrate that we know the patient's current situation. For example, we may have arranged or changed an appointment, or perhaps the patient included in the complaint has died.

22. When you have dealt with all the issues, make the last paragraph positive.
   • “In conclusion, I very much hope that this helps to explain why ………………… Please accept my apologies for the distress and anxiety that you experienced.”
   • “I was very pleased to learn that your wife has fully recovered and has now returned home.”
   • “I understand that you now have a date for your surgery. I hope this goes well and that you are soon fully recovered”.
   • “I understand you had an appointment with Dr ………….. on (insert date). I trust the outcome was satisfactory and you are now making a good recovery.”

23. The following are also useful examples of how to conclude a letter

   • If not upheld
   “In summary, I am confident that based upon the results of our investigation, the care you received was appropriate. However, I am sorry that you feel your care was not to the standard that you would have expected and would like to thank you for bringing this matter to my attention.”
The Trust welcomes comments from patients, relatives and carers as these help us to improve our services.

- **If partially upheld**
  "In summary, I believe that certain aspects of your care did not reach the high standard of care that we aim to provide to all patients. I apologise for this, and would like to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services. I hope my letter has reassured you that we are addressing those aspects of patient care which need improving."

- **If upheld**
  "In summary, I believe that your care did not meet the high standard that we aim to provide to all of our patients. I would like to apologise for the shortfalls we have identified, and to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services. I hope my letter has reassured you that we are addressing those aspects of patient care which need improving."

24. Empathise with the complainant and consider how you would feel if you received the proposed response letter. Is there anything in there that would cause further distress or aggravation? Can anything be misinterpreted? Is there anything left unanswered? Is the answer rather vague? Would you feel satisfied with this response and believe that the Trust had taken your complaint seriously? Would you feel comfortable about engaging in further resolution if necessary? Would you or your family come back to the trust for future care?

25. The Directorate complaints lead should quality assure the draft letter.

26. The final draft should be sent to the Patient Experience Team. Please do not be discouraged or annoyed if the Patient Experience Team makes some changes. They are seeing it with a fresh pair of eyes. Also, it is most likely that they have been in verbal contact with the complainant and have an understanding of what the patient will be expecting in a letter of response.

Occasionally, the team will return letters to the investigating officers advising that some elements have not been addressed. Please accept that this is a benefit of having someone outside the service to review the responses – the Patient Experience Team will not know exactly what the service can, or should offer so they will read the response with the limited knowledge that a complainant may have.

Similarly, sometimes the responses may read as too dismissive of the concern, or defensive of the staff in question, so the Patient Experience Team will suggest amendments to redress the balance.

The Patient Experience Team will check all response letters meet the Complaints Regulations and Trust requirements and make necessary amendments and additions.
Guidance notes for meetings with complainants

Meetings can be a particularly effective way of diffusing a potential complaint, resolving an ongoing complaint, or providing clarification following a final response to a complaint. It is sometimes easier to discuss issues and avoid misinterpretation through verbal communication rather than correspondence.

Before the meeting

- Agree the issues for discussion and who will be attending with the complainant.
- Agree a venue, date and time occasionally it may be best in some cases to meet at an off-site and neutral venue at a time negotiated between both parties.
- In difficult cases you may wish to set a deadline at which the meeting will end, so that all parties are aware of how much time is available and can focus on the main points to be covered.
- The meeting should be chaired by an appropriate senior member of the Division i.e. Matron or Head of Service or Department or a person nominated by them. Try to balance the number of staff attending with who is attending regarding the complaint, e.g. a patient and their support person would be overwhelmed by more than 3 staff. If the patient or complainant is attending alone, consider having no more than two members of staff attend.
- The Patient Experience Team will confirm all arrangements and send a letter of invitation.
- Review the complaint and investigation findings with staff that will be at the meeting, to maintain honesty and consistency.
- Ensure staff who attend the meeting are briefed and offered support; they should not be left to take the full brunt of a complainant’s potential anger.
- If you feel the complainant or their family may be intimidating to a staff member you may take the decision not to have that staff member at the meeting.
- Ensure drinks and tissues are available in the meeting room.

The meeting

- If recording equipment is to be used, read out the recording of meetings agreement contained within the Standard Operating Procedure for the Management of Complaints and Concerns.
• Begin with introductions and your understanding of the reasons for the meeting.

• Have a note-taker at the meeting so that you can concentrate on the issues at hand.

• Have the complaint letter, response letter and action plan with you for reference. If it is relevant e.g. the patient had a prolonged care pathway, then the clinical records may also be needed for reference.

• Listen first – ask the complainant to outline their key issues. Clarify outstanding issues from those that might already have been addressed.

• Acknowledge mistakes and apologise where necessary. Avoid apologising indirectly. Try and avoid phrases like “we are sorry that you felt the organisation or an individual did something wrong”. Apologise for it going wrong instead.

• At the end of the meeting summarise the key points and any actions agreed and who will undertake them. Tell the complainant what will happen next and when.

• If the patient wants to have access to their case notes, be ready to advise them of the process to be followed to request these Subject to Access Request (SARS).

• If the complainant raises that they are considering legal action, simply say that if that is their intention, the trust will of course cooperate fully with their solicitor. Do not be drawn to make any further comment on this matter.
CAPTURING COMPLIMENTS AND MESSAGES OF THANKS

Please populate the table below for your area for each calendar month. This information should be forwarded by email to rgh-tr.compliments@nhs.net for collation and inclusion in a monthly report to the Board of Directors no later than the 5th day of the following month.

Division…………………………

Ward/department………………      Month and year………………………

Number of verbal compliments, cards, letters* or other messages of thanks and gifts received

<table>
<thead>
<tr>
<th>Verbal</th>
<th>Cards</th>
<th>Letters</th>
<th>Copy of publication e.g. newspaper article</th>
<th>Chocolates/ biscuits/ sweets</th>
<th>Tea/coffee/ non-alcoholic beverage</th>
<th>Other gifts</th>
</tr>
</thead>
</table>

*Whilst we cannot possibly view all cards or letters received if they are particularly articulate in identifying what it is that we did so well, please scan and email as well. Please do not send hard copies of cards, letters etc. to the Patient Services department.

Gifts

Staff must refuse gifts, benefits, hospitality or sponsorship of any kind which might reasonably be seen to compromise their personal judgement or integrity and to avoid seeking to exert influence to obtain preferential consideration. All such gifts must be returned and any hospitality refused.

It is recognised that small gifts are commonplace and often deserved and in some cases can be accepted. However moral judgement should be exercised, especially when dealing with vulnerable people. Staff must declare and register gifts, benefits, hospitality or sponsorship of any kind, (using the Standards of Business Conduct (SoBC) declaration form, if they are worth £50 or more, whether refused or accepted. Similarly, a declaration must be made if several small gifts, benefits, hospitality or sponsorship of any kind are offered totalling over £200 from the same or a closely related source in a 12-month period. A declaration is required when:

- items have been refused or returned; or
- approval is required to accept the item(s) being offered

Gifts of money or alcohol must ALWAYS be refused. Staff could suggest the money is instead donated to the hospital charity or the alcohol is donated to the hospital charity as a raffle prize.

The Standards of Business Conduct (SoBC) and declaration form can be found on the intranet.
Guidance for the recording and reporting of compliments

The Trust logs and reports concerns and complaints and it is also important to log and report compliments from across the Trust to help provide a more complete picture regarding people’s views of the services the Trust provides.

Compliments provide an opportunity to learn from good practice and to recognise the excellent work that staff do.

The number of verbal compliments, cards, letters, small token gifts etc. received by wards and departments should be logged on the ‘capturing compliments and thank you’ form.

Heads of Service or Departments and Matrons are asked to ensure all departments and wards log their compliments on a monthly basis using the new form. Completed forms should be sent electronically to the compliments email; rgh-tr.compliments@nhs.net by the 5th of each month.

Heads of Service or Departments and Matrons should share compliments information with their staff.

The Safe & Sound Quality Directorate will collate all compliments received Trust wide and report to the Patient Experience Group on a Bi-monthly basis.
POLICY FOR THE MANAGEMENT OF CONCERNS AND COMPLAINTS

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING
8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

Chief Executive
Chief Nurse
Deputy Chief Nurse
Medical Director
Trust Management Committee
Lead Nurses/Heads of Service/Departments
Clinical Directors
Patient Experience Team
Document Ratification Group

9. APPROVAL OF THE DOCUMENT

This document was approved by the Patient Experience Group

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Document Ratification Group on behalf of the Trust Board

11. EQUALITY AND DIVERSITY

All systems and processes will be tailored to meet the specific needs of individuals; for example, for children and young people, patients/complainants with physical and sensory impairments or those where English may not be their first language.

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full Equality Impact Assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please contact the Patient Experience Team in the first instance. The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure.
This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

11.1 **Recording and Monitoring of Equality & Diversity**

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover all strands of equality legislation and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

11.2 **Equality Impact Assessment Statement**

An Equality Impact Assessment (EIA) 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.

12. **REVIEW AND REVISION ARRANGEMENTS**

This document will be reviewed by the Head of Patient Experience every three years unless such changes occur as to require an earlier review.

13. **DISSEMINATION AND 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>Document Ratification Group Admin Support</td>
<td>Author</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Remove watermark from ratified document and inform the Document Ratification Group Administrator of a revision and where it should be located on the intranet. Ensure all documents templates are uploaded as word documents.</td>
</tr>
<tr>
<td>Communication Team documents ratified by the Document Ratification Group (DRG)</td>
<td>Author</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Communication team to inform all email users of the location of the document.</td>
</tr>
<tr>
<td>To be disseminated to</td>
<td>Disseminated by</td>
<td>How</td>
<td>When</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------</td>
<td>-----</td>
<td>------</td>
<td>----------</td>
</tr>
<tr>
<td>All email users</td>
<td>Communication Team</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Communication team will inform all email users of the policy and provide a link to the policy.</td>
</tr>
<tr>
<td>Key individuals Staff with a role/responsibility within the document</td>
<td>Author</td>
<td>Meeting / Email as appropriate</td>
<td>When final version completed</td>
<td>The author must inform staff of their duties in relation to the document.</td>
</tr>
<tr>
<td>Heads of Departments / Matrons</td>
<td>Heads of Departments / Matrons</td>
<td>Meeting / Email as appropriate</td>
<td>As soon as received from the author</td>
<td>Ensure evidence of dissemination to staff is maintained. Request removal of paper copies. Instruct them to inform all staff of the policy including those without access to emails.</td>
</tr>
</tbody>
</table>

14. IMPLEMENTATION AND TRAINING PLAN

Training aimed at staff responsible for conducting investigations into complaints and writing complaint response letters will be delivered by members of the Patient Experience Team.

This policy will be displayed on the Trust website and staff intranet and sent to Divisions / Clinical Service Units / Corporate Teams for cascade to all staff groups.

All staff need to know how to react and what to do if someone makes a complaint / raises a concern as their initial response may help to resolve the situation quickly and/or provide reassurance to the complainant that their concerns will be dealt with appropriately.

Those staff who are identified as Investigating Officers for formal complaints will receive training directly by members of the Patient Experience Team on how to manage a formal complaint.

These staff are often also identified as staff who would be responsible for completing Serious Incident Investigations and will have completed Root Cause Analysis (RCA) Training where the principles of investigation are the same.

Where other staff (i.e. front line) feel further training is required on how to manage concerns, deal with conflict this requirement will be identified (in conjunction with their line manager) and be managed as a training need through the Trust’s Learning and Development Team.

Bespoke training sessions can also be delivered by the by members of the Patient Experience Team for individuals and teams as and when required.

Information about dealing with concerns/complaints will also be given at Corporate Induction.
### 15. 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 by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>PDR process</td>
<td>Line Managers</td>
<td>Annual</td>
<td>Line manager</td>
<td>Line manager</td>
</tr>
<tr>
<td>How the Trust listens and responds to concerns and complaints from patients, their relatives and carers</td>
<td>Internal Audit</td>
<td>Head of Patient Experience and Complaints Manager</td>
<td>Annual</td>
<td>Divisional Governance Meetings</td>
<td>Patient Experience Group</td>
</tr>
<tr>
<td>How the Trust makes sure that patients, their relatives and carers are not treated differently as a result of a concern or complaint</td>
<td>Complainant satisfaction survey</td>
<td>Head of Patient Experience and Complaints Manager</td>
<td>Quarterly / Annual</td>
<td>Patient Experience Group</td>
<td>Patient Experience Group</td>
</tr>
<tr>
<td>How the Trust makes improvements as a result of raising a concern concerns or complaint</td>
<td>Internal audit</td>
<td>Head of Patient Experience and Complaints Manager</td>
<td>Annual</td>
<td>Divisional Governance Meetings</td>
<td>Patient Experience Group</td>
</tr>
<tr>
<td>How joint complaints are handled between organisations</td>
<td>Internal audit</td>
<td>Head of Patient Experience and Complaints Manager</td>
<td>Annual</td>
<td>Head of Patient Experience and Complaints Manager</td>
<td>Patient Experience Group</td>
</tr>
<tr>
<td>Key performance indicators</td>
<td>Internal audit</td>
<td>Head of Patient Experience and Complaints Manager</td>
<td>Monthly / Quarterly / Annual</td>
<td>Directorate Governance Matron</td>
<td>Directorate Governance Group/ Patient Experience Group</td>
</tr>
</tbody>
</table>

Note – any issues with compliance will be escalated to higher groups or committees as decided by the Patient Experience Group.
15.2 **Key Performance Indicators (KPIs)**

Previously, the Trust had 20 complaint KPIs which related to the timeliness of complaint responses. The improvement of response times remains a high priority for the Trust and is the focus of the Patient Experience Team and the Divisional Heads of Nursing.

As part of the Complaints Management Improvement Action Plan there has been a revision with the number reduced and divided appropriately between PET and the Divisions to ensure ownership.

<table>
<thead>
<tr>
<th>PET</th>
<th>Divisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standard of 100% of formal complaints to be acknowledgement within 3 working days upon receipt.</td>
<td>• Standard of 80% of meetings held within 40 working days of the request being made.</td>
</tr>
<tr>
<td>• Standard of 100% divisions to be informed of the complaint and provided with the complaints management plan within 3 working days of receipt.</td>
<td>• Standard of 100% of all complaints will have a PET action plan completed where appropriate.</td>
</tr>
<tr>
<td>• Standard of 100% for all complaints to be risk graded upon receipt.</td>
<td>• Standard of 95% responses within 30 working days (when the target is 30 days).</td>
</tr>
<tr>
<td>• Standard 95% of PHSO requests responded to in time.</td>
<td>• Standard of 95% responses within 40 working days (when the target is 40 days).</td>
</tr>
<tr>
<td></td>
<td>• Standard of 95% of meeting notes/CD's issued within 14 working days of meeting.</td>
</tr>
<tr>
<td></td>
<td>• Standard (aim for less than) of 5% re-opened complaints.</td>
</tr>
</tbody>
</table>
**EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL**

**Document Name:** Policy for the Management of Concerns and Complaints  
**Date/Period of Document:** June 2023

**Lead Officer:** Samantha Robinson  
**Job title:** Head of Patient Experience

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<table>
<thead>
<tr>
<th>Function</th>
<th>Policy</th>
<th>Procedure</th>
<th>Strategy</th>
<th>Other: (State)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☑</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe the overall purpose / intended outcomes of the above: To listen, to acknowledge mistakes, explain what has happened and to consider prompt appropriate and proportionate remedies to put things right, if necessary.

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>Does this have a significant negative impact on equality in relation to each area?</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1 Age</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2 Disability</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3 Gender reassignment</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4 Marriage and civil partnership</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5 Pregnancy and maternity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6 Race</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7 Religion and belief</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>8 Sex</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>9 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 ☑ No
- Will any group be excluded because of the policy?  
  - Yes ☑ No
- Will the policy have a negative impact on community relations?  
  - Yes ☑ No

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?  

<table>
<thead>
<tr>
<th>Explain how will it meet our duty to:</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<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>HIGH ☑</td>
<td>MEDIUM ☑</td>
</tr>
</tbody>
</table>

Date assessment completed: November 2019  
Is a full equality impact assessment required?  
- Yes ☑ No

Date EIA approved by Equality and Diversity Steering Group:

---

212
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>234/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Quarterly Responsible Officer Report</td>
</tr>
<tr>
<td>Author</td>
<td>Dr Callum Gardner, Executive Medical Director, Responsible Officer</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B5</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision</td>
</tr>
</tbody>
</table>

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

To present to the Board details of activity related to Medical Appraisal and Revalidation, as per NHS England and GMC regulations.

Key points:

- Due to COVID-19, the Trust is not currently required to submit an annual final report (Comparator Report) to NHS England this year.
- The Medical Director took over formal responsibility for the Responsible Officer role effective from 1 June 2020, with gratitude to Dr Cooper for standing in as Interim Responsible Officer (RO) for the last 2 years.
- All Appraisals were suspended by the National Medical Director from 19/03/2020, although those able to complete them are still being encouraged to do so.
- Overall engagement with Appraisal has declined slightly to 89.7% from 92% 12 months ago, but the number of Prescribed Connections has increased by 30 Doctors to 264 (as at 31/03/2020).
- All appraisers attended half-day refresher training on 14/02/2020.
- The number of trained appraisers has dropped slightly from 20 to 17; the minimum required should be 25; appraiser interviews are booked for 11/08/2020 with 9 applicants.
- 84 doctors due to Revalidate during 2019/20, of which 12 were deferred.
- Due to COVID-19, the GMC have deferred all Revalidation recommendations required between 17 March 2020 and 16 March 2021 by 12 months, although we will continue to make recommendations, where able and appropriate to do so.
- 11 staff members completed Case Investigator (PPAS) training.
- 19 doctors and 1 dentist attended Mentor training.
- The Responsible Officer Advisory Group continues to meet quarterly and reviews all aspects of the RO’s responsibilities.

**Recommendations**

It is recommended that the Board notes the quarterly data.

**Appendices**

1. Medical Appraisal Figures for 2019/20
# Medical Appraisal Figures for 2019/20

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1 01/04/2019-30/06/2019</th>
<th>Q2 01/07/2019-30/09/2019</th>
<th>Q3 01/10/2019-31/12/2019</th>
<th>Q4 01/01/2020-31/03/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Name of designated body (or NHS England Area Team or Region)</td>
<td>TRFT</td>
<td>TRFT</td>
<td>TRFT</td>
<td>TRFT</td>
</tr>
<tr>
<td>Note: Please ensure your organisation’s name is written exactly as it is recorded on GMC Connect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Number of doctors with whom the designated body has a prescribed connection</td>
<td>235</td>
<td>233</td>
<td>252</td>
<td>264</td>
</tr>
<tr>
<td>3 Number of doctors(^1) due to hold an appraisal meeting in the reporting period</td>
<td>51</td>
<td>62</td>
<td>66</td>
<td>85</td>
</tr>
<tr>
<td>Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor’s agreed appraisal month, whichever is the sooner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Number of those within 3 above who held an appraisal meeting in the reporting period</td>
<td>45</td>
<td>53</td>
<td>59</td>
<td>80</td>
</tr>
<tr>
<td>3.2 Number of those within 3 above who did not hold an appraisal meeting in the reporting period [These to be carried forward to next reporting period]</td>
<td>6</td>
<td>9</td>
<td>7</td>
<td>27 (cumulative)</td>
</tr>
<tr>
<td>3.2.1 Number of doctors(^1) in 3.2 above for whom the reason is both understood and accepted by the RO</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>3.2.2 Number of doctors(^1) in 3.2 above for whom the reason is either not understood or accepted by the RO</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>20</td>
</tr>
</tbody>
</table>
### Agenda item 235/20

#### Report
**Responsible Officer's Annual Report & Statement of Compliance**

#### Executive Lead
Dr Callum Gardner, Executive Medical Director

#### Author
Dr Callum Gardner, Responsible Officer

#### Link with the BAF
B5

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

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

The Responsible Officer’s (RO) annual report to Board is a statutory requirement, and includes a Statement of Compliance to be signed and returned to NHS England by 26th September 2020.

In the last 12 months, support and governance arrangements around the RO's statutory responsibilities have continued to be improved.

Overall engagement with Appraisal is 89.7%. NHS England recommended that appraisals should be suspended from 19th March 2020; without this disruption, figures would have been improved on the previous 12 months.

The number of trained appraisers is 17 for 264 doctors.

#### Recommendations
It is recommended that:
- the Board note the improvements over the last 12 months; and
- the Board approves the report and the Statement of Compliance.

#### Appendices
Appendix 1: Designated Body Annual Board Report 2020
Designated Body Annual Board Report 2020
Section 1 – General:

The Board of The Rotherham NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been suspended due to COVID-19.

   Date of AOA submission: N/A
   Action from last year: Improve engagement across all sectors (until March 2020).
   Comments: Overall engagement was 89.7% vs 88.3% (2017/8) and 92% (2018/9).
   Action for next year: Recovery of activity after interruption.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: Dr Gardner appointed RO from 1st June 2020.
   Comments: Dr Gardner to attend refresher RO training in September 2020.
   Action for next year: Review current processes to identify further opportunities for improvement.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes
   Action from last year: There has been a significant investment in training to support the RO’s responsibilities, which should improve capacity and quality.
   Comments: In the last 12 months, training has been funded for Mentors, Case Investigation, Trauma Resilience and Appraisal. In addition, funding has been made available to support individual interventions as required. However, overall budget remains unclear.
   Action for next year: Clarification of resources available within MD/RO budget.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Action from last year: Nil required.
   Comments: This is maintained and updated regularly.
   Action for next year: Maintain current activity.
5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

| Action from last year: Enhanced Support Policy has been renewed, local MHPS withdrawn and the national version of MHPS is in use until a new agreement reached. Trauma Resilience policy written and training started for peer supporters. Mentoring policy written. |
| Comments: New local MHPS under discussion, plus new Managing Attendance Policy to include support to keep in touch for those with professional roles. |
| Action for next year: Complete above plus Trust-wide roll out of Trauma Resilience peer supporters. New Associate Medical Director – Human Factors appointed. |

6. A peer review has been undertaken of this organisation’s appraisal and revalidation processes.

| Action from last year: Refresher training for all appraisers was provided with a focus on the Section 19 summary. |
| Comments: No external or peer review has been undertaken in the last 12 months, with a focus being on appointing a Deputy Appraisal Lead and refresher training for all. |
| Action for next year: Continue to develop the skills of Appraisers. New RO to review quality of narrative provided in Section 19. |

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

| Action from last year: Improve engagement of short-term contract holders. |
| Comments: New starters now have a priming appraisal with the Medical Appraisal & Revalidation manager, as approved by NHS England, as part of a drive to improve the engagement of short-term contract holders. Monthly notification of new starters with some background information has aided this process. |
| Action for next year: Continue this process. |

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor’s fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

| Action from last year: Engagement has remained good, with improved flows of information about complaints and SI’s plus assurance from other locations where our doctors work. |
Comments: No comparator report available this year.

Action for next year: Explore the use of IT (eAppraisal) to enhance flows of information into appraisal.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Track those who are late and understand the reasons.

Comments: A number of appraisals were affected due to NHS England guidance issued 19th March, resulting in a higher than usual number of approved missed.

Action for next year: Continue to track missed appraisals to understand reasons and to support colleagues to complete their appraisals on time. Support in year catch up where possible. New RO clear that only those appraisals where there is appropriate and accepted reasons for non-completion should be accepted with low tolerance for non-approved missed appraisals.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board’s approval (or by an equivalent governance or executive group).

Action from last year: Up to date copy on Trust intranet.

Comments: N/A

Action for next year: N/A

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Overall the number of doctors has risen faster than the increase in appraisers, so although we have recruited, more are required.

Comments: 6 newly appointed over last FY, now all trained. There are currently 17 Appraisers versus a target of 26.

Action for next year: Recruit and train a further cohort over the next 12 months to replace the expected retirements. Interviews scheduled within next 2 months.

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers\(^1\) or equivalent).

Action from last year: Attendance at forum is monitored and feedback provided about individual performance. All appraisers attended a refresher session in February 2020 provided by an external trainer.

\(^1\) http://www.england.nhs.uk/revalidation/ro/app-syst/

\(^2\) Doctors with a prescribed connection to the designated body on the date of reporting.
Comments: Collated feedback is generally good; individual doctors receive their own feedback annually. Appraisers have an annual review meeting with the Deputy Medical Appraisal lead.

Action for next year: Continue to use forum meetings for discussion and benchmarking of practice.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

   Action from last year: Actions from NHS review completed. RO’s Advisory group reviews activity quarterly. This group includes lay representation.

   Comments: The RO’s advisory group can provide a range of expertise to support and challenge the processes in place.

   Action for next year: Continue quarterly Board reporting.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

   Action from last year: 100% compliance.

   Comments:

   Action for next year: Continue with above.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

   Action from last year: All deferral recommendations are discussed and agreed with doctor prior to being made.

   Comments:

   Action for next year: Continue as above.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

   Action from last year: Improved information from complaints and SI’s to inform appraisal.
Comments: All doctors now routinely informed about complaints and SI’s they were involved in, which can be cross-checked against statements made during appraisal if required. Monthly data is now provided.

Action for next year: Explore how to improve routine flow of information about clinical performance and the ease of access to information.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Flows of information to the RO have improved.

Comments: New appointments to AMD roles should further support this.

Action for next year: There is a process established for responding to concerns about any licensed medical practitioner’s fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: New policy agreed; has been used to support a colleague.

Comments: Feedback from all concerned would be useful about the effectiveness of the new policy.

Action for next year: Seek and respond to feedback.

3. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year: RO’s group supports this function.

Comments: Group established and reporting has commenced. This complements regular detailed discussion with GMC ELA. Data collection should now be possible with the agreement to establish a case tracking system.

Action for next year: Still very small number who have been involved, limiting the opportunity for feedback.

4. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

The Medical Profession (Responsible Officers) Regulations 2011, regulation 11:
5. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor’s practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

| Action from last year: Establish RO’s group to monitor this activity. |
| Comments: RO’s group established. Numbers too small currently to comment. Aware of national data around this issue. |
| Action for next year: Review of cases to be presented at RO’s Advisory Group. |

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

| Action from last year: Monthly data now provided to RO about new starters. |
| Comments: Annual review is not required, provided monthly update continue. |
| Action for next year: Maintain monthly reporting and seek further clarification around the processes for locums via NHSP. |

Section 6 – Summary of comments, and overall conclusion

The GMC has deferred a cohort of doctors due to revalidate between 16th March 2020 to 15th March 2021 due to the pandemic. It has also offered the option to revalidate them where we have sufficient information and in many cases we can do this. NHS England recommended suspending Appraisals on 19th March 2020, but we did not find it necessary to completely stop, and indeed were approached by some doctors wishing to complete their appraisal. Where possible, these have been done.

The main issue 12 months ago was a lack of appraisers to support the system. We have been fortunate to recruit and train 6 new colleagues and overall engagement has improved. However, maintaining adequate numbers of appraisers remains an ongoing issue.

Processes for responding to concerns have improved and progress has been made in resolving a number of historical concerns, with all historical MHPS investigations now closed. Two colleagues are still receiving enhanced support in line with the revised guidance. Their formal programmes have been suspended due to COVID-19.
and will hopefully resume soon. One new issue has been identified, which has been approached in line with the revised policy working in collaboration with the doctor.

In seeking to support colleagues, the flow of information could still be improved. Over the last 12 months, we have agreed processes to share information about complaints and SI’s, but easier access to routine data would be beneficial.

AMD - Clinical Effectiveness should be invited to attend and support the RO’s advisory Group with a view to informing the group about access to and the value of currently available clinical information reflecting quality and to assist with working towards the recommendations of the Pearson review.

The RO’s advisory group should invite other expertise as required to support the RO as the new roles within the Trust develop.

Succession planning for the Appraisal, Revalidation and Mentoring Lead role has resulted in the appointment of Dr Shekar as Deputy Medical Appraisal Lead.

Overall conclusion:

Overall engagement remains good and reflects the enthusiasm of the current group of appraisers. This is also seen in the feedback from appraisers in the last 12 months. Appraisals have continued to be offered using remote technology where appropriate.

Still scope for improvement in access to information to support appraisal.

On a positive note, there has been a welcome and significant investment in time and training for activities which support the RO’s role and which will benefit the Trust going forward.

Section 7 – Statement of Compliance:

The Board / executive management team – [delete as applicable] of [insert official name of DB] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ___________________________________________________________________

Name: ___________________________________________________________________ Signed: ___________________________________________________________________

Role: ___________________________________________________________________

Date: ___________________________________________________________________
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>236/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Quarterly Guardian of Safe Working Report</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Dr Callum Gardner, Executive Medical Director</td>
</tr>
<tr>
<td>Link with the BAF</td>
<td>B1, B2, B4</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision</td>
</tr>
</tbody>
</table>

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

The Guardian of Safe Working is required to report to the Board on a quarterly basis that working in the Trust is safe for Junior Doctors and patients; or, where this is not the case, that measures are taken to address this, with the Board's help if necessary.

**Summary of Key Points:**

Junior Doctors' rotas have changed to address the COVID-19 pandemic.

**Recommendations:**

It is recommended that the Board note this report and support doctors in training to the best of its ability during the current crisis.

**Appendices**

N/A
1. **Introduction**

1.1 The Junior Doctor Contract 2016 has been in force in TRFT since 7 Dec 2016 and all Junior Doctors, not on run-through training at the time of introduction, are now on the contract. NHS employers and the British Medical Association (BMA) have, however, agreed to default to the 1998 Working Time Regulations (WTR) for Junior doctors for the duration of the COVID-19 pandemic. This allows the suspension of many of the safeguards of the 2016 contract, while still guaranteeing minimum rest periods. New work schedules have been implemented to reflect this.

1.2 This report has been produced at a time when all Doctors’ working hours have been, and continue to be, drastically impacted as a result of COVID-19.

2. **Exception Report (ER) Quarterly update**

2.1 In the last quarter, 3 Exception Reports have been completed. However, it should be noted that Junior Doctors, recognising the extraordinary circumstances, have not in general been generating Exception Reports for this period. Exception Reports are therefore not an accurate reflection of issues currently encountered.

3. **Exception Report Quarterly details**

3.1 **Working hours**: 3 Doctors (1 FY1, 1 CT1 and 1 ST2), submitted 3 Exception Reports. Of these, 2 related to hours worked:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Exceptions</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Medicine (all subspecialties)</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

3.2 **Pattern**: 1 Doctor submitted 1 Exception Report from Surgery concerning the new rotas and the fact that his rota changed at short notice.

4. **Qualitative examples of Exception Reports**

“Due to short-noticed switch to Amber Rota, I am doing fifteen 12.5 hours shifts in a month time (from 23/03/2020 to 23/04/2020). In summary, I have done 187.5 hours of oncall (100 hours of night shifts, 37.5 hours of weekend on calls and 50 hours of weekdays oncall shifts) and 64 hours of normal ward shifts, which makes it 251.5 hours in a month (average 58.6 hours per week). This is way above normal contractual hours, especially unsocial hours.”

5. **Actions taken to resolve**

5.1 The Junior Doctor Forum meetings have resumed via video-conference for the time being. The major issues have been around direct streaming from UECC resulting in increased intensity of work, inability to take leave, and excessive hours during the COVID-19 rota. A letter from the Junior Doctor body detailing these concerns was discussed at the last meeting.

5.2 The Junior Doctor in the Exception Report above was disadvantaged by converting from an onerous section of her old rota to the amber COVID-19 rota. She has been assisted to claim payment for the extra hours worked.
5.3 Educational Supervisors are dealing with Exception Reports as best they can. Granting of time off in lieu (TOIL) is impractical and extra hours will be dealt with by payment.

6. Work Schedule Reviews

6.1 All Doctors are working hours in excess of 2016 contract for the foreseeable future and new Work Schedules are in force. Reviews are inappropriate for the time being. The Guardian would like to request that the Board help to ensure adequate support with facilities, accommodation and appropriate recompense once the current emergency is passed, to all trainees volunteering to work above and beyond their usual contracted duties.

7. Fines

7.1 No fines have been imposed this quarter for exceeding 48-hours average or 72-hours total weekly hours. Pending guidance from Health Education England (HEE), it is reasonable to suspend any fines during the current emergency.

8. Conclusion

8.1 Working patterns for Doctors in training have changed dramatically owing to the COVID-19 pandemic.

Dr Gerry Lynch
Guardian of Safe Working
June 2020
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>237/20</th>
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</thead>
<tbody>
<tr>
<td>Report</td>
<td>Register of Sealings</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</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision</td>
</tr>
<tr>
<td>Executive Summary (including reason for the report, background, key issues and risks)</td>
<td>The Board is asked to note that the Trust Seal has not been used since last reported to the Board on 4 February 2020.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>It is recommended that the Board of Directors note the report.</td>
</tr>
<tr>
<td>Appendices</td>
<td>None</td>
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Board of Directors’ Meeting  
07 July 2020

<table>
<thead>
<tr>
<th>Agenda item</th>
<th>238/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Register of Interest</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</td>
</tr>
<tr>
<td>Purpose</td>
<td>Decision  To note  Approval  ✓  For information</td>
</tr>
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</table>

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

The Trust is required to maintain a Register of Interests for the Board which is available to the public\(^1\). The Register is routinely updated as new information is provided by Board members.

NHS England (NHSE) Conflicts of Interest Guidance, which came into force in June 2017, requires all colleagues to declare material interests on an annual basis and within 28 days of a new interest arising. Regular communications are in place reminding all colleagues to make any relevant declarations, and all colleagues at band 8D (or equivalent) and above are required to either make a declaration or submit a nil return. The new Register of Staff Interests is published on the Trust website.

The Board of Directors work plan also provides opportunities twice a year for the Board Register to be formally presented to ensure that it remains accurate.

**Recommendations**

Board Members are requested to approve the contents of the Register

**Appendices**

1. Register of Interest

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\(^1\) §20 (1) (d), Schedule 7, National Health Service Act 2006
Register of Interests of the Board of Directors – June 2020

<table>
<thead>
<tr>
<th>Name</th>
<th>Interests Declared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin Havenhand</td>
<td>• Niece is Associate Operations Director of One Health</td>
</tr>
<tr>
<td></td>
<td>• Member of Rotherham Together Partnership Board</td>
</tr>
<tr>
<td></td>
<td>• Chair of Ambition Rotherham Board</td>
</tr>
<tr>
<td></td>
<td>• Director of Corporate Trustee</td>
</tr>
<tr>
<td>Joe Barnes</td>
<td>• Member of the Labour Party</td>
</tr>
<tr>
<td></td>
<td>• Director of Corporate Trustee</td>
</tr>
<tr>
<td>Nicola Bancroft</td>
<td>• Business in the Community Member of Finance and Risk Committee</td>
</tr>
<tr>
<td></td>
<td>• Sister employed by Sheffield Teaching Hospitals NHS Foundation Trust</td>
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<tr>
<td></td>
<td>• Director of Corporate Trustee</td>
</tr>
<tr>
<td>Heather Craven</td>
<td>• Niece is a final year trainee midwife. Currently employed at Wythenshawe Hospital</td>
</tr>
<tr>
<td></td>
<td>• whilst finishing training.</td>
</tr>
<tr>
<td></td>
<td>• Director of Corporate Trustee</td>
</tr>
<tr>
<td>Mark Edgell</td>
<td>• Employed in a senior role by the Local Government Association (LGA), leading</td>
</tr>
<tr>
<td></td>
<td>• their work with all Councils and partners (including NHS England and PHE) in</td>
</tr>
<tr>
<td></td>
<td>• Yorkshire and Humber, East Midlands and North East.</td>
</tr>
<tr>
<td></td>
<td>• Wife employed as Senior Lecturer in Midwifery at Northumbria University</td>
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<tr>
<td></td>
<td>• Member of the Labour Party</td>
</tr>
<tr>
<td></td>
<td>• Director of Corporate Trustee</td>
</tr>
<tr>
<td>Lynn Hagger</td>
<td>• Company Secretary, Suburbaret Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Corporate Trustee</td>
</tr>
<tr>
<td>Rumit Shah</td>
<td>• Principal GP in Hatfield, Doncaster</td>
</tr>
<tr>
<td></td>
<td>• Local Medical Committee Chair, Doncaster</td>
</tr>
<tr>
<td></td>
<td>• Primary Care Network Clinical Director East Doncaster</td>
</tr>
<tr>
<td></td>
<td>• Managing Director Beckingham Medical Services Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director of Corporate Trustee</td>
</tr>
<tr>
<td>Michael John Smith</td>
<td>• Non-Executive Director Humber Teaching NHS Foundation Trust (HTFT)</td>
</tr>
<tr>
<td></td>
<td>HTFT manages the Local Health Care records</td>
</tr>
<tr>
<td></td>
<td>Exemplar Project (LHCRE) of which Rotherham FT is a paid partner.</td>
</tr>
</tbody>
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**Executive Directors**

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Position</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard Jenkins, Interim Chief Executive</td>
<td>Chief Executive at Barnsley Hospital NHS Foundation Trust</td>
<td>Director of Corporate Trustee Barnsley Hospital NHS Foundation Trust, Executive Reviewer (Well-led Reviews) for the Care Quality Commission, Member of Liberal Democrats, Wife employed as a Nurse at York Teaching Hospital NHS Foundation Trust, Director of Corporate Trustee</td>
</tr>
<tr>
<td>George Briggs, Chief Operating Officer</td>
<td>Shareholder in Briggs Health Ltd</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td>Callum Gardner, Executive Medical Director</td>
<td>Owner &amp; Director of Innovative Medicine Ltd</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td>Steve Ned, Director of Workforce</td>
<td>Director of Steven Ned Ltd</td>
<td>Workforce Director at Barnsley NHS Foundation Trust, Director of Corporate Trustee</td>
</tr>
<tr>
<td>Simon J Sheppard, Director of Finance</td>
<td>Wife employed as a Specialist Nurse at Sheffield Children’s NHS Foundation Trust</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td>Angela Wood, Chief Nurse</td>
<td>No general interests to declare</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td>Michael Wright, Interim Deputy Chief Executive</td>
<td>No general interests to declare</td>
<td>Director of Corporate Trustee</td>
</tr>
<tr>
<td>Anna Milanec, Company Secretary</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**Company Secretary/Director of Corporate Affairs**

- Anna Milanec, Company Secretary