The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Trust Board Meeting
held in public on Wednesday 31 July 2013 in the Boardroom

Present:
Dr Bryan Jackson, Chairman (Chair)
Mr Graham Bragg, Acting Chief Executive
Mrs Lindsey Webb, Deputy CEO & Director of Nursing, Governance & Strategy
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Mrs Amanda Markall, Director of Operations
Mr Robert Millinship, Non-Executive Director
Mr Tim Pile, Non-Executive Director
Mr Andrew Meehan, Non-Executive Director
Ms Elizabeth Mountford, Non-Executive Director

In attendance:
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Roger Tillman, Interim Deputy Medical Director
Mr Mel Grainger, Clinical Director for Spinal Surgery (agenda item 07/13/1446)
Mr Edward Davies, Clinical Director for Research & Development (agenda item 07/13/1447)

ACTION

07/13/1433 **Apologies and welcomes**
Apologies were received from Professor Tauny Southwood, Non-Executive Director and Professor Francis Kirkham, Non-Executive Director

07/13/1434 **Introductions & Welcome**
None

07/13/1435 **Declarations of Interest**
No other Declarations of Interest than those registered previously.

07/13/1436 **Minutes of the Trust Board meeting held on 29th May 2013**
The minutes were approved as a correct record subject to the following amendments:

05/13/1413 – Third bullet point should read Specialist Commissioning Team met Local Area Team.

07/13/1437 **Action Points**

The action notes were updated (see separate sheet).

07/13/1438 **Chairman's & Chief Executive's Update**

- GB reported the retirement on ill health grounds of the Trust's CEO, Donal O'Donoghue. It was noted that a low-key presentation had been made by a small group of staff at the end of June. All Board members wished him well in these difficult times.
- GB formally reported the resignation of Lindsey Webb as Director of Nursing, Governance & Strategy and confirmed that the Board Nominations and Remuneration Committee would meet after the Board meeting to finalise interim and recruitment arrangements. This meeting would also finalise arrangements for CEO recruitment.
- GB also reported that Heidi Peakman, Deputy Director of Nursing & Governance had been granted a 6 month secondment for family reasons and an interim cover arrangement was being sought.
- BJ reported that the Trust had ranked 19th in the national Friends and Family data which was to be commended.
- GB reported that the staff party held on the 5th July had been well attended and was very well received and this had helped to raise morale.
- GB advised that ADCU would open from late August with a managed start process and snagging log to ensure that the transition was as smooth as possible. TP asked if it was worth getting together those who had expressed concerns to walk the patient pathway and understand how it was going to work. AP confirmed that doctors were visiting and TP suggested this be insisted upon. It was noted that the Chairman's recommendation to manage issues as they arise was to be followed.
- Medical staff engagement was on-going and GB and AP had held the first of a planned series of dinners with invited medics. The overall outcome will be reported back to a future Board meeting.
- The Trust had been out to tender for an orthotics contract to review the provider. Using the agreed competitive tender process and selecting bidders from the national framework, the proposed provider is not the current provider. The key difference was on quality. **The recommendation was supported by ADM and the Board approved the selection**.
- GB reported that the Trust had yet to receive notification from Monitor as to whether it would review the Trust's Annual Plan in detail. **It was agreed to circulate all Board members once the position became known.** **GB**

- GB reported that the staff engagement interviews were almost complete and that the results of these would be fed back to a workshop in the autumn.
- JS reported on the marketing meeting which had been well supported by doctors and the key decisions would be who we marketed what to and how we chose the routes to get to that market. RT felt that GPs referred in a completely ad-hoc way. TP had suggested we secure a marketing expert on secondment for a day a week for a few weeks; AP had a contact that may be able to do this. The Board supported this approach. GB asked for an action plan and timetable to be provided for EMT to consider. JS also advised that the Trust was putting up success posters to notify staff and patients of good news. **AP** **JS**
- Interviews for two anaesthetists took place yesterday and one appointment will be offered.

07/13/1439 **<u>Medical Director's Report</u>**

AP presented the Medical Director's Report.

BJ asked if the Trust was at risk because of the low rates of mandatory training take up among doctors. AC commented that there had been a review from the commissioners as it is a quality standard within the contract and as such, the Trust would be at risk. AP advised that appraisal is mandatory in order for a doctor to be revalidated. An extra mandatory training session had been put on at the end of September. BJ asked if the training was deemed worthwhile and AC indicated that staff perceive it as a 'must-do' and the content is dry and repeated each year. EM had attended and felt that it was adequate but that on an annual basis it would not be a high priority in terms of interest despite it being an essential requirement. Some specialist clinical sessions that are mandatory but are perceived as not relevant, face particular difficulties in securing attendance. **EM offered to support AC in developing improvements.** **AC/EM**

The Board noted the update.

07/13/1440 **<u>Medical Staff Committee Update Report</u>**

GB presented the Medical Staff Committee (MSC) report following the MSC meeting held on the 26 July 2013.

Issues raised included:

- Destruction of hospital notes. GB expressed disappointment at this item given the extensive work undertaken over many months by staff teams to consider this issue. This highlighted that, despite discussion with Clinical Directors, there did not appear to have been a wider discussion within their teams. The Trust proposals had taken account of the paediatric and oncology issue

but the issue on implants was not accepted as it would cover the majority of trust work. RT and AP confirmed that notes had to be retained for eight years and that theatre records would remain available and these detailed implants. EM asked why the Trust did not scan records and was advised that the Trust hoped to do this following a reduction via the destruction policy. The Board noted the MSC bullet points and confirmed its support for the destruction of hospital notes as outlined by the Executive Team, being assured that both paediatrics and oncology had already been considered as exceptions and that the issue of implants be the subject of further clarification with the Chairman of MSC. **The Board asked the Chairman to agree any executive proposals with the Acting CEO.** **BJ/GB**

- The Board noted the concerns of MSC about the potential for additional pressures on medical secretaries due to the requirement to issue discharge letters to patients. It was advised that there were a wide range of views expressed with some doctors having worked in this way for many years. RT felt that there were instances where letters were not understood by patients and secretaries were called for explanation. AP felt that the advanced systems used at UHB where patients could access letters electronically would be very simple. AM commented that this requirement is within the NHS constitution. BJ felt that this should be enforced as it is a key requirement of NHS organisations.
  GB would write back to the MSC. **GB**

The Board noted the update from MSC.

07/13/1441 **Nursing Staff Report**

The Board noted the first report from nursing staff. The Director of Nursing & Governance stated that all issues were being addressed following a recent Ward Managers away day.

Strategy and Organisation Development

07/13/1442 **Francis Report**

LW reported that executive groups had begun to meet and that Non-Executive Director involvement was welcomed. BJ volunteered for creating the right culture. **Other Non-Executive Directors to contact LW**. **NEDs**

07/13/1443 **Board Committees**

JS introduced the report which had draft terms of reference for Board Committees following a recent review. The biggest difference was the change from Integrated Governance to Clinical Governance and this had been discussed in principle with the chairs of both Audit and IGC and was felt to be the right

solution.

Board Terms of Reference had also been included and these were based on recommended best practice from the Foundation Trust Network.

ADM felt that the Audit Committee should include reference to both Monitor and corporate governance.

BJ suggested that Board review should be every 3 years.
Committees were asked to review their terms of reference and make amendments ready for formal adoption in October (on the proviso that such amendments maintained the integrity of purpose outlined in the illustrative diagram contained within the report). **ADM/TS/ JS/PA**

07/13/1444 **Council of Governors' Constitution**

JS gave a verbal update to confirm that the paper which had been circulated to Board members for consideration was for comments by the 15th August. It was planned to take forward ideas agreed by Board members by having discussions with the Trust's legal advisors in order to pull together a comprehensive proposal for consideration by the Council of Governors in the autumn. This would ensure that the Trust was able to change the constitution in the way it proposed rather than suggest something to governors which might then prove impossible to enact. JS had reported that FK supported this approach and confirmed that she was entirely comfortable with the changes being proposed. In response to a question from GB, JS confirmed that the Trust was not at risk for not agreeing the constitution. **ALL**

JS would then contact lawyers and feedback with their views and a timetable at the September Board meeting. **JS**

07/13/1445 **Board Assurance Framework**

LW presented the proposed approach to the Board Assurance Framework (BAF) and proposed high level risks for consideration by the Board.

BJ asked LW to clarify the difference between the BAF and CRR (Corporate Risk Register). BAF risks are those which challenge strategy. Inherent scores are scores when the risk is identified – start scores, current is as of a given date and final is the outcome desired score.

ADM felt that the proposed risks were much better in terms of big BAF risks. **The addition of a risk on finance was agreed.**
The Board approved the BAF revisions as suggested. **PA**

07/13/1446 **Spinal Deformity Presentation**

MG attended the meeting and gave a presentation on the spinal service.

The service is recognised nationally and internationally and patients experience extremely low levels of complications. Areas for continuous improvement however do remain such as lack of outcomes data, capacity versus demand and consultant engagement in the wider Trust.

Over the last year the service had experienced a range of unplanned staffing issues which compounded issues that were already known and really impacted on capacity to deliver surgery. Co-incidental with this, the commissioners demanded that the Trust eliminate its 52 week waiters.

Outstanding issues remain in terms of appointment processes which can cause delays. Delays in treating spinal deformity in children can result in more complex surgery being required and it is intended that this be avoided wherever possible. Imaging resources cause issues, particularly the CT scanner (a replacement is in process). There remain issues in working with the Children's Hospital and lack of anaesthetic and medical back-up is not always ideal given complexity of cases.

Looking forward, the Trust has major strength in deformity and bone tumour and has additional capacity and a strong functional restoration programme. There remains a challenge from UHB and its major trauma centre. Not having trauma impacts on the range of training we can offer to junior doctors.

RM asked what the top priorities were. MG responded that outcome data was essential and strength of medical back-up. MG was asked whether the staffing issues of the last year had been mitigated and he said that as far as was possible any forward scenario planning had taken place.

GB felt that the Board should be reassured that Spinal Services were acknowledged as a growth service. GB gave credit to MG for the achievements he had made in coming to terms with and managing the challenges of this service. AC felt that longer term planning for the skills needed in the workforce was necessary. MG gave an example of a more junior colleague who may be available to join the Trust in a couple of years. BJ suggested considering recruiting staff from the army medical corps as their role in Afghanistan declined. MG was actively courting interest.

The Board asked GB to review the situation with outcomes data. **GB**

TP felt that there should be a real focus on the support structures such as IT and administration processes in order to ease delivery.

07/13/1447 **Proposal for Option Appraisal Commercial Tissue Requests**

ED attended the meeting to present the option appraisal for consideration of the Trust supporting surplus unused tissue requests for use by commercial companies and for financial gain from the Trust. The Trust was given details on ethical assurance and precedent as part of the discussion.

The issue for consideration by the Board was not ethics but reputational risk. BIOPTA was confirmed as a large and established commercial company. Patient approval processes were clear and included in the submitted paperwork.

One question for consideration posed was 'is it right to discard tissue that could be used for research?'

Four options were presented:

1. Pilot collaboration with Biopta
2. Collaborate with Biopta and other commercial partners
3. Don't collaborate with industry partners
4. Review situation at a later date

ADM asked what percentage of research was undertaken in the private versus public sector and ED confirmed that it was the majority.

RM asked whether the Trust would have to house significant volumes of tissue in case of demand and ED confirmed that supply would be on demand in most cases.

ED referred to the information he had supplied from the House of Lords which reflected the view that there was a dearth of human tissue and that animal tissue had to be used instead.

TM asked if there was a financial arrangement between Trusts and the university repository. ED confirmed the ROH has not at this point but may in future if volumes determine.

EM asked what feedback Biopta had given following the discussion at IGC in terms of reputational damage and ED confirmed that they had a very positive line about their healthcare benefits. It was also confirmed that Biopta was not in a position to shield the Trust from any negative press.

AMD felt it was a very clear decision and TP felt that the use of income generated should be for the purpose of further research.

The Board supported the collaboration with Biopta for commercial gain. Subject to on-going maintenance of thorough, informed and robust consent from patients. In addition any company worked with should be thoroughly assessed against UK standards and ethics.

RT commented that theatre staff should have this process fully explained. This was agreed. **ED**

Performance Management/Assurance Reports

07/13/1448 **Corporate Performance Report & PMO**

PA and AC gave a presentation on the June 2013 Corporate Performance Report.

The Board congratulated the Operations Team for the achievement of the referral to treatment (RTT) targets. 52 week waits had reduced significantly and commissioners had confirmed they will not issue fines if the decline continues for at least Q1 and Q2. RM asked, in light of the presentation on spinal service pressures, what the key factors had been in achieving this excellent outcome and AM advised there were multiple factors from revalidation of waiting lists to re-grouping the staff team and way of working.

EM asked if this was the beginning of a change in attitude within the team and AM said it was beginning but the Clinical Director was supporting this.

PA highlighted the impact on surplus of facing costs attributable to the additional activity.

The Trust's cash position had been adversely affected by delays in commissioner payments (circa £1.2m variance).

Three issues causing quarterly financial variance were highlighted :

- Outsourcing for MRI capacity £59k – being reviewed by the Intensive Support Team
- Junior doctor locum spend £23k – this is part of a major review by AP and AC and anticipated mitigation through the appointment of medical fellows had not materialised.
- Clinical agency cost £78k – some elements of over-recruitment and failure to secure good substantive replacements for expensive agency staff had contributed to this.

AC presented workforce issues:

- Turnover - continued to be high across Nursing (Qualified and HCA), Scientific and Technical staff and Non-Training Doctors and actions were in train including leadership

stability, review of the medical workforce model, and gathering exit interview data to assess themes and triggers especially among nurses. Staff engagement activity would help support better results. BJ suggested that existing staff were asked why they stay as well.

- Vacancies – 60 FTE vacancies with 90 people for the roles (part time as well as full time). Another 59 staff from bank, junior doctors and clinical workers also contribute to the recruitment activity in the Trust. Short term this creates huge demand for servicing in HR and teams and BJ felt this must have potential to impact negatively on quality as staff get involved in the recruitment process. LW commented that the Trust was being more stringent in its assessment citing the use of an assessment centre approach for theatre vacancies.

  Executive challenge and review of vacancies with directorates continues and processes are being streamlined.

- Sickness – levels were marginally improving. In theatres there were particular issues of long term sickness.
- Mandatory training and appraisals – this had been focused on and significant improvements achieved with non-medical staff. Clinical Directors had been asked for plans for medical staff. These not having been provided AP and AC will hold a meeting with them. BJ asked if this was in their objectives and was advised that it is not yet there.

The Board noted the report.

07/13/1449 **<u>Quarter One Workforce Report</u>**

AC presented the Quarter One Workforce Report and asked the Board to note that the job planning outcomes requested by the Board were contained in section 3 of the paper.

The Board noted the report.

07/13/1450 **<u>Patient Safety Report</u>**

LW introduced the Patient Safety Report and highlighted the following:

- The Ward Dashboard had improved and HDU, where there had been improvements remained red.
- Three meetings on safety had been held and this was encouraging.
- Two SIRIs had occurred which related to patient notes and the Information Governance Manager is actively reviewing processes. Safeguarding issues had been raised as a result of a failure to undertake routine

pregnancy testing. The morphine overdose had caused no adverse long term effect on the patient.

The Board noted the Patient Safety Report

07/13/1451 **Integrated Governance Committee Report – 26 July 2013**

EM presented the report prepared by TS following the Integrated Governance Committee meeting held on the 26 July 2013. EM added comments that the discussion of the human tissue matter had provided IGC significant challenge and resulted in a much more cogent proposal coming to the Board. LW commented that the quality report contained information on review of SIRIs.

The Board noted the update.

07/13/1452 **Audit Committee Report – 16 July 2013**

ADM provided an update following the Audit Committee meeting held on the 16 July 2013.

The Annual report of the Audit Committee will be considered by the Board in September. **JS**

The Board noted the update.

07/13/1453 **Trust Board Risks**

BJ proposed that the Board's risk around capability be maintained at its current risk rating. The document should be updated to say that the new element of risk was the loss of the Director of Nursing, Governance & Strategy. The current rating remains amber.

JS and GB to update the risk treatment action plan. **JS/GB**

07/13/1454 **Quarter One Governance Quarterly Declaration Report**

GB introduced the declaration and asked the Board to support the declaration of compliance with targets.

The Board approved the Q1 Declaration.

Board Committees & ad-hoc Groups not covered elsewhere

07/13/1455 **Remuneration Committee – 10 June 2013**

BJ reported that the committee had focused on arrangements for the retirement of the CEO, which had now taken place.

07/13/1456 **Investment Committee – 29 July 2013**

RM tabled a report from the Committee.

The meeting met representatives of Bournville Village Trust to discuss their development on the former Bournville College site. ADM highlighted the financial exposure of £25k and the scheme

offered huge potential to grow.

The Board supported the submission of a letter of intent to BVT confirming the Trust's aspiration to offer physiotherapy services in the Health and Wellbeing Centre on the site subject to a business case. **AM**

RM reported that there was commitment to supporting work to reduce surgical site infections. GB and PA will meet to prepare a submission for potential support from charitable funds. **GB/PA**

The committee also recommended for support to enhance the sports injury development. **This was approved**. **AM**

07/13/1457 **Items for Executive Question Time/CEO Briefing**
Item not discussed

07/13/1458 **Any Other Business**
None

07/13/1459 **Date and Time of Next Trust Board Meeting**
No meeting in August
Trust Board meeting Wednesday 25 September 2013 at 8.30 am in the Board Room, AGM to be held late afternoon/early evening (time tbc)

The Board resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

The Royal Orthopaedic Hospital NHS
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PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 31 July 2013

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
03/12/11 86 07/13/1443	Trust Board Terms of Reference To be reviewed in 6 months' time. Board Committees Committee's to review ToR and make amendments ready for formal adoption in October.	JS/LW ADM/TS/ JS/PA	July 2013 – revised date October 2013	√	On July Trust Board agenda in draft.
04/13/13 97	Q4 Workforce Report Appraisal forms to be refreshed.	AG	Nov 2013		Part of implementation of new national pay deal in 2013/14.
04/13/14 02 07/13/1446	Q4 Monitor Governance Declaration Clinical Director for Spinal Services to attend a future Board meeting. Spinal Deformity Presentation GB to review the situation with outcomes data.	AP/GB GB	May 2013 September 2013	√	Mel Grainger attended July Board meeting.
05/13/1414 07/13/1439	Medical Director's Report Mid-year review to be given to the Board in September. EM offered support to AC in developing mandatory training sessions.	AP AC/EM	September 2013 September 2013	√	All presenters are reviewing their session (content and delivery) with Head of Learning & Development for delivering from October. All presenters offered an opportunity to refresh their delivery skills at a 'presenting

05/13/1415	Medical Staff Committee Update Report Executive Directors to consider radiological staffing and to report back to the Board in July. Report to be completed by October.	Execs	October 2013		yourself powerfully' day in November. The Board were updated that a wider project is now being undertaken with input from the Intensive Support Team to understand better both additional workforce and additional equipment (in particular MRI) requirements. It was agreed that a report would be completed by
07/13/1440	Destruction of Hospital Notes Chairman to agree any executive proposals with the Acting CEO. GB to write back to the MSC.	BJ/GB GB	September 2013 August 2013	√	
05/13/1420	Capital Programme GB to discuss with AM investment of beds and chairs for ADCU to ensure of a high standard.	GB	October 2013		GB updated that capital spend requirements for equipment on ADCU had now been satisfied through both charitable and other funds. An update should be given in October.
05/13/1424	National Inpatient Survey Timescale for improvement around food to be determined. The Board noted the results of the 2012 National Inpatient Survey and supported the monitoring of the action plan to address the findings by the Quality Committee.	AM	October 2013		AM noted at July meeting that patient satisfaction had improved significantly and that further improvements were anticipated with the appointment of a new chef. LW confirmed that serving of food was also being addressed to ensure patients received hot and well-presented meals. EM and PA stated that on their ward visits patients had reported that they were satisfied with their meals. A further update will be provided in October.

05/13/1425	Equality Duty Report Workforce & OD Committee to establish KPIs. Data to be tracked over time in order to ensure that the Trust improved in meeting its diversity obligations.	AC AC	July 2013 Feb 2014	√	Objectives agreed relating to completeness of record keeping and staff perception of discrimination (staff survey). Progress to be included in next annual Equality Duty Report
07/13/1438	Chairman & CEO Update GB to circulate all Board members once the position was known as to whether Monitor would review the Trust's Annual Plan. Marketing AP to provide contact for potential marketing expert. Action plan and timetable to be provided for EMT to consider action.	GB AP JS	August 2013 August 2013 August 2013	√	Monitor had confirmed that they would not be reviewing the Trust's Annual Plan.
07/13/1442	Francis Report NED's to contact LW regarding involvement with Francis working groups.	NED's	August 2013		
07/13/1444	Council of Governors' Constitution Comments on the constitution to be sent to JS by 15 August. JS to contact lawyers and feedback with their views and a timetable at the September Board meeting.	ALL JS	15 August 2013 September 2013		Lawyers contacted and awaiting a response.
07/13/1445	Board Assurance Framework Finance risk to be added to the BAF.	PA	September 2013		
07/13/1447	Proposal for Option Appraisal Commercial Tissue Requests Process to be fully explained to theatre staff.	ED	September 2013		
07/13/1452	Audit Committee Report Annual Report of the Audit Committee to be considered by the Board in September.	JS	September 2013		On the September Board agenda.

07/13/1453	<u>Trust Board Risks</u> JS/GB to update the risk treatment action plan.	JS/GB	September 2013		
07/13/1456	<u>Investment Committee</u> Letter of intent to BVT confirming the Trust's aspiration to offer physiotherapy services in the Health & Wellbeing Centre on the site subject to a business case to be actioned. GB/PA to meet to prepare a submission for potential support from charitable funds for work to reduce SSI's. Sports injury development to be taken forward.	GB GB/PA AM	August 2013 September 2013 September 2013	 √	 A project team has been established with first clinics to commence in October 13.

The Royal Orthopaedic Hospital NHS
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Date of Trust Board: 25 September 2013 **ENCLOSURE NUMBER: 3**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Andrew Pearson**
AUTHOR(S)	**Andrew Pearson**

TITLE	**Medical Director's Update (Mid-year review) September 2013**

SUMMARY

This paper provides an update and mid-year review from the Medical Director.

RISK & IMPLICATIONS

Governance
Financial
Operational

RECOMMENDATIONS

The Board is asked to note this update.

Medical Director's Update (mid-year review) September 2013

I have listed below a number of meetings which I have been involved in during the past 6 months.

External meetings:

- Department of Health – Piloting of Tariff versus PROMS
- Clinical Lead for Orthopaedics at the Queen Elizabeth Hospital
- Medical Director at the Queen Elizabeth Hospital
- Medical Director Network Meeting
- Responsible Officer Network Meeting
- Strategic Orthopaedic Alliance meeting

Internal Meetings

- Joint Local Negotiating Committee – Job planning discussions
- Junior Doctors Committee – Chairman of this meeting
- Clinical Directors Committee – Co-Chair of this meeting
- One to one meetings with the Clinical Directors
- Information Governance Committee
- Small Group Consultant
- Member of Board Link Groups:-
- Governance
- Theatres/HDU/ADCU
- Lead for the Francis Report Group – Care of the Older Patient
- Clinical Lead – Enhanced Recovery Team

Personal Development

- GMC Responsible Officer Training
- Caldicott (2) Guardian Training
- Adult Safeguarding (Level 2)
- Case Manager Training
- Leading Change Conference

Current Issues

Junior Doctor Rotas/Compliancy

There are significant agency cost pressures due to the organisation's reliance on locum cover.

Solution – Working with the Director of Workforce to engage with external advisor(s) designing 'future hospital'.

Appraisal/Mandatory Training/Revalidation

On-going problem of low 'take up' rates amongst medical staff with a risk of non-compliance resulting in fines by commissioners.

Solution - Robust process, GMC backing with clear sanctions, one to one discussions with individuals and support of the Clinical Directors

Job Planning

Historically job planning has not been robust or regular with many of the consultants only having the job plan from when they were appointed. Therefore the Trust does not know what doctors are meant to be doing and in some cases neither do the doctors!

Solution – Robust annual job planning process commenced which is being run by the directorates but overseen by the Director of Workforce and the Medical Director which will result in a much clearer understanding that consultant activity in the job plan will be aligned with Trust strategy/

Quality

There are currently 2 consultant investigations:

(I) Resolved – The doctor has returned to work with no sanctions

(II) On-going – The doctor is under some restrictions and the GMC are showing a very close interest in this case.

The Royal Orthopaedic Hospital NHS
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Report to Trust Board

Date: **25 September 2013**

Report Title:	Site Development
Report by:	Stuart Lovack – Head of Estates & Facilities
Report presented by:	Graham Bragg – Acting Chief Executive
Purpose of the Report:	To agree the procurement strategy for the next phase of the site development plan including site demolitions
Recommendation:	For the Trust Board to note and approve

1.0 **Summary/Background**

At the Trust Board meeting in April 2013 the Estates Development Control Plan (DCP) was presented. The DCP showed the proposed phased development plans for the site and updated the Board on their progress.

The Trust Board supported the proposed DCP and requested further updates on the proposed major developments for the site.

The Trust's three-year capital investment programme was discussed and agreed at the Trust Board meeting in May 2013. The major schemes within the programme relate to the development of an Admissions & Day Case Unit (ADCU), replacement of the Decontamination Unit, refurbishment /centralisation of the Stores function and re-provision of the Medical Records storage/office facilities (Phase II). The final phase of this development package is the replacement of our aging Theatres 1, 2 and 4 (Phase III).

The first phase of the ADCU development has been successfully handed over to the Trust; this included ADCU, the Decontamination Unit and the Medical Records storage facility. The final works in this project (Medical Records Offices and Central Stores) will be undertaken in November 2013 when the Trust has relocated its

medical records files to their new location.

The ADCU development was competitively tendered in May 2012 through a tender evaluation/value engineering exercise. This confirmed the preferred contractor for the scheme to be E. Manton Limited at the lowest tendered cost of £3,201,823.74 + VAT + Fees.

The Contractor was commissioned using an industry standard contract, this being the JCT Standard Building Contract with Quantities 2011. The Contract incorporates a variation clause for the alteration or modification of the design, quality or quantity of the works.

The project has been supported by a professional Design Team who was commissioned in consultation with our Procurement Department using the Healthcare Purchasing Consortium (HPC) Framework Agreement.

The project has progressed well; it has been completed within the allocated timeframe, within the agreed cost and to a high quality standard.

The Trust has established a good working relationship with the contracted professional Design Team and the main Contractor. It is recommended to extend the current Contracts to cover enabling works which consist of the relocation of departments under the footprint, car park works and site demolitions. The extension to Contract would also cover the works to refurbish the bedrooms damaged by the Short Stay Fire.

Extending the current Contract would enable the Trust to maintain its momentum in moving forward its Development Control Plan.

The extension to contract would cover the following works:

- Demolition of the old Stores building
- Car park re-configurations including turning circle
- Relocation of cardboard compactor
- Temporary relocation of Medical Records offices and Orthotics Department
- Relocation of the Linen Room, Clinical Skills Room, Staff-Side Office, Bed Workshop and Staff Gymnasium
- Refresh of the Orthotics Department
- Demolition of the former Staff Gymnasium, Block 45
- Demolition of the former Wards 5 and 7, Block 26

	The relocations, enabling and demolition works described above will prepare the site for the construction of a new three-storey development which will be discussed at a future meeting. The added advantage of undertaking the above enabling works is the clearance of the site adjacent to our Theatre complex. This gives the Trust the ability (should there be a major failure with our aging Theatres 1, 2 and 4) to locate temporary mobile theatres in close proximity to our main Theatre complex to maintain service.
2.0	**<u>Capital Programme/Procurement</u>** The current Trust's rolling three year Capital Programme has the following approved amounts associated with the identified major schemes:

<u>Scheme</u>	FY13/14 £'000	FY14/15 £'000	FY15/16 £'000	FY16/17 £'000
Ambulatory Care /Theatres	1,777			
Decontamination	10			
Replace Windows (Part)	50			
Enabling Works Gas	75	75	50	50
Enabling Works Electricity	50	75	50	50
3-Storey Development		3,000	2,500	2,000
Electrical Infrastructure		400		
Short Stay Ward – Fire	347			
Total:	2,309	3,550	2,600	2,100

The available resource (as detailed above) in FY 13/14 is sufficient to cover the following works:

ADCU spend at end Q2	£ 836,000
ADCU remaining spend 13/14	£ 350,000
Demolition of old Stores	£ 43,000
Car park works/ relocate compactor	£ 43,000
Relocate departments within footprint/demolitions	£ 495,000
Refurbishment of Short Stay Ward (Fire)	£ 347,000
Total:	£2,114,000

	A report from our appointed 'Cost Consultant' confirms the previous Tender represents value for money; it is, therefore, recommended that the Trust extends the contract with E. Manton Limited for the works identified above. The cost of this extension to Contract is £629,000 + VAT + Fees totalling £928,000.
3.0	**Programme/Progress** The anticipated programme for the above works is detailed below: Final phase of ADCU — Nov 2013 to Jan 2014 Demolition of old stores — Nov 2013 to Jan 2014 Car park works/relocate compactor — Nov 2013 to Jan 2014 Asbestos removal — Nov 2013 to Aug 2014 Relocate department under footprint — Nov 2013 to April 2014 Refurbish Short Stay Ward — Jan 2014 to April 2014 Old Ward 7 is to be used as a decant ward to enable the Paediatric Ward to be vacated while it is upgraded following the recent CQC visit. On completion of these works the old wards will then be de-commissioned and demolished. The demolition of Wards 5 and 7 is scheduled from June 2014 onwards. The site enabling works involve a number of complex service diversions and isolations; the Trust has established a good working relationship with the main contractor and its sub-contractors. The extending/varying of the contract will enable this relationship to continue/foster and all the site knowledge gained over the last eighteen months will be maintained.
4.0	**Revenue Consequences** The revenue consequences of the planned investment are currently modelled in the three-year capital programme.
5.0	**Risk Considerations** A review of the Contract documentation is to be undertaken by Frances Kirkham on Friday 20th September 2013, the outcome of this will be discussed at the Trust Board meeting.

6.0	**Consultation** On completion of the enabling works package the next stage of the major site development plan will be communicated widely throughout the Trust.
7.0	**Conclusion and Recommendations** It is recommended the Trust Board: • Approve the continuation of the established Design Team and main Contractor for the departmental relocations, site demolitions and refurbishment of the Short Stay Ward. • Approve the variation of the existing ADCU Contract to include site demolitions, car park works, departmental relocations and refurbishment of the Short Stay Ward.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to Trust Board

Date: 25th September 2013

Report Title:	Carbon Reduction Strategy Annual Report
Report by:	Head of Estates and Facilities
Report presented by:	Director of Operations
Purpose of the Report:	To present the end of year position 2012/13
Recommendation:	To note the Report

1.0	**Summary/Background** The Trust's strategy is to meet the government's target for carbon reduction by reducing its carbon footprint from our base year in 2006 by 10% by the year 2015. Mr C Monk was the Non-Executive Trust Board nomination and the Good Corporate Citizen's Group (GCCG) is the management group to oversee the delivery of the strategy.
2.0	**Detail** The GCCG is chaired by the Head of Estates and Facilities and meets bi-monthly. The Trust has around 30 members registered on the Group; however, attendance at the meetings is patchy. Further notification has been sent out encouraging staff to attend/join the Group but to date there appears to be low commitment from staff to attend or join. The Trust has, however, been successful in developing a number of staff as 'Carbon Champions' who help to promote energy/carbon reduction initiatives throughout all areas of the Trust. The GCCG endeavours to help reduce the Trust's carbon footprint through good communication and promotion. The strategy is aimed at encouraging staff to participate in all aspects of good housekeeping which we consider will make a major contribution in driving down the Trust's energy usage and carbon footprint.

The GCCG has focussed on raising the carbon footprint profile through the use of screen savers and local promotion. The group also organised a number of external energy and green travel companies to attend the Trust during 'Climate Week' to raise its profile.

The Trust has continued to invest in saving carbon through energy saving investments such as LED lamps, better controls for our building management systems and modification of our gas consuming plant. The Trust has been successful in its stage one bid for funding from the Government; this is targeted at schemes which make a long-term contribution to reducing energy. The Trust's scheme increases the thermal properties of the building which provides accommodation for our Paediatric Ward and Therapy Services Department.

We are currently reviewing the building which contains the Hydrotherapy Pool to see if energy performance can be further improved.

In 2012/13 we set ambitious targets at the beginning of the year to continue to move towards our 2015 national target for carbon footprint savings. Progress is as follows:

	Actual 2010/11	Actual 2011/12	Target 2012/13	Actual 2012/13	National Target 2015
Gas (Tonnes)	1368	1170	1270	1471	1278
Electricity (Tonnes)	1570	1512	1450	1427	1385
Staff travel (Tonnes)	1180	900	900	845	990
NEA (Tonnes)	76	Not available	74	Not available	84
Waste - landfill (Tonnes)	148	138	135	115	125
Water (M3)	22967	20424	21000	22314	26392

The gas target was missed by 201 tonnes; the weather in 2012/13 was more unsettled which is likely to have contributed to the increased gas usage. The energy supplier in early 2012 also replaced our gas meters which supply the Hospital.

The electricity local target was achieved and the Trust continues to work towards the national target.

	The local and national staff travel target was achieved. In 2013 the Trust changed its Ambulance provider; figures from the previous provider were not forthcoming/available. The 'landfill waste' local and national target was achieved, the Trust continues to segregate its waste stream and the following figures are now available: Recycled waste: 27 tonnes Confidential waste: 40 tonnes Skip waste: 26 tonnes Clinical waste: 135 tonnes The local water usage target was missed by 1314 cubic metres. This may be due to the major construction scheme which is on site. The Trust is within its national water usage target. The 2012/13 figures will be used to set targets for future years. The size of the Trust's estate will increase when we commission the new Admissions and Day Case Unit (which includes a new Decontamination Unit). This will put further pressure on the Trust in trying to achieve its targets. Sustainability reporting in the NHS has been made mandatory for 2012/13 and the NHS Manual for Accounts has been updated to reflect this. The Trust completed its sustainability reporting for 2012/13. Sustainability is also reported in the Trust's Annual Report.
3.0	**Timescale** To achieve the 2015 targets.
4.0	**Financial Considerations** There has been no published information on any financial penalties for not achieving the 2015 targets.
5.0	**Revenue Consequence Implications** Further work is required on reducing our carbon footprint as this will have a direct effect on revenue savings for the Trust.
6.0	**Risk Considerations** Failure to meet the 2015 target.

7.0	**Consultation** None.
8.0	**Conclusion and Recommendations** The Trust's main focus for 2013/14 must be to reduce its gas consumption; to achieve the national target a 15% reduction is required. In response to this the Trust applied for external funding through the Department of Health NHS Energy Efficiency Fund, in July it was confirmed that the Trust had been successful with its bid and would receive £90,931.00 as public dividend capital. The funding is to be invested in improving the energy efficiency of our Paediatric Ward and Therapy Services Department. This will result in an annual recurring saving of 4,144.00 for the Trust. The Trust launched its 'Every Can Counts' event in July, this event has kick started the Trust's recycling initiative with the intention of transferring at least 10% of its landfill waste to a recycling base. The GCCG will continue to involve staff in saving energy initiatives working towards reducing the Trust's carbon footprint through good housekeeping and investment. The strategy and targets for 2013/14 will be discussed and proposed at the next GCCG meeting which takes place in July 2013.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 25 September 2013 **ENCLOSURE NUMBER: 6**

SUMMARYOF REPORT TO
Integrated Governance Committee

NAME OF DIRECTOR:	**Joy Street**
SUBJECT:	**Risk Assessment Framework Assurance update**

TITLE: Risk Assessment Framework Assurance update

SUMMARY

The trust board received a report at the end of last financial year giving information on the draft Risk Assessment Framework (RAF) being proposed by Monitor to replace the Compliance Framework. The final version was published on August 27th 2013 and the attached paper provides IGC and the Board with assurance on the trust's readiness to comply with this when it comes into effect on October 1st 2013.

IMPLICATIONS

Compliance with the reporting in the RAF is vital in order for the trust to maintain its licence conditions.

RECOMMENDATIONS

IGC is asked to consider the attached report and advise the Board on the Trust's anticipated compliance with the terms of the RAF.
Executive recommendations are that the trust will maintain compliance with the requirements of the RAF:
Joy Street, Company Secretary; Paul Athey, Director of Finance; Amanda Markall, Director of Operations; Lindsey Webb, Director of Nursing and Governance.

REPORT ATTACHED:

Report Reference:

Risk Assessment Framework – published by Monitor, 27 August 2013.

The company secretary has reviewed the document and has sought confirmation from the Director of Finance, Director of Operations and Director of Nursing and Governance that they are satisfied of the trust's ability to comply.

The full document is available to download from www.monitor-nhsft.gov.uk.

A summary of the key elements is provided below.

1 Purpose of document

Monitor will use the reporting mechanisms outlined in the document to identify when there is:

- a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or
- poor governance at an NHS foundation trust.

This is necessary to ensure continuity of service to patients.

Monitor will issue risk ratings to all trusts based on information provided as follows:.

The *Risk assessment framework* divides the information Monitor may routinely request into four broad categories:
(i) **annual submissions:** plans, statutory reporting requirements of the licence holder, and other annual requirements specified in the licence;

(ii) **in-year submissions:** financial and, for NHS foundation trusts, other service performance information submitted during the year, generally quarterly;

(iii) **exception reports:** other information that may have material implications for a licence holder's compliance, but which is not routinely requested by Monitor. An example might be reports from the medical Royal Colleges; Monitor would not routinely request these, but we would expect to receive such a report from an NHS foundation trust if it identified concerns relevant to the trust's governance of quality (and therefore to the trust's compliance with its licence); and

(iv) **other information from NHS foundation trusts:** Monitor considers that foundation trusts should carry out periodic reviews of their governance. Monitor would expect that trusts should report the findings of external reviews covering areas of governance, to help inform our assessment. (Guidance on this will be published later in 2013.)

2 Differences between the RAF and Compliance Framework

Much of the reporting is the same as that currently provided, but there are some differences and these are highlighted below.

Overall compliance issues have been assessed by the Company Secretary as follows:
The RAF identifies some additional requirements beyond those of the Compliance Framework. This allows Monitor to use some of the work it has undertaken with aspirant trusts to be reflected as requirements now for all FTs.

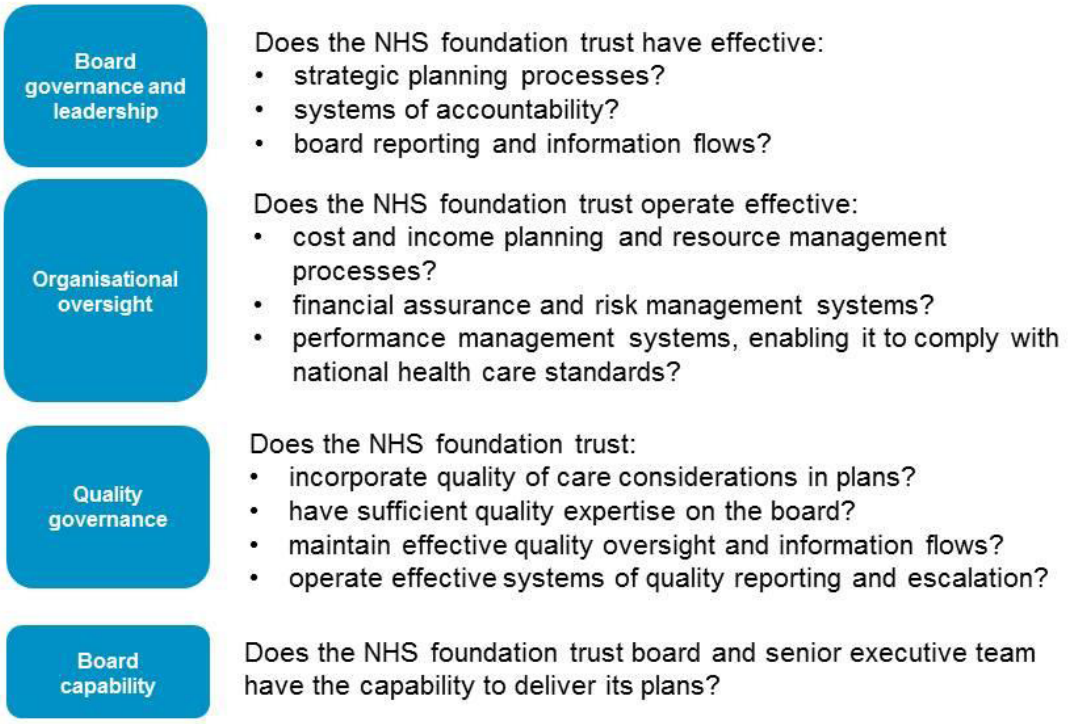
2.1 A three yearly review of governance is to be required with more detail on specific requirements to be published by Monitor at the end of 2013.

Monitor explains:
'We consider that such a review should cover at least one of the following areas of governance:

- **board governance and leadership**, including information the board receives, planning processes and how it holds management to account;
- the effectiveness of **organisational oversight**, including risk assurance processes, performance management systems, internal controls and escalation processes;
- **quality governance**, assessed against Monitor's *Quality Governance Framework*; and
- the **board's capability**, including its composition and the effectiveness of subcommittees.

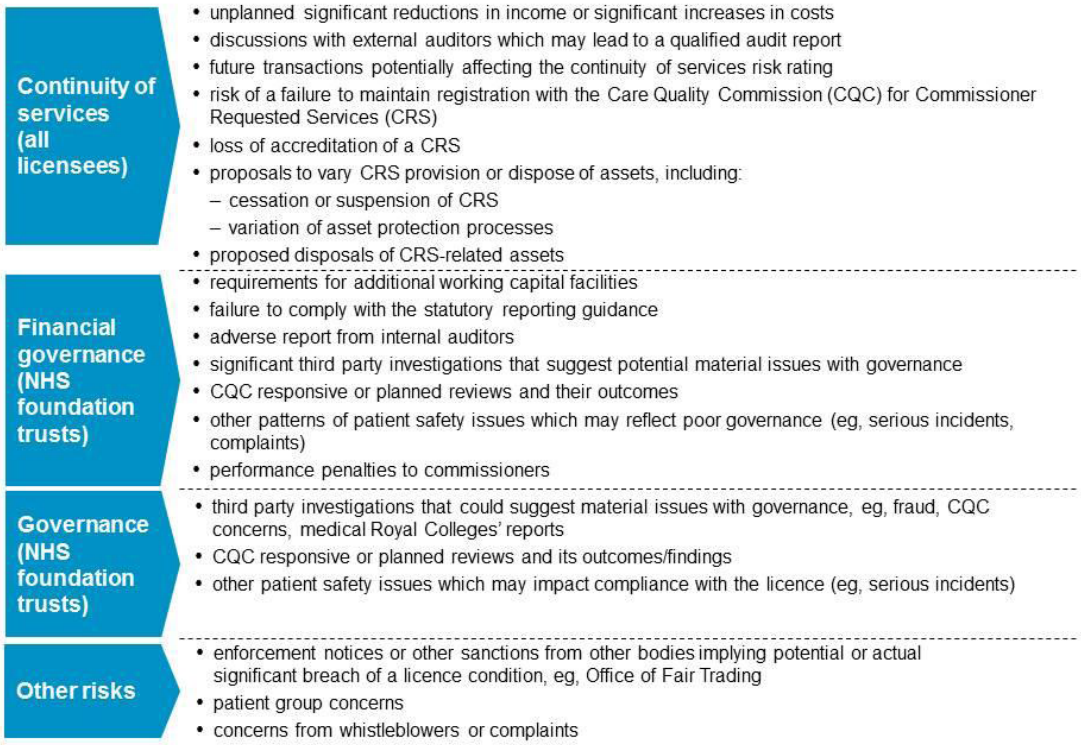
To support a minimum standard of assurance for these reviews, Monitor will publish guidance, including setting a proposed scope for these reviews, and the areas for inspection. The scope will mirror areas currently covered in the application process and hence laid out in our *Guide for Applicants*; and provide guidance in the form of indicative selection criteria that could be used by trusts in line with their procurement policies.
Monitor sees these as primarily an opportunity to develop the sector's processes for building governance assurance. Provided the reviews that NHS foundation trusts commission cover at least the scope set out in guidance, trusts are free to set the overall scope of the reviews they carry out. They should report the findings of the review to Monitor. Where they raise issues of concern that might reflect on compliance with its governance condition, we will consider whether to investigate further.
The Trust Board will need to consider which area it is best to review and in which year. Reports will be expected to be rigorous – indicative costs form earlier discussions are minimum £25k and they will be of use to the trust but reportable to Monitor within 60 days of presentation to the Trust Board under the RAF. (see examples of scope below)

Areas of scope:



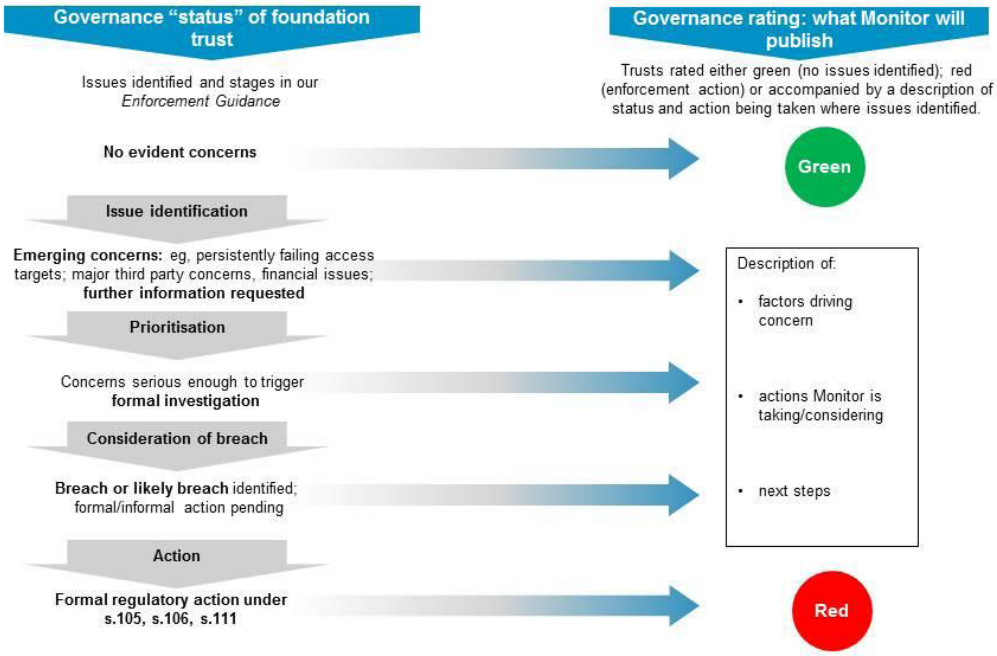
2.2 The production of a corporate governance statement which replaces the board statements previously required. (This is detailed in Appendix D of the RAF)
and must be submitted within three months of the end of the financial year. The statement includes identification of risks and mitigations. ***It is not anticipated that ROH will be unable to comply with the requirements of this statement***.

2.3 Assessment of Quality will now include more direct use of findings from staff surveys and factors such as staff and executive turnover, sickness and agency usage, as well as triangulation form third parties such as patient groups or Royal Colleges (provided either from the FT itself or direct to Monitor). ***ROH should consider how to factor this into its quarterly reports to Monitor and how to make use of exception reporting. (examples below)***



2.4 – the governance risk rating itself

The rating moves from the current red through to green to one of red or green:



2.5 The financial risk- rating (Continuity of Services risk rating)

This is calculated differently from previous Monitor methodologies and the Director of Finance has made the following comments (most of the detail is in Chapter 3 of the full document):

- The focus of the assessment of financial risk has changed in the new Risk Assessment Framework. The Continuity of Services risk rating is designed to identify the level of risk to the ongoing provision of Commissioner Requested Services. This is different from the old financial risk rating, which was used to identify breaches of trusts' terms of authorisation and was generally used more as a measurement of current financial performance.
- The Continuity of Services risk rating is made up of two components:
    - Liquidity – the number of days of operating costs held in cash or cash-equivalent forms; and
    - Capital Servicing Capacity – the degree to which the organisation's generated income covers its financing obligations
- Each of these components make up 50% of the overall risk rating, and are scored between 1 (high risk) and 4 (low risk) based on a set formula and scores.
- These components are then averaged to calculate the overall Continuity of Services risk rating, with decimals rounded up where required.
- The table below shows the regulatory implications of these ratings:

Continuity of services risk rating[1]	Description	Monitoring frequency	Regulatory activity
4	No evident concerns	Quarterly	None
3	Emerging or minor concern potentially requiring scrutiny	Potential monthly	None
2*	Level of risk is material but stable	Potential monthly	None
2	Material risk	Monthly or greater	Consideration for potential investigation (see Chapter 5)
1	Significant risk	Monthly or greater	Potential investigation (see Chapter 5) Potential appointment of contingency planning team

[1] Weighted average, *rounded up*, across the two components of the continuity of services risk rating.

- The 2* rating has mainly been created to satisfy Trust's with significant PFI developments. The Capital Servicing Capacity of these Trust's will almost certainly be scored as a 1, however Monitor acknowledges that these Trust's may still be regarded as robust, financially stable organisations.
- The ROH's three year financial plan generates a Continuity of Services risk rating of 4 for each of the three financial years.
- In year performance against the Continuity of Services risk rating will be recorded in the monthly Corporate Performance Report.

2.6 Compliance with target requirements
These have been assessed by the Director of Operations (pp48-58 of the full document): and her comments are:

- C Difficile targets remain as a de minimis of 12 cases in year with breaches giving rise to investigation if they meet certain thresholds against cumulative quarter targets. It is not felt that this risk differs from that in the Compliance Framework.

- There is no change to the Referral to Treatment waiting times targets and it is expected that ROH will continue to achieve these following improvements in waiting list management along with input from the Intensive Support Team.

- Cancer waiting time targets also remain unchanged however our ability to consistently achieve these is less certain due to 2 factors: we are a regional specialty centre for sarcoma and a high number of our cases are "shared" with other centres and as such there is an inherent risk that breaches in both 31 and 62 day targets can occur due to late referrals. This is further compounded by our low number of referrals (as low as 11-13 per quarter), therefore only 1-2 breaches can result in failure of the target.

- As the ROH is an elective centre, A and E indicators and ambulance turnaround targets are not applicable

- Community services data completeness is not applicable to the ROH as we have no services that are commissioned through and funded under the community services contract

Indicator (see Appendix A)	Driver of a governance concern

Meeting the C. difficile objective	• Has greater than 12 cases in the year to date, and either:
	  • breaches the cumulative year-to-date trajectory for three successive quarters; or
	  • breaches its full year objective;[1] or
	  • Reports important or significant outbreaks of C. difficile.

Referral-to-treatment (RTT) waiting times	• Breaches[2]:
	  • the admitted patients 18 weeks waiting time measure for a third successive quarter;
	  • the non-admitted patients 18 weeks waiting time measure for a third successive quarter; or
	  • the incomplete pathway 18 weeks waiting time measure for a third successive quarter.

A&E indicator	• Fails to meet the A&E target twice in any two quarters over a twelve month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.

Cancer waiting times	• Breaches:
	  • the 31-day cancer waiting time target for a third successive quarter; or
	  • the 62-day cancer waiting time target for a third successive quarter.

Ambulance response times	• Breaches:
	  • either category A 8-minute response time targets (Red 1 and Red 2) for a third successive quarter; or
	  • the category A 19-minute response time target for a third successive quarter.

Community services data completeness	• Fails to maintain the threshold for data completeness for:
	  • referral to treatment information for a third successive quarter;
	  • service referral information for a third successive quarter; or
	  • treatment activity information for a third successive quarter.

Any other indicator	• Breaches the indicator for three successive quarters.

2.7 Compliance with quality governance requirements

These have been considered by the Director of Nursing and Governance (this includes CQC compliance, third party reviews, Quality Governance Framework and infection control targets) Detail is in Chapters 2 & 4). Her comments are:

- It is quite difficult to give a certain opinion on CQC at a time when the inspection regime is changing. Based on experience with CQC on their current regulatory regime it is unlikely to pose a material risk but I am not as confident until we understand more about the new CQC regime.

- Examples of exception reporting under governance are similar to those in place now.

The board should note the Trust's current scores as presented in a separate paper on the Quality Governance Framework as these will give a level of assurance with regard to overall risk.

3 Conclusion

The requirements of the RAF are demanding and in the first year these demands are applicable to FTs only. The trust has historically maintained an open relationship with Monitor and made appropriate use of exception reporting. Given that some of the factors used by monitor to assess governance ratings include staff and executive turnover, agency usage and third party information, ROH should continue to maintain careful control over these issues and continue close dialogue with Monitor when instances that might otherwise cause concern arise. ROH is well-placed to meet these requirements but should pay particular attention to the Quality Governance Framework and to the major three yearly governance review of Board effectiveness. These are area areas where more recently authorised FTs will have the advantage as they have formed a major element of the FT approval process. ROH is applying these standards retrospectively rather than designing them in. The separate work undertaken on the quality governance framework does, however, provide assurance as to the trust's position.

The trust executive can give assurance that the conditions of the new Risk Assessment Framework have been fully considered and that the trust is ready to comply when they come into force on October 1st 2013.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 25TH September 2013 **ENCLOSURE NUMBER: 7**

REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Lindsey Webb** **Director of Nursing and Governance**
SUBJECT:	**Quality Governance Framework (QGF)**

BACKGROUND

At the Board workshop in August 2013 to undertake the self-assessment against Monitor's QGF Board members:

- Received a presentation from colleagues at Monitor on the QGF
- Reviewed the QGF and previous self-assessments
- Discussed and identified assurances and areas for further work
- Requested the executive team undertake a more detailed piece of work that would enable all Board members to have a better understanding of the assurances and areas for further work during 2013/14

This piece of work has now been completed, the output of which is provided in this paper.

RISKS

The Board has to confirm in each quarterly declaration to Monitor that it has completed a self-assessment against the QGF and has met the required standard for aspirant FTs i.e. a score of not greater than 3.5.

RECOMMENDATIONS

The Board are asked to:

- **Approve** the self-assessment score against the QGF
- **Note** the associated action plan
- **Agree** to continue the quarterly review process by IGC for presentation to the Board to inform each declaration

QUALITY GOVERNANCE FRAMEWORK SEPTEMBER 2013

SUMMARY

		Q2	Q3	Q4
1. Strategy	1aDoes quality drive the trusts strategy	Green = 0		
	1b Is the Board sufficiently aware of the potential risks to quality	Green = 0		
2. Capabilities and culture	2a Does the Board have the necessary leadership , skills, knowledge to ensure the delivery of the quality agenda	Green = 0		
	2b. Does the Board promote a quality focused culture throughout the trust	Green = 0		
3. Processes and structures	3a Are there clear roles and accountabilities in relation to quality governance	Amber = 0.5		
	3b. Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance	Amber = 0.5		
	3c. Does the Board actively engage patients and staff and other key stakeholders in quality	Amber = 0.5		
4. Measurement	4a Is appropriate quality information being analysed and challenged	Amber = 0.5		
	4b Is the Board assured the of the robustness of the quality information	Red = 1.0		
	4c Is quality information used effectively	Amber = 0.5		
Total score		3.5*		

*Score of 3.5 or less required for Monitor authorisation

SELF ASSESSMENT AND ACTION PLAN

		Examples of assurance	Gaps	Actions required	Lead	Date	Update	Current score
1 Strategy	1aDoes quality drive the trusts strategy	Quality Account Corporate performance report CQUINs Contract targets Monitor annual plan Quality metrics key priority in performance meetings Engagement of stakeholders in development of Quality Account	Annual business plan Directorate objectives coming from annual business plan Identifying and developing future medical leaders Improve engagement of staff, patients and stakeholders in the quality agenda	Complete annual business plan for current year Complete annual business plan for 14/15 Establish directorate objectives for 14/15 Communicate the annual business plan across the organisation Develop medical leadership programme Ensure that the quality agenda is part of engagement strategies with all parties	LW GB GB GB AG/AP GB	August 2013 December 2013 March 2014 September 2013 March 2014 October 2013	Complete	G
	1b Is the Board	BAF/CRR	Board approval of 13/14 BAF	Board approval of BAF	LW	August 2013	Complete	G

	sufficiently aware of the potential risks to quality	IGC/Audit Committee review of BAF/CRR Initial and ongoing quality impact assessments of CIPs Whistleblowing policy Evidence that staff concerns are investigated and addressed (HDU)	Systematic post implementation evaluation of projects Regular benchmarking of nurse/Dr staffing levels Use of internal audit function to provide overview of quality governance Ensure terms of reference for Board and sub-committees are fit for purpose with regard to quality governance Link between clinical audit programme and internal audit programme ensuring both	All PMO/CIP projects to have formal post implementation review Complete nursing skill mix review and repeat annually Complete benchmarking of Dr staffing levels Include quality governance in internal audit programme Review Terms of reference for Board and its sub committees Review clinical audit/internal audit programme against annual business plan to ensure links to quality agenda.	PA LW AP LW JS LW/PA	September 2013 December 2013 March 2013 October 2013 September 2013 October 2013		

			are aligned to quality agenda					
2. Capabilities and culture	2a Does the Board have the necessary leadership , skills, knowledge to ensure the delivery of the quality agenda	Board undertakes annual review of NED and ED performance through appraisals. Quality is covered within this. Chair of IGC and fellow committee members are key to providing assurance through their quarterly declarations. Skills gaps identified when vacancies arise.	Agreement of regular 3 yearly whole board review criteria	Chairman to consider board review	BJ/JS	Feb 2014		G
	2 b Does the Board promote a quality focused culture throughout the trust	Board agenda Board comms via CEO briefing; Directorate presentations on quality. Key focus on clinical audit and outcomes through COEC up		Improve score on staff survey with regards to responsiveness to incidents in particular. Use the action plan associated with this to track against milestones.	AG/LW	Ongoing and as per action plan for staff survey.		G

		to board via IGC. Walkabouts and team buddying						
3. Processes and structures	3a Are there clear roles and accountabilities in relation to quality governance	Directorate Structure through which Service Line Management is delivered. TBALD implemented with a standardised agenda for Directorate meetings including SIRI feedback as well as HR, finance. Quality and service performance Lead clinician identified for each directorate with responsibility for Quality and Safety and PMO projects	Lack of evidence to illustrate feedback and learning both within and cross directorates. Devolvement of responsibility to Directorates requires progression. Data provided to Directorates to assist decision making is not to the standard of SLR. Teams are small and it is not possible to service all directorates on TBALD. Not all directorates are	Review use of clinical audit, including attendance, output and feedback Review Directorate Structure and related governance arrangements both inter, across and external to Directorates Executive team to agree further devolvement of responsibilities. IST will continue to work with IT and Information team to develop dashboards with real time data which is consultant specific CDs or lead clinician to be identified as Director lead on PMO projects Directorate structure and corporate support to this is being re-examined. Review meeting purpose (TOR), membership and	AP AM GB AM AP ALL ALL	Jan 2013 March 2014 March 2014 Dec 2013 Dec 2013 March 2014 Nov 2013		AG = 0.5

		Designated directorate lead for all corporate departments (HR, governance, finance and patient services) Quality Committee, OMG, EMT, Health and Safety Committees all in place with Directorate membership	regularly represented at all committees therefore feedback may be limited	attendance to reflect SLM model. Provide meetings with key objectives that reflect service delivery needs	ALL	Nov 2013		
	3b Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance	Directorate Structure through which Service Line Management is delivered is in place Directorate meetings take place alternate months on TBALD with MDT attendance. Directorate Performance meetings chaired by Director of	There is a lack of Drs who aspire to be medical leaders Data provided to Directorates to assist decision making is not to the standard of SLR	Develop medical leadership program Continue to improve directorate reports	AG/AP PA	March 2014 March 2014		AG = 0.5

		Ops occur at least quarterly with some directorates having monthly reviews. Activity Review Group meets weekly to review and action RTT and other performance issues Corporate Performance Report is provided monthly and discussed at EMT and Trust Board Directorate Dashboards are provided monthly and discussed at directorate meetings and performance meetings Monitor, DoH RTT, SCG and CCG						

		targets are monitored monthly and have all been achieved in Q1 PMO projects including pre-op process/ pathway is in place with MDT and cross-directorate involvement Modernising Admin Process meetings have occurred and identified new work streams SOPs to support waiting list management have been developed Top 30 staff with long term sickness issues is examined by DOps and DHR and directorate						

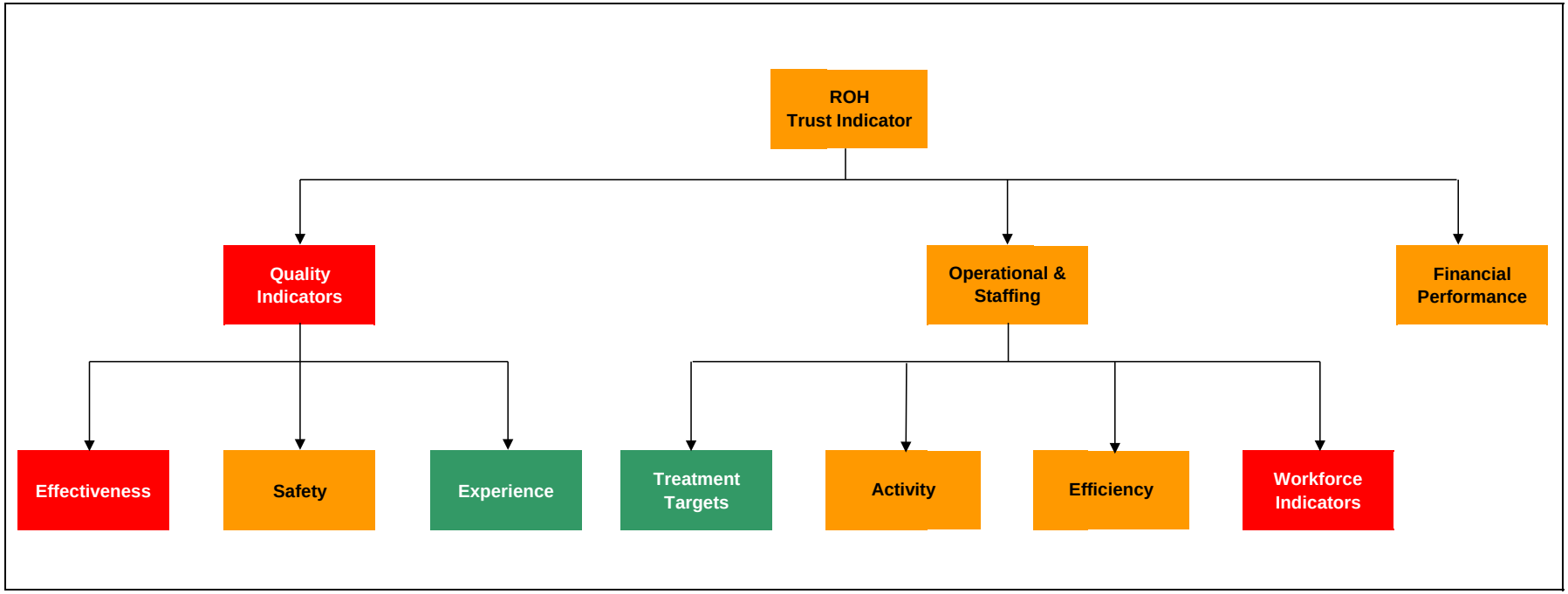
		teams quarterly HR Confirm and Challenge with DOps and DHR and Directorate teams in place monthly						
	3c. Does the Board actively engage patients and staff and other key stakeholders in quality	Board, Exec and Non Exec Director links are established Involvement of Governors on large capital projects Reports to Board from MSC and Ward Managers to improve "ward to Board" communication. CEO drop in sessions Q and A at TBALD Weekly newsletter	Lack of wider engagement/involvement strategy for hard to reach groups	Patient involvement in Francis T&F groups Patient involvement/engagement workstream from Francis	ALL JS/LW	Sept 2013 Nov 2013		AG = 0.5

		Real time patient survey Friends and family survey Use of MSB to test "temperature" of organisation Cascade arrangements throughout directorates are in place CCG and governors involved in Quality Account						
4. Measurement	4a Is appropriate quality information being analysed and challenged	CPR – highlights national and local priorities & links to Monitor Risk ratings. Appropriateness of information reviewed and updated at least annually Quality Accounts	Outcomes data, particularly linking quality information with clinical audit Drilling down of information to Directorate & Consultant level is variable	Review of current outcomes data to ensure reporting of current data is appropriate and sufficient Support IT infrastructure project, ensuring that new IT portal includes access to outcomes data and facilitates links to other quality information	AP GB	October 13 November 13		A/G = 0.5

		Internal & External Audit Reviews	Linking information and reporting to patient expectations	Development of data warehouse and portal to give real-time information allowing full drill-down facility Purchase and development of Fabio system to increase patient feedback information Use of patient feedback to drive corporate quality targets	GB JS JS	April 14 April 2014 Dec 2013		
	4b Is the Board assured the of the robustness of the quality information	Internal Audits including data quality, coding, dashboards etc. External Audit review of Quality Account Challenge via Audit Committee and IGC Good practice in SIRI process – triangulation of information with complaints, RCA	Regular self-audits (i.e. Medical Records audit, fully functioning data quality audit process for by trust managers) Real-time feedback from front line clinicians (lots of information from processes, not from people Heavy reliance	Development of board links to directorates to allow regular front-line feedback from staff, allowing board members to link quality information with staff and patient feedback Updated data quality audit work-plan for self-audit, including re-audit where appropriate Development of Data warehouse and TIE functionality to enable automatic reporting of quality information, reducing	ALL GB GB	October 13 October 13	Complete	A/R = 1.0

		with actions that are re-checked	on manual collection methods – High risk of human error Re-audit processes to ensure improvements have been embedded	the need for manual intervention				
	4c Is quality information used effectively	Information in CPR meets good practice guidelines: - RAG rated - Trend analysis - Timely information Robust challenge as evidenced in Board minutes	Benchmarking data not used regularly, limiting ability to interpret Trust data Information is not available in real time, meaning it can't be used effectively as an operational tool	Identify opportunities for benchmarking against national standards / best practice Development suite of benchmarking metrics & review appropriate reporting mechanisms Development of Data warehouse and TIE functionality to enable automatic reporting of quality information, providing real time information	ALL PA GB	October 13 November 13 March 2014		A/G

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending August 2013



Quarterly Detailed Report
Executive Summary as at August 2013

Headlines

- An overall red for quality has been identified as a result of an unexpected death, an avoidable grade 3 pressure ulcer and the non-achievement of the VTE target.
- The Trust's surplus for the first 5 months of the year stands at £729,000 against a planned target of £1,087,000. Despite this underperformance, the Trust has still has a forecast Financial Risk Rating of 4.
- Provisional Cancer Indicators for the month are 100% however early figures for September suggest the Trust is highly likely to miss the quarter 2 target for 62 day patients.

Monitor Compliance Framework Targets	August 2013 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.8%	95.5%	0	6
Referral to treatment time - Admitted %	90%	90.3%	91.2%	0	6
Referral to treatment time - Incomplete Pathways %	92%	93.7%	93.9%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	100%*	87.5%	0	6
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%*	100%*	0	6
Cancer 31 day wait from diagnosis to first treatment	96%	100%*	100%*	0	6
Cancer 2 week (all cancers)	93%	100%*	100%*	0	6
Clostridium Difficile cases	2 (Full Year)	0	0	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating	None				

* The current month's cancer outturns are provisional position only. The cancer position for the quarter is based on provisional in-month and confirmed previous months data.

Indicative Monitor Governance Risk Rating	**Green**
Indicative Monitor Financial Risk Rating	**4**

Key Trust Targets		August 2013 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	4		3
	Complaints	<=12	7		4
	CQUINS	100%	90%	-	11
	Total Unexpected Hospital Deaths	0	1		5
Efficiency & Workforce	Total Backlog Patients	<400	444		6
	Incomplete 14 - 18 Week Waiters	<500	630		6
	Total Inpatient Activity vs Plan	100%	92.8%		7
	Unused Theatre Sessions	<44	102		8
	Sickness	4.1%	3.1%		9
Financial	Surplus	£1,087k	£729k		10
	CIP	£1,330k	£1125k		12
	Agency Expenditure	£91k	£144k		11
	Locum Doctor Expenditure	£46k	£67k		11

Trust Summary

The Trust is Amber rated for August, with key concerns relating to quality, workforce and finance.

An overall red for quality has been identified as a result of an unexpected death, an avoidable grade 3 pressure ulcer and the non-achievement of the VTE target. Further investigation into the causes is underway and more detail is provided in the Safety Report.

Workforce continues to be rated as red due to concerns around training and appraisal levels but performance in both areas continue to improve. Attendance at the first two mandatory training courses in September exceeded 70 delegates and therefore further improvement is expected in September. The key areas with large numbers of staff still to be appraised are doctors, medical secretaries, Theatres, IT, R+T and Informatics. The majority of medical and theatre staff will be appraised by the end of September. Plans will be secured for R+T, IT and Informatics.

The gap between staff in post and establishment reduced in August by 12 wte meaning vacancies of c60wte or 7% of the funded establishment. A further reduction of 12 vacancies is expected in September.

For the month of August the Trust made a surplus of £127,000 against a planned surplus of £120,000. The Trust therefore has a year to date surplus of £729,000 against a plan of £1,087,000 which is £358,000 behind plan. It is forecast that the Trust has a Monitor Financial Risk Rating of 4 for the year to date.

Some cost pressures do exist particularly around agency pay, outsourced MRI and non-recurrent costs but much of the variance against plan is caused by the underperformance against inpatient activity and a shortfall on the Cost Improvement Programme. Significantly underperforming Directorates are providing rectification plans and a CIP Programme Board has been established to performance manage delivery.

All 18 week RTT targets were achieved for the sixth successive month. The number of 52 week waiters has again reduced to 6 from 7 at the end of July. The backlog of patients waiting over 18 weeks has increased slightly to 444 from 404, however this was as predicted given seasonal variation related to patient choice to "pause" treatment.

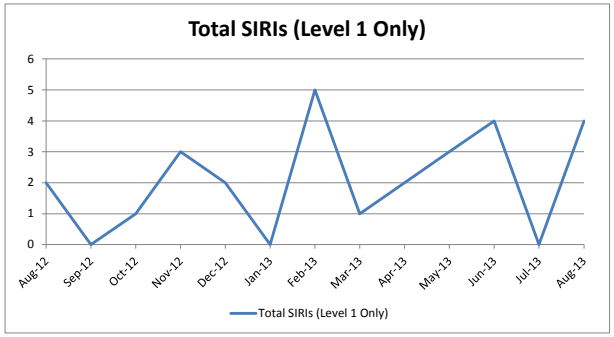
In July there was 1 patient who breached the 62 day cancer waiting time target due to a requirement for complex surgery with bone irradiation which gas reduced achievement to 87.5% for the quarter. Given the total number of patients on cancer pathways delivery of the Q2 target is at risk and as such an exception report has been submitted as the Trust may miss this target.

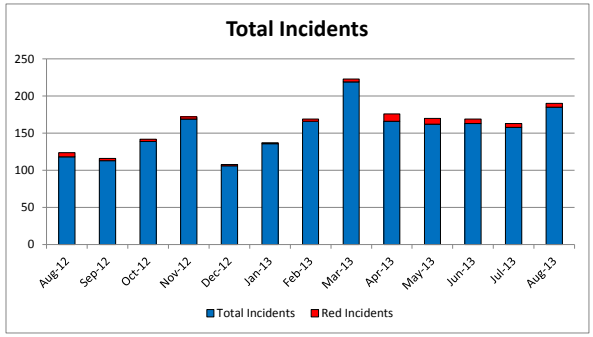
Monthly Report
Safety Indicators as at August 2013

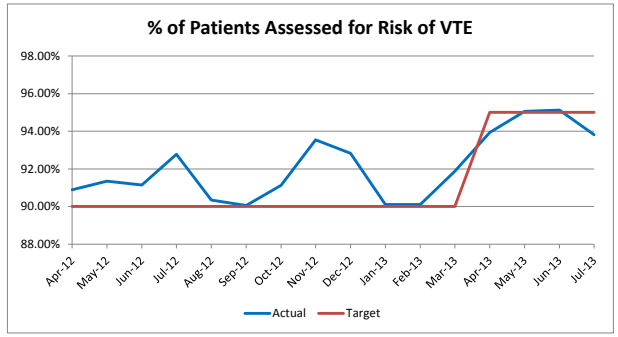
Headlines

- Drug errors increased in the month compared to June and July
- VTE Risk Assessment is reported one month in arrears and the target was not achieved in July
- Following a reduction in the number of reportable inpatient adult falls in June and July this has increased in August

	Monitor	National	CQC Standard		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	13/14 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	2	0	1	3	2	0	5	1	2	3	4	0	4	13
			4,16	SIRI per 1000 bed days	0.63	1.03	0.33	0.98	0.84	0.00	1.36	0.34	0.62	1.12	1.32	0.00	1.27	0.84
			4,16	Total Incidents	118	113	139	169	106	136	166	219	166	162	163	158	185	834
			4,16	Incidents per 1000 bed days	37.24	38.66	45.26	55.08	44.41	46.31	56.23	74.19	51.83	60.23	53.95	47.07	58.96	54.13
			4,16	Red Incidents	6	3	3	3	2	1	3	4	10	8	6	5	5	34
			9,16	Total Drug Errors	11	6	9	26	15	17	19	66	31	21	15	15	23	105
			9,16	Drug Errors per 1000 bed days	3.47	2.05	2.93	8.47	6.28	5.79	6.44	22.36	9.68	7.81	4.96	4.47	7.33	6.81
		N	1	Mixed Sex Occurrences	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			9	% Patients Assessed for Risk of VTE	90.34%	90.06%	91.12%	93.55%	92.83%	90.10%	90.11%	91.88%	93.94%	95.06%	95.13%	93.82%		94.50%
			9	Incidence of Hospital Related VTE	0	0	3	1	0	0	1	1	0	0	1	1	0	2
			4	Patient Falls - Inpatients	10	8	8	5	8	0	6	7	4	7	6	4	9	30
			4	Patient Falls per 1000 bed days	3.16	2.74	2.61	1.63	3.35	0.00	2.03	2.37	1.25	2.60	1.99	1.19	2.87	1.95
			4,16	% Harm Free Care	98.02%	98.82%	97.96%	98.85%	92.86%	97.22%	93.26%	93.26%	97.89%	96.19%	97.94%	98.90%	97.85%	97.71%







Safety Commentary

VTE Risk Assessment is reported one month in arrears and the target was not achieved in July. The 95% target is included as a CQUIN target for the trust, and so failure against this target in July will result in £16,000 of lost CQUIN income in Quarter 2.

There were 4 SIRI's in month, further detail of which are included in the patient safety report.

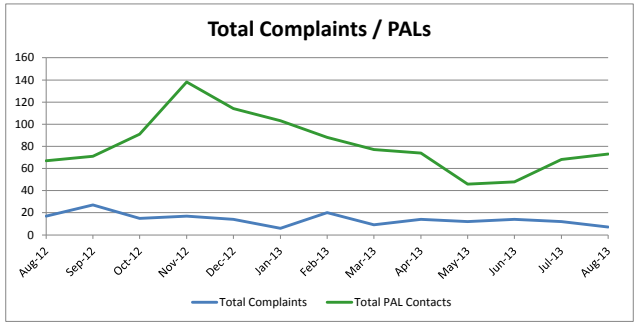
Drug errors increased in the month compared to June and July, as did the number of reportable inpatient adult falls.

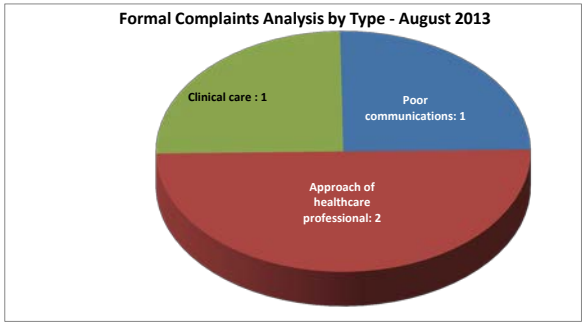
Monthly Report
Experience Indicators as at August 2013

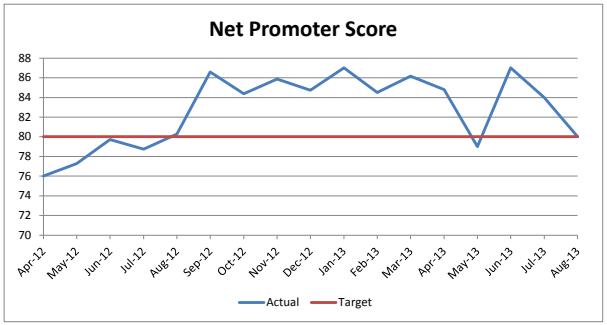
Headlines

- There has been an decrease in the volume of complaints received this month from 12 to 7 (4 formal)
- August performance for real time patient survey of food was 92.4% positive

	Monitor	National	CQC Standard		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	13/14 Full Year Position
Experience			17	Complaints to Complements Ratio	1:17	1:9	1:28	1:13	1:33	1:63	1:20	1:46	1:25	1:25	1:29	1:32	1:46	**1:30**
			17	Total Complaints	17	27	15	17	14	6	20	9	14	12	14	12	7	**59**
			17	Complaints reverted to informal <48 hrs	1	10	7	3	0	0	1	0	1	0	1	1	3	**6**
			17	Formal	16	17	8	14	14	6	19	9	13	12	13	11	4	**53**
			17	Complaints per 1000 bed days	5.36	9.24	4.88	5.54	5.87	2.04	6.78	3.05	4.37	4.46	4.63	3.57	2.23	**3.83**
			17	Total PAL Contacts	67	71	91	138	114	103	88	77	74	46	48	68	73	**309**
			17	PALS Contacts per 1000 bed days	21.14	24.29	29.63	44.98	47.76	35.07	29.81	26.08	23.11	17.10	15.89	20.26	23.27	**20.06**
			17	Total Compliments	293	239	419	223	456	380	404	414	347	295	404	386	320	**1752**
			17	Compliments per 1000 bed days	92.46	81.77	136.44	72.69	191.03	129.38	136.86	140.24	108.35	109.69	133.72	114.99	101.99	**113.71**
				Food - Real Time Patient Survey	59.23%	62.37%	63.36%	72.19%	66.07%	75.00%	69.75%	77.54%	77.50%	85.43%	86.67%	90.48%	92.40%	**85.02%**
			17	Friends and Family Net Promoter Score	80.27%	86.58%	84.37%	85.86%	84.73%	87.00%	84.50%	86.18%	84.8	79.0	87.0	84.0	80.0	**83.7**







Experience Commentary

COMPLAINTS

There has been an decrease in the volume of complaints received this month from 12 to 7 (4 formal) representing a drop of 42%. This is in line with the usual pattern of a quieter month in the summer quarter.

The number of complaints responded to in agreed timescale in August is 11/12 or 92% which is above agreed KPI of 80%. The one complaint that was overdue was as a result of delay to signoff by Executive Director.

COMPLIMENTS

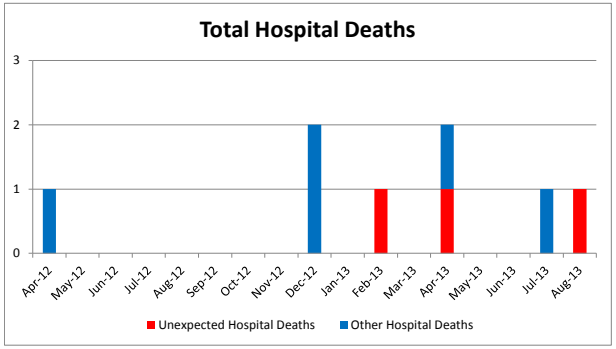
Number of Compliments by Directorate:
Directorate
Compliments August 2013
Clinical Support - 14
Small Joint - 8
Large Joint - 140
Oncology - 35
Paediatrics - 73
Spinal - 5
Theatres - 33
Corporate - 12
Total - **320** (17% down on last month's total of 386)

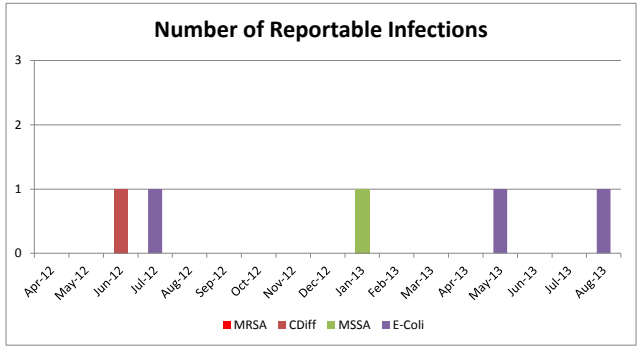
Monthly Report
Effectiveness Indicators as at August 2013

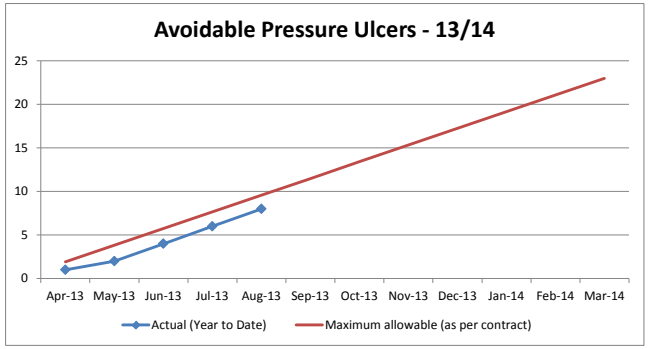
Headlines

- There was one unexpected death in the month of a female patient following a primary knee replacement.
- Two avoidable pressure ulcers occurred on Ward 1 which is a matter of concern
- A case of E-coli was identified

	Monitor	National	CQC Standard		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	13/14 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	0	0	0	2	0	1	0	2	0	0	1	1	4
			4,18	Hospital Deaths per 1000 bed days	0.00	0.00	0.00	0.00	0.84	0.00	0.34	0.00	0.62	0.00	0.00	0.30	0.32	0.26
			4,18	Unexpected Hospital Deaths	0	0	0	0	0	0	1	0	1	0	0	0	1	2
			8	MRSA % Screened	143.8%	150.0%	161.2%	165.3%	149.7%	138.7%	135.5%	114.3%	129.56%	129.13%	140.59%	145.53%	127.51%	134.55%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	M	N	8	Total ROH CDIF	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH MSSA	0	0	0	0	0	1	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	0	0	0	0	0	0	0	1	0	0	1	2
			8	HCAIs not attributable to ROH	1	0	1	1	2	0	1	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	0	0	0	0	0	0	0	1	1
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	4	3	7	3	3	5	5	5	1	1	2	2	1	7
			4	Avoidable Pressure Ulcers per 1000 bed days	1.26	1.03	2.28	0.98	1.26	1.70	1.69	1.60	0.31	0.37	0.66	0.60	0.64	0.52







Effectiveness Commentary

There was one unexpected death in the month of a female patient following a primary knee replacement. This patient was also discovered to be infected with e-coli bacteraemia. More detail is provided in the patient safety report.

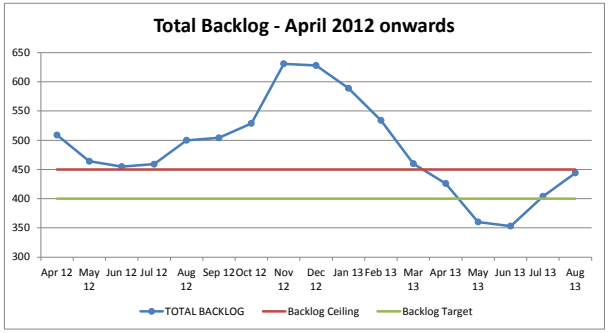
Two avoidable pressure ulcers occurred on Ward 1 which is a matter of concern. The overall trajectory remains below contract levels for avoidable pressure ulcers, however the presence of an avoidable Grade 3 pressure ulcer does mean the Trust has breached one of it's CQUIN targets, which is likely to result in a loss of £60,000 of CQUIN income.

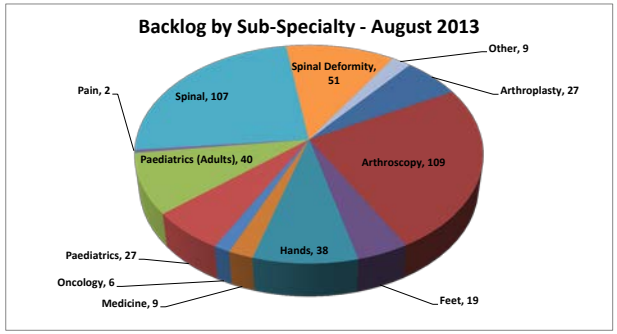
Quarterly Detailed Report
Treatment Targets as at August 2013

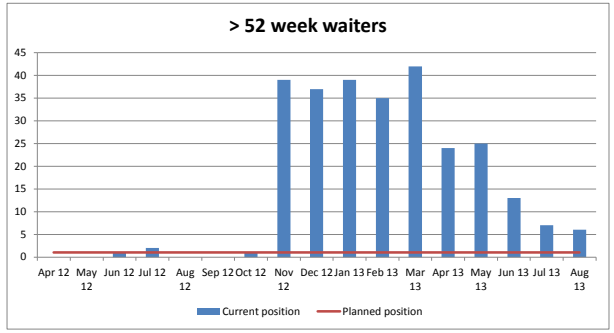
Headlines

- The Trust has achieved all 3 18 week targets for the 6 month running
- 18 week backlog patients have increased for the second month and are now approaching the backlog ceiling above which the 18 week targets are put a risk
- Provisional Cancer Indicators for the month are 100% however an exception report submitted as the Trust is likely to miss quarter 2 target for 62 day patients.

	Monitor	National	CQC Standard		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	13/14 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	0	0	1	39	37	39	35	42	24	25	13	7	6	6
	M	N	4	Referral to treatment time - Non Admitted %	95.38%	96.22%	95.06%	95.28%	95.09%	95.03%	95.07%	95.18%	95.24%	95.08%	95.35%	95.29%	95.78%	95.35%
	M	N	4	Referral to treatment time - Admitted %	91.14%	90.49%	90.07%	90.38%	90.59%	90.42%	90.37%	90.00%	90.22%	90.38%	91.37%	92.05%	90.33%	90.92%
	M	N	4	Referral to treatment time - Incomplete Pathways %	92.66%	92.46%	92.02%	90.56%	90.52%	90.68%	91.09%	92.01%	92.77%	94.36%	94.77%	94.18%	93.71%	93.99%
			4	Non admitted Backlog - Pathways waiting >18 wks	169	198	118	208	438	221	199	187	155	121	110	131	159	159
			4	Admitted Backlog - Pathways waiting >18 wks	331	306	411	423	457	368	335	273	271	239	243	273	285	285
			4	Total Backlog - 18 week pathways waiting >18 wks	500	504	529	631	895	589	534	460	426	360	353	404	444	444
			4	Incomplete 14 -18 Week Waiters	646	561	740	698	717	610	629	535	346	411	504	477	630	630
	M	N	4	Cancer 2 week (all cancers)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100%*
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.33%	100.00%	100.00%	100.00%	100%*	98.33%*
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%*
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.00%	100.00%	66.67%	80.00%	100%*	87.50%*
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	100.00%	100.00%	100.00%	100.00%	100.00%	99.98%	100.00%	100.00%	99.24%	100.00%	99.52%	99.20%	99.09%	99.53%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			1,21	Data Quality on Ethnic Group - Inpatients	95.46%	95.32%	95.11%	100.00%	95.12%	95.20%	95.11%	91.99%	95.07%	95.04%	95.35%	95.08%	95.06%	95.12%







Treatment Targets Commentary

The Trust has achieved all 3 18 week targets for the 6 month running

18 week backlog patients have increased for the second month and are now approaching the original backlog ceiling above which the 18 week targets are put a risk however, the increase in backlog was predicted due to seasonal variation related to patient choice to "pause" their treatment. In addition, although the number of patients in the backlog has increased, the % achieved at 93.71% is 1.71% above the 92% target which demonstrates that as an organisation we are over achieving against the target and that the number of patients on the waiting list has increased which therefore increases the number in backlog.

The number of patients waiting more than 52 weeks has reduced by 1 to 6

Provisional Cancer Indicators for the month are 100% however an exception report submitted as the Trust is likely to not achieve the quarter 2 target for 62 day patients due to late referrals in September and low numbers of referrals in Quarter 2 .

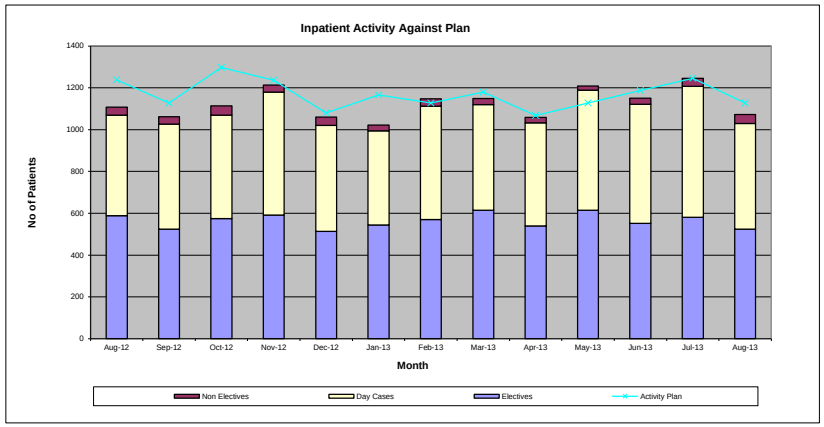
Note: The current month's cancer outturns are provisional position only. The YTD Cancer position is based on provisional in-month and confirmed previous months data.

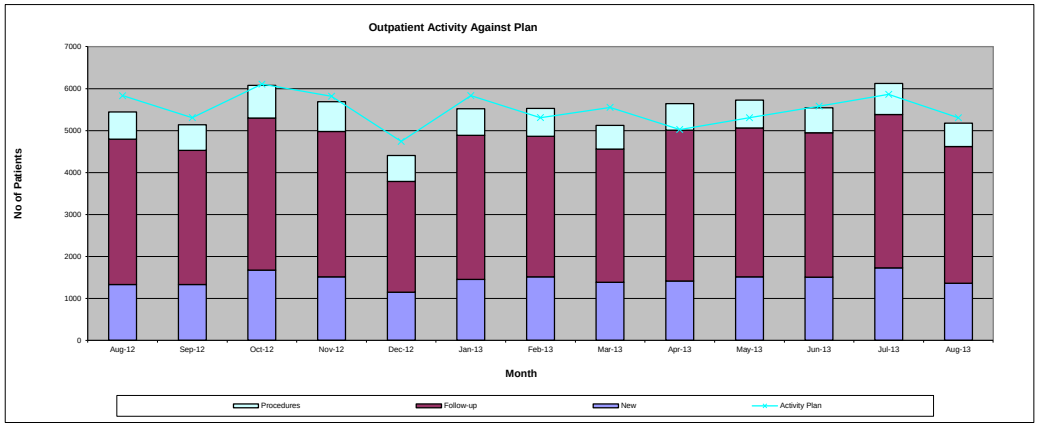
Quarterly Detailed Report
Activity Targets as at August 2013

Headlines

- Elective inpatients underperformed by 50 cases or 10% in August
- Non electives have increased again in August and are above plan in the month
- Day cases underperformed in the month for the first time this financial year by 2%.

	Monitor	National	CQC Standard		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	13/14 Full Year Position
Activity			4	Total Discharged Elective Patients	589	524	575	592	513	544	570	614	540	615	551	580	524	2810
			4	Total Discharged Non Elective Patients	38	34	44	34	39	27	35	29	25	20	30	38	43	156
			4	Total Discharged Day Cases	481	503	494	588	508	451	542	506	493	574	570	627	506	2770
			4	Total New Outpatients	1332	1330	1674	1517	1146	1455	1510	1381	1416	1513	1508	1728	1359	7524
			4	Total Follow Up Outpatients	3462	3196	3628	3458	2641	3435	3356	3179	3590	3548	3438	3653	3259	17488
			4	Outpatient Procedures	650	609	774	716	622	631	662	562	635	662	594	743	560	3194
			4	Elective as % Against Plan	94.6%	92.4%	88.1%	95.2%	94.4%	92.8%	100.5%	108.3%	99.24%	107.1%	91.1%	91.4%	91.2%	95.83%
			4	Non Elective as % Against Plan	90.4%	88.8%	99.9%	81.0%	106.3%	68.2%	91.4%	75.8%	72.4%	54.8%	78.1%	94.3%	117.9%	83.79%
			4	Day Cases as % Against Plan	83.9%	96.3%	82.2%	102.7%	101.5%	83.5%	103.8%	96.9%	100.7%	111.1%	104.8%	109.8%	97.9%	105.01%
			4	% New Outpatients Against Plan	89.2%	97.8%	107.0%	101.7%	94.3%	97.3%	111.0%	101.5%	111.1%	112.5%	106.5%	116.2%	101.0%	109.57%
			4	% Follow Up Outpatients Against Plan	97.0%	98.3%	97.0%	97.1%	91.0%	96.2%	103.3%	97.8%	113.6%	106.3%	97.9%	99.0%	97.7%	102.65%
			4	% Outpatient Procedures Against Plan	84.8%	87.3%	96.4%	93.6%	99.8%	82.3%	94.9%	80.6%	107.6%	106.3%	90.6%	108.0%	89.9%	100.48%





Activity Commentary

Elective inpatients underperformed by 50 cases or 10% in August. Based upon an average price this equates circa £250,000.

Non electives have increased again in August and are above plan in the month for the first time since December 2012.

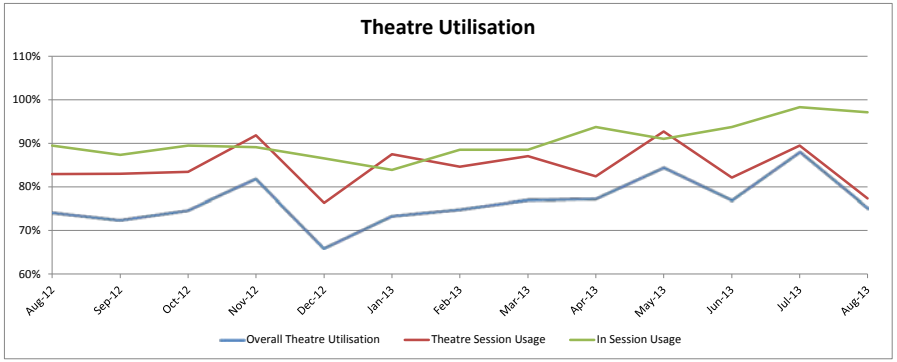
Day cases underperformed in the month for the first time this financial year by 2%.

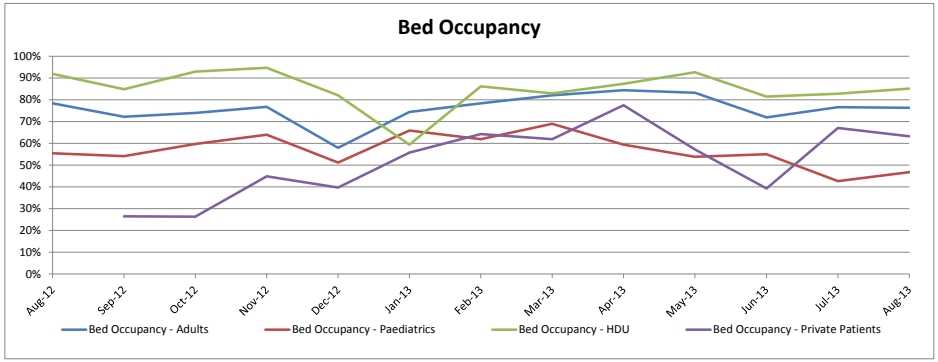
Monthly Report
Efficiency Indicators as at August 2013

Headlines

- Theatre utilisation and usage reduced in month to 75% and there were 102 unused theatre sessions.
- Overall bed occupancy remains low which is consistent with inpatient activity levels.
- The number of cancelled operations on the day has increased to 14

	Monitor	National	CQC Standard		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	13/14 Full Year Position
Efficiency			4	Overall Theatre Utilisation	74.2%	72.5%	74.7%	81.8%	66.0%	73.4%	74.9%	77.0%	77.30%	84.41%	76.95%	87.98%	75.15%	80.80%
			4	Theatre Session Usage	82.97%	83.01%	83.47%	91.85%	76.30%	87.50%	84.60%	87.07%	82.45%	92.72%	82.09%	89.50%	77.38%	84.86%
			4	In Session Usage	89.5%	87.3%	89.5%	89.1%	86.5%	83.9%	88.5%	88.5%	93.76%	91.04%	93.73%	98.31%	97.11%	95.21%
			4	Unused Theatre Sessions	78	70	79	37	92	57	63	53	76	30	77	50	102	233
			4	Number of Cases per Theatre Session	2.78	2.82	2.60	2.79	3.45	2.46	3.13	3.11	2.82	3.01	3.08	2.79	2.91	2.92
			4	Total Cancelled Operations (On Day or Day Before)	71	90	95	91	95	108	78	52	91	72	63	88	58	314
			4	Total Cancelled Operations (On Day or Day Before) - Avoidable														
			4	Total Cancelled Operations (On Day or Day Before) - Unavoidable														
			4	Total Cancelled Operations by Hospital (On Day)	5	7	7	6	6	5	4	2	4	5	5	8	14	36
			4	% Cancelled Operations by Hospital	0.47%	0.72%	0.68%	0.52%	0.59%	0.51%	0.37%	0.18%	0.40%	0.43%	0.46%	0.67%	1.38%	0.66%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.87	2.66	2.37	2.49	2.51	2.63	2.30	2.59	2.76	2.44	2.53	2.24	2.53	2.48
			4	Pain Review-To-New Ratio	3.44	2.89	3.26	3.99	3.83	3.65	3.70	2.99	3.53	4.65	2.90	4.02	4.24	3.69
			4	Outpatient DNAs	8.36%	8.78%	8.50%	8.91%	9.37%	10.51%	9.05%	10.52%	7.70%	8.79%	9.23%	8.70%	9.34%	8.63%
			4	Bed Occupancy - Adults	78.40%	72.19%	73.96%	76.67%	57.92%	74.44%	78.34%	81.96%	84.37%	83.16%	71.91%	76.53%	76.26%	78.41%
			4	Bed Occupancy - Paediatrics	55.38%	54.17%	59.68%	63.89%	51.18%	65.86%	61.90%	68.89%	59.44%	53.76%	55.00%	42.71%	46.77%	51.41%
			4	Bed Occupancy - HDU	91.93%	84.77%	92.86%	94.68%	81.99%	59.35%	86.06%	82.89%	87.36%	92.53%	81.44%	82.76%	85.15%	89.08%
			4	Bed Occupancy - Private Patients		26.46%	26.27%	44.90%	39.63%	55.64%	64.29%	61.91%	77.47%	57.14%	39.29%	66.96%	63.13%	61.30%
			4	Admissions on the Day of Surgery	394	365	383	429	357	384	400	457	380	433	403	417	364	1633
			4	AVLOS for APC (excl day cases)	5.04	4.36	5.03	4.01	4.36	3.87	4.71	4.30	4.71	5.63	4.16	4.58	5.06	4.75





Efficiency Commentary

HDU BED OCCUPANCY: Reflects occupancy up to 28/07/2013 (inclusive).

Theatre utilisation and usage reduced in month to 75% and there were 102 unused theatre sessions.

The number of cancelled operations on the day has increased to 14

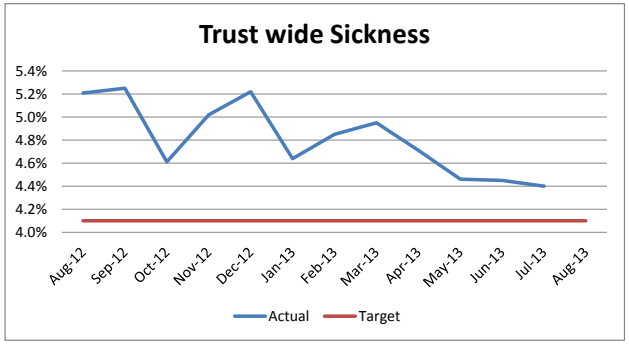
Overall bed occupancy remains low which is consistent with inpatient activity levels.

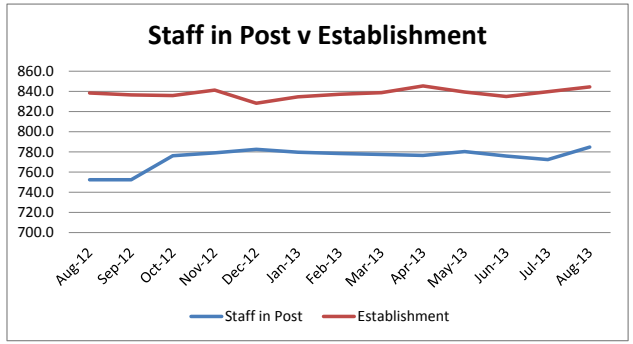
Monthly Report
Workforce Indicators as at August 13

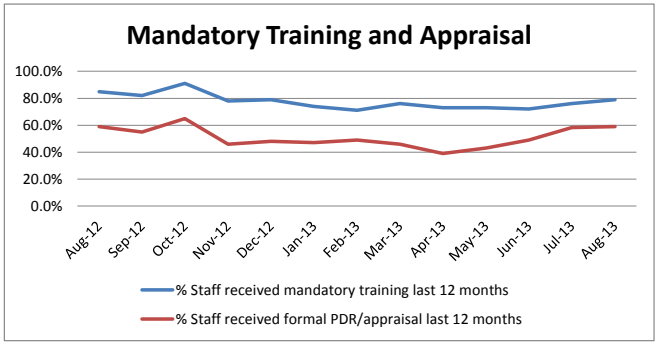
Headlines

- The number of staff employed has increased and the level of vacancies reduced
- Sickness has reduced significantly
- Mandatory Training and Appraisal rates have improved but do remain below target

	Monitor	National	CQC Standard		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	13/14 Full Year Position
Workforce			13	Total WTE Employed	752.4	752.3	776.2	779.0	782.6	779.6	778.6	777.5	776.5	780.5	775.8	772.5	784.9	
			13	Total WTE Employed as % of Establishment	89.7%	89.9%	92.9%	92.6%	94.5%	93.4%	93.0%	92.7%	91.8%	93.0%	92.9%	92.0%	92.9%	
			13	Staff Turnover (%)	10.0%	10.4%	10.3%	10.4%	10.4%	11.1%	12.6%	12.7%	11.6%	12.0%	12.6%	12.5%	12.5%	
			13	% of Sickness - Trust wide	5.2%	5.3%	4.6%	5.0%	5.2%	4.6%	4.9%	5.0%	4.7%	4.5%	4.5%	4.4%	3.1%	
			13	Agency % of Staff Cost	7.5%	5.4%	5.4%	4.2%	4.2%	5.6%	6.4%	8.7%	6.1%	8.0%	8.4%	6.1%	6.5%	
			13	Temporary staffing hours as a % of establishment														
			13	% Staff received mandatory training last 12 months	85%	82%	91%	78%	79%	74%	71%	76%	73%	73%	72%	76%	79%	
			13	% Staff received formal PDR/appraisal last 12 months	59%	55%	65%	46%	48%	47%	49%	46%	39%	43%	49%	58%	59%	
			13	% of required staff receiving safeguarding training									33%	30%	21%	49%		
			13	Qualified Nurse / Bed ratio														
			13	Staff Net Promoter score									3.84					
													36.570795	34.81075	34.52177	33.98956	24.33221	







Workforce Commentary

There has been a net growth of 12WTE in August and a further net growth of circa 12WTE is expected in September. Recruitment activity continues to be high to support this increase in the workforce

Mandatory training increased by 9% in August and attendance at the first two courses in September exceeded 70 delegates and therefore further improvement is expected in September

Appraisal levels have increased by 4% in August. The key areas with large numbers of staff still to be appraised are doctors, medical secretaries, Theatres, IT, R+T and Informatics. The majority of medical and theatre staff will be appraised by the end of September. Plans will be secured for R+T, IT and Informatics

The increase in agency spend is due to increased usage in ADCU associated with the opening and staff sickness levels and in Theatres.

Sickness has reduced in all areas of the Trust most notably in Theatres during August

Monthly Report
Financial Performance as at August 13

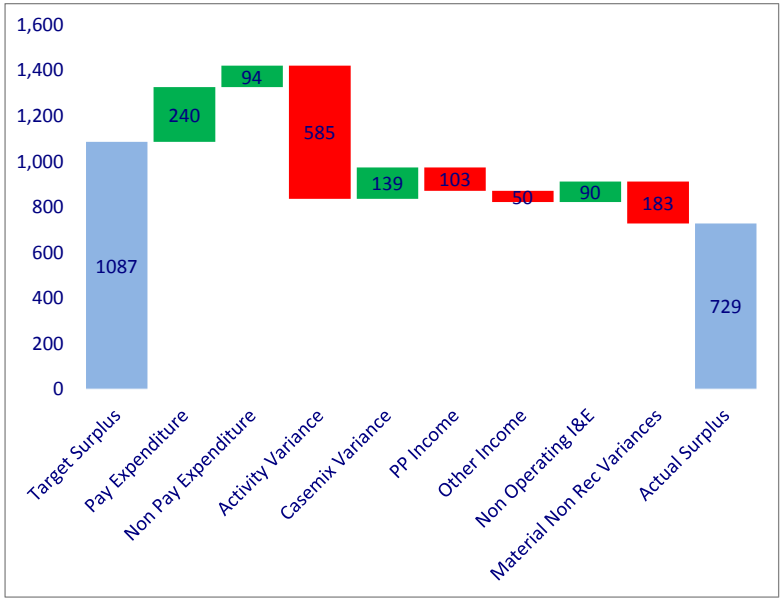
Headlines

- The Trust achieved a Month 5 financial surplus of £729,000 against a plan of £1,087,000 which is £358,000 behind trajectory.
- For the third month running we have seen an under recovery in healthcare income primarily due to elective inpatient underperformance.
- Achievement against the Trusts CIP target currently sits at £1,125,000, of which 92% is recurrent. This is £205,000 behind the August target of £1,038,000.

Trust Financial Metrics

	Year to Date		
	Actual	**Plan**	**Risk Rating**
EBITDA Margin	7.2%	8.4%	3
EBITDA Achieved (%)	83.4%	100.0%	3
Net Return after Financing	3.0%	4.5%	5
I&E Margin	2.4%	3.5%	4
Liquidity Risk (Days)	76.43	82.43	5
Overall Risk Rating			4

Trust Performance Bridge Graph - Actual v Monitor Plan



Executive Financial Summary

Overall Performance
For the month of August the Trust made a surplus of £127,000 against a planned surplus of £120,000. The Trust therefore has a year to date surplus of £729,000 against a plan of £1,087,000 which is £358,000 behind plan. This is a minor improvement of £7,000 from the end of month 4.

It is forecast that the Trust has a Monitor Financial Risk Rating of 4 for the year to date.

The normalised surplus for the Trust, having removed both material income and expenditure non-recurrent items stands at £912,000.

Income
We continue to under recover in healthcare income compared to plan. The primary driver for this is an underperformance in elective inpatient activity which in August was 50 cases or 10% behind plan for the month. This trend has been consistent for the past 3 months.

On the positive side were have seen an increase in the average price of elective inpatient episodes and have not been required to pay fines to commissioners for over 52 week waiters which has partly mitigated elective inpatient underperformance.

Pay
The paybill reduced by £72,000 from July to August but still remains above that expected given the levels of activity and is £50,000 or 2% higher than 12 month average. This continues to be driven by the on-going cost of agency staffing and the premium cost out of hours work which are both in line with the average for the past 12 months as opposed to the reduction that would be hoped for given reduced activity levels in August.

Compared to the Monitor plan we are spending less on pay than predicated. When the Monitor plan was set we were anticipating activity over performance to meet the £1.1m income CIP target. This and the associated costs are yet to materialise which shows as a negative activity variance and a positive pay variance on the Performance Bridge Graph. Slippage on Business Planning Developments is also contributing.

Non Pay
Non pay spend was low for the month (£120,000 less that the average for the first 4 months) driven by the reduced activity in August and underperformance in elective inpatient activity which tend to have high non pay costs (particularly in prosthesis). As with pay we are now showing a positive variance which is driven by the general underperformance plus not achieving planned activity growth.

CIP
Achievement against the Trusts CIP target currently sits at £1,198,000, of which 92% is recurrent. This is £132,000 behind the month 5 target of £1,330,000.

Balance Sheet & Cash Flow
The Trust finished the period with a Statement of Position broadly in line with plan. Cash balances remain healthily but is £2.9m behind plan which continues to be driven by delays in payments from newly established commissioning organisations (£1.3m) and lower than planned creditor accrual levels (£2.0m).

Monthly Report

Financial Efficiency Indicators as at August 13

Headlines

- The Trust's monthly paybill of £3.25m is £0.05m greater than the yearly average, driven by the cost of premium rate working and continued use of agency staff
- The agency usage has been reducing over the last four months which coincides with the increase in bank staff usage.
- Trusts surplus is behind target by £358,000.

		Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Cost of Staffing	Total Paybill	£3,168,000	£3,075,000	£3,138,000	£3,071,000	£3,069,000	£3,168,095	£3,247,000	£3,388,000	£3,216,996	£3,313,000	£3,259,000	£3,324,000	£3,252,000
	Substantive Pay	£2,729,000	£2,652,000	£2,737,000	£2,723,000	£2,713,000	£2,800,783	£2,813,000	£2,841,000	£2,809,592	£2,852,000	£2,822,000	£2,864,000	£2,806,000
	Bank Pay	£195,000	£251,000	£227,000	£214,000	£222,000	£183,483	£226,000	£246,000	£203,441	£187,000	£197,000	£252,000	£230,000
	Overtime Pay	£5,000	£6,000	£4,000	£4,000	£5,000	£5,665	£4,000	£5,000	£9,915	£4,000	£4,000	£4,000	£5,000
	Agency Pay (excluding Medical Locums)	£147,000	£137,000	£108,000	£66,000	£75,000	£140,543	£123,000	£234,000	£139,565	£241,000	£191,000	£150,000	£144,000
	Medical Locum Pay	£91,600	£29,000	£62,000	£64,000	£54,000	£37,621	£80,000	£62,000	£54,484	£28,000	£81,000	£54,000	£67,000
	ADH Payments - Surgical	£20,000	£30,000	£16,500	£20,000	£25,000	£28,000	£45,000	£40,000	£26,000	£38,000	£20,000	£17,000	£26,000
	ADH Payments - Clinics	£16,000	£11,000	£15,000	£10,000	£7,000	£14,000	£20,000	£17,000	£11,000	£14,000	£7,000	£17,000	£9,000
	ADH Payments - Anaesthetics	£33,000	£21,000	£22,000	£25,000	£27,000	£35,000	£48,000	£84,000	£46,000	£47,000	£48,000	£63,000	£46,000
	ADH Payments - Spot Work & Strategy	£1,000	£1,000	£2,000	£1,000	£1,000	£1,000	£1,000	£0	£0	£0	£0	£0	£0
Income & Efficiency	Trust Surplus	£957,000	£1,716,000	£2,057,000	£2,485,000	£2,350,000	£2,033,000	£2,074,000	£2,203,000	-£66,000	£250,000	£305,000	£602,000	£729,000
	Normalised Surplus	£957,000	£960,000	£1,301,000	£1,740,000	£1,605,000	£1,397,000	£1,409,000	£1,853,000	-£66,000	£250,000	£443,000	£891,000	£912,000
	Total Income	£5,599,000	£5,540,000	£6,110,000	£6,032,000	£5,815,000	£5,395,000	£5,727,000	£6,409,000	£5,910,000	£6,135,000	£5,914,000	£6,575,000	
	CIP	£3,181,000	£3,244,000	£3,309,000	£3,531,000	£3,579,326	£3,630,122	£3,679,000	£3,820,000	-	£339,000	£561,000	£869,000	£1,125,000

Summary

The Trust's monthly paybill decreased by £72,000 between July and August, there has also been reduction in bank and agency usage

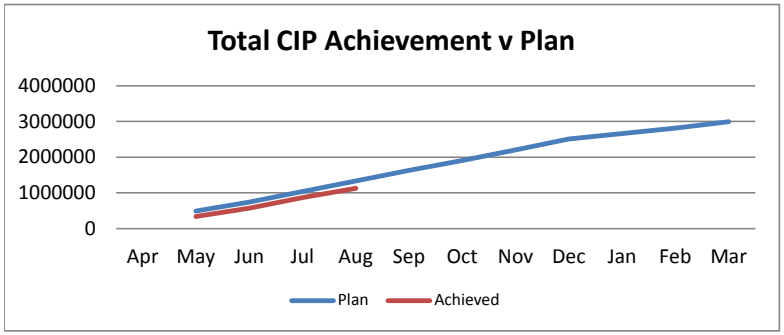
Monthly Report

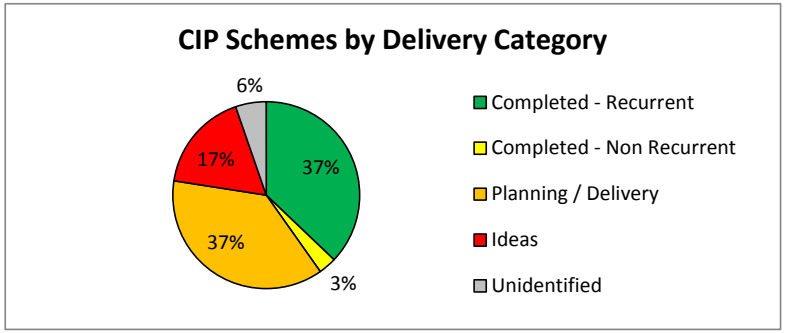
Cost Improvement Performance as at August 2013

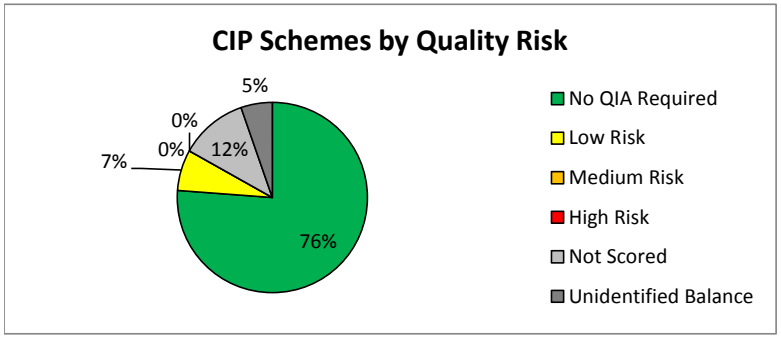
Headlines

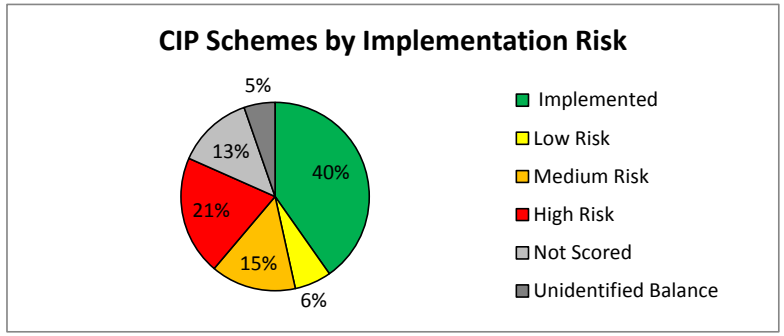
- Achievement currently sits at £1,198,000, of which 92% is recurrent. This is £132,000 behind the target after Month 5
- To date only 40% of the required CIP value is completed and implemented. 23% is not identified or ideas at this stage
- No medium of high risk quality issues have been raised or identified

Cost Improvement Programme		%age Achieved	Target £'000	C/F £'000	Revised £'000	Completed - Recurrent £'000	Completed - Non Recurrent £'000	Planning / Delivery £'000	Ideas £'000	Unidentified £'000
	Clinical Directorates	40%	1,119	(11)	1,108	400	47	158	303	198
	Corporate Areas	58%	774	0	774	406	45	152	211	(40)
	Income	27%	1,100	0	1,100	300	0	800	0	0
	Total	**40%**	**2,993**	**(11)**	**2,982**	**1,106**	**92**	**1,110**	**514**	**158**
							1,198			









The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board : 25th September 2013 **ENCLOSURE NUMBER: 9**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Lindsey Webb** **Director of Nursing and Governance**
SUBJECT:	**Patient Safety and Experience Report**

SUMMARY

This paper will update the Board on patient safety and experience issues during the month.

RISKS

Patient safety and experience must remain a high priority for the organisation and it is anticipated that this report will assist the Board in bringing together key patient safety and experience issues.

RECOMMENDATIONS

The Board is asked to:

- **discuss** the Patient Safety and Experience report
- **identify** areas of risk requiring further assurance
- **identify** any other patient safety and experience issues for inclusion in future reports

1. Serious Incidents requiring investigation (SIRI)

There were 4 SIRI's in month; an increase from 0 the previous month (see appendix 1)

2. Deaths

There was one unexpected death in the month of a female patient following a primary knee replacement. Cause of death was noted as 1a. Myocardial Infarction 1b. Ischaemic heart disease 2. Chronic renal failure. The patients past medical history includes angina, peripheral vascular disease, and angioplasty x2. The family have been fully informed under Duty of Candour of the subsequent investigation

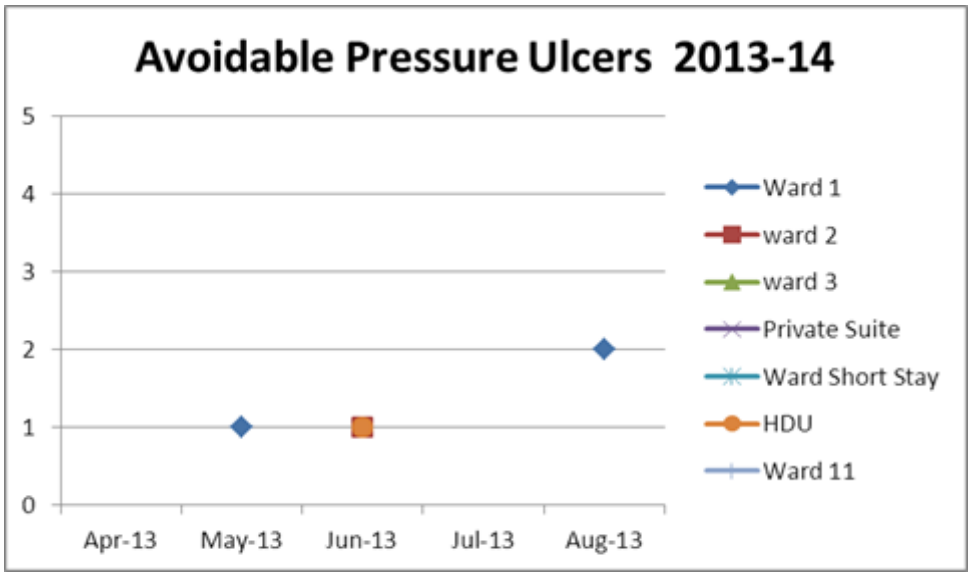
3. E-coli bacteraemia

The E-coli bacteraemia was identified in blood cultures from the patient that died. These were taken during the peri-mortem period in an attempt to identify the cause of the deterioration in her clinical condition. The Consultant Microbiologist has confirmed that the patient did not present a clinical picture of sepsis and that it would not appear to be a contributory factor in her death as confirmed by the post mortem report.

4. Incidents

Early anecdotal information from ADCU is suggesting that drug incidents as a result of patients not being prescribed their usual medication are falling. The new POAC process is also enabling early identification of clinical issues that previously would not have been picked up until the day of surgery therefore reducing cancellations. Data to support this will be presented in future reports.

5. Pressure ulcers



The two avoidable pressure ulcers occurred on Ward 1 which is a matter of concern. The subsequent investigations have identified a range of contributory factors including lack of appropriate skin inspections, lack of use of pressure relieving equipment, poor documentation, no referral to the tissue viability team and inadequate repositioning of the patient. The Matron and Ward Manager in this area have taken steps to address these issues with the staff concerned both in terms of addressing training needs as well as clarifying expectations re standards of care and consequences if these are not met.

Wider learning from this case has been shared across the organisation and additional training for Ward Managers on holding their staff to account and having difficult conversations has been provided on a recent away day.

The value of the financial penalty incurred via the contract for the avoidable grade 3 pressure ulcer is currently under discussion.

It should be noted that year to date there have been 5 avoidable pressure ulcers, a 50% reduction from the same period last year.

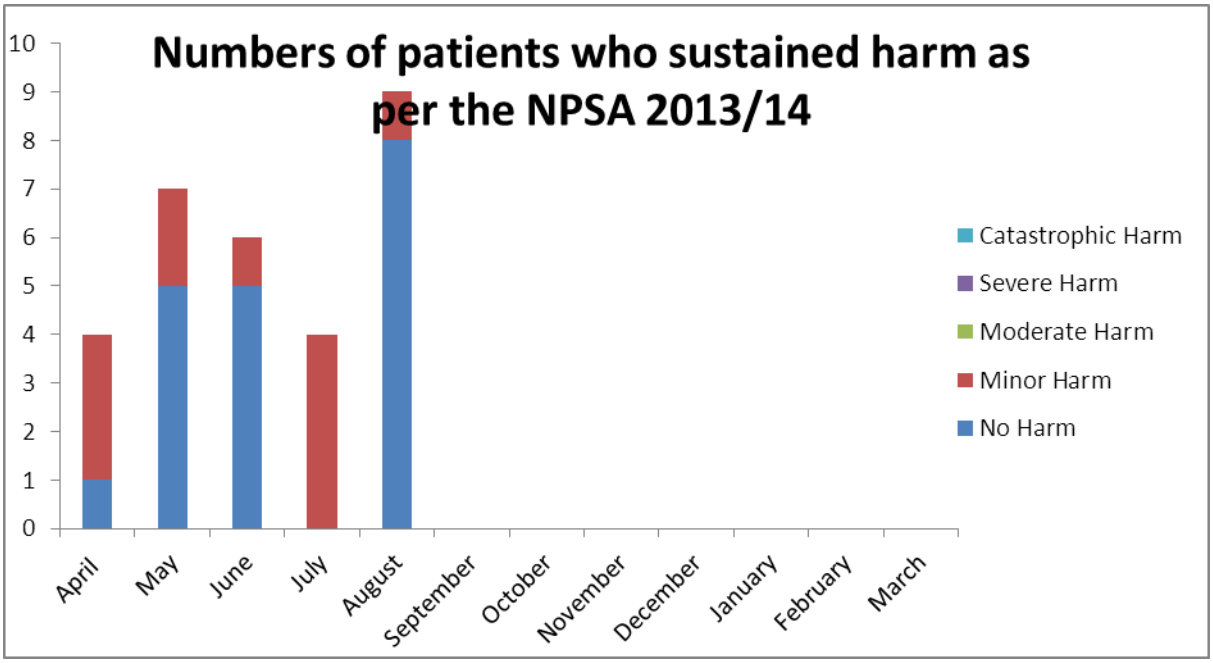
6. Vte risk assessment

The CQUIN target has not been achieved in month with two areas not meeting the required 95% target, ADCU and Ward 1. These returns are completed manually and, at the time of writing, opportunities to further review notes to more accurately identify completed risk assessments are being considered.

7. Falls

There has been a reduction in the number of reportable inpatient adult falls for the second consecutive month. Further details on level of harm is outlined in the table below.

The number of patients who have sustained harm as a result of a fall.



Number of falls reported in each area

Location of Falls	April	May	June	July	August
Ward 1			5	1	1
Ward 2	1	5		1	1
Ward 3	3	1	1	2	5
Ward 10		1			
Ward 12					2

		April	May	June	July	August
Q1.	**Has the falls assessment been completed within 6 hours of admission?**	100%	100%	95%	96%	96%
Q2.	**If the patient is identified as high risk is a care plan in place?**	95%	95%	95%	92%	84%

A review of the increased number of falls on ward 3 has been undertaken and has highlighted that of the 5, 3 occurred when patients chose not to follow advice from clinical staff and mobilised before anaesthetic blocks had worn off.

The fall with a fracture in OPD is not reportable externally into the Safety Thermometer as only inpatient falls are counted.

8. Ward dashboard

HDU continues to achieve in month improvements (despite an overall red rating) with safety moving to amber this month. Workforce and safety are expected to be green by September with training amber by October and green by January.

Ongoing management by the Matron with support from HR continues in Ward 12.

9. National cancer inpatient survey

The Trust has now received the results of the National Cancer In-patient Survey. The ROH was one of 155 acute hospitals, providing cancer services, to take part. We had 50 respondents, of whom 32 had sarcoma, 4 had haematological malignancies and 14 other cancers. The respondents were adults over 16 years of age diagnosed with cancer, who had been an in-patient or day case between September 1st 2012-November 30th 2012.

The survey included the whole patient experience both in primary and secondary care. Their overall NHS care experience was rated as 78%. This is significantly lower than 2011/12 (90%) but it not possible to say which particular area this appertains too in their patient journey.

As before, the ward environment has scored excellently with 100% of patients feeling their privacy was respected and 98% feeling their dignity was maintained.

The main areas where patients felt improvements could be made were information around diagnostic tests, who their specialist nurse was and how to contact them, support groups, financial help, inclusion in research and written information. This was disappointing as the M.D.T. had worked vigorously to improve patient information, as this was highlighted in the previous survey. This was in addition to the National Bone Sarcoma Information pathway that has been developed by the five Bone Sarcoma Centres across England.

We have also worked to raise the profile of our support group, ROHBTS, and to advise patients about Macmillan Cancer Support, which includes a Macmillan patient information hub and life sized posters. Since the survey there have been notable improvements to the environment on ward 3 including 2 side rooms sponsored by The Teenage Cancer Trust and the day room has been upgraded sponsored by ROHBTS.

The Trust is currently piloting a pre-diagnostic MDT which should improve waiting times for information, speedier access to the service and earlier introduction to their CNS(key worker) as they do at Stanmore who scored better than the ROH for the initial stages of the journey but not so well for ward/hospital doctors.

The Oncology specialist nursing team are developing an action plan to address the findings of this survey and this will be monitored via the Quality Committee.

10. Patient led assessments of the care environment (PLACE)

The PLACE assessments have replaced the previous PEAT inspections with the intention of greater patient involvement in assessing the care environment. These scores were released nationally on 18th September. The ROH scores are as follows:

Cleanliness	97.34%
Food	92.09%
Privacy, dignity and wellbeing	89.5%
Condition, appearance and maintenance	93.61%

The slightly lower score for privacy and dignity relates to Ward 7 (now closed and re-provided by ADCU) and some ongoing estates issues e.g. the open courtyard.

Benchmarking with other organisations will now take place and opportunities for using this feedback identified.

11. Complaints/PALS/Compliments

COMPLAINTS

There has been a decrease in the volume of complaints received this month from 12 to 7 (4 formal) representing a drop of 42%. This is in line with the usual pattern of a quieter month in the summer quarter.

Number of complaints responded to in agreed timescale in August is 11/12 or 92% which is above agreed KPI of 80%.

Areas for formal complaints received this month are broken down as follows:

- Poor communications
- Approach of healthcare professional x 2 (hand therapist and anaesthetist)
- Clinical care

PALS:

PALS contacts rose slightly this month to 73 (+7%) compared to 68 last month.

- Numbers of PALS received by Directorate:

Corporate	13
Small Joint	4
Large Joint	19
Oncology	6
Clinical Support	18
Paediatrics	0
Spinal	13
Theatres	0
Total	**73**

Highest areas of concern:

- Reimbursement of expenses, DLA enquiries
- Provision of disabled parking spaces
- Work experience requests
- Interpreter requests
- Update on care and treatment plans – large joint and spinal
- Copy medical records requests

The number of complaints and PALS with regard to administrative issues continues to reduce.

COMPLIMENTS

- Number of Compliments by Directorate:

Directorate	Compliments August 2013
Clinical Support	14
Small Joint	8
Large Joint	140
Oncology	35
Paediatrics	73
Spinal	5
Theatres	33
Corporate	12

Total **320** (17% down on last month's total of 386)

- Highest numbers of compliments received
  Private Suite 33
  Short Stay 70
  Ward 11 72

APPENDIX 1

New SIRIs August 2013 – 4

Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final report due
11417	15/8/13	15/8/13	Unexpected death	None	Oncology (Orthopaedic)	Investigation underway	24/10/13
11265	16/7/13	19/8/13	Fracture following fall	None	OPD/Support Services	Investigation underway	22/10/13
11420	17/8/13	17/8/13	Grade 3 pressure ulcer - unavoidable	Moderate	Oncology	Final report submitted 4/9/13	23/10/13
11461	23/8/13	23/8/13	Grade 3 pressure ulcer - avoidable	Moderate	Spinal	Investigation underway	30/10/13

SIRI update report:

Ref No.	Description	Findings	Actions recommended / taken	Due date	Remove from Board report
11058/11061	Radiation exposure during pregnancy /Safeguarding concerns	Radiation exposure during pregnancy /Safeguarding concerns	Investigation on-going. Extension granted due to complexity of case. Draft report being prepared for review w/c 9/9/12.	6/9/13 extended to 18/9/13.	No
11103/11104/11113	Morphine overdose	This incident appears to have occurred due to high workload resulting in the nurses becoming distracted. This led to unsatisfactory care provision to the patient and resulted in an overdose of Morphine being administered to the patient.	Report submitted to commissioners 22/8/13. Professional discussion with both staff nurses involved as per drug error procedures Review of direct admissions late in the evening onto HDU and compliance with this Implementation of the Supernumerary Co-ordinator on all shifts to assist staff on busy shifts and ensure adequate supervision of junior team members.	23/8/13 (submitted 22/8/13).	Yes

	July 2013						Large/Small joints			Spinal/Paeds/Oncology			Theatres/Anasethetics					OPD/POAC		
							Sarah Needham			Evelyn O'Kane			Lisa Pim					Stacey Keegan		
							Ward 2	Ward 12	Ward 10	Ward 1	Ward 11	Ward 3	HDU	Recovery	Day Unit	Ward 7	CCO	POAC	ROCS	OPD
1	Workforce: Overall RAG sc	Matron scoring				Monthly														
2	Training: Overall RAG score	Matron scoring				Monthly														
3	Patient Experience /Feedback: Overall RAG	Matron scoring				Monthly														
4	Safety: Overall RAG score	Matron scoring				Monthly														
5	Efficiency: Overall RAG score	Matron scoring				Monthly														
6	Outcomes: Overall RAG score	Matron scoring				Monthly														
	Matron and Managers overall score										↑									

	TH 1	TH2	TH3	TH4	TH5	TH6	TH7	TH8	TH9	TH 10
Workforce										
Training										
Patient Experience										
Safety										
Efficiency: Overall RAG score										
Outcomes: Overall RAG score										

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 25th September 2013 **ENCLOSURE NUMBER: 10**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Lindsey Webb - Director of Nursing and Governance**
AUTHOR:	**Sarah Mimmack – Senior Nurse, Infection Prevention and Control**
TITLE:	**Infection Prevention and Control Annual Report 2012-13**

SUMMARY

As part of the requirement of the Health Act 2008 (The Hygiene Code), the Board is required to receive and approve an infection prevention and control annual report.

In addition to this mandatory requirement the Integrated Governance Committee also receive six monthly progress reports from the Infection Control Committee.

Key achievements in year include:

- Achievement of all local and national HCAI targets
- Implementation of the Bone Infection Unit
- Identification of 4 year 30 day surgical site infection (SSI) rates for arthroplasty

RISK

Areas of risk that will be priorities within the 2013/14 annual plan include standardisation of best practice, on-going improvements to the theatre environment, addressing outliers of 30 day SSI rates, improved compliance with Saving Lives care bundle and the expansion of SSI surveillance.

RECOMMENDATIONS

The Board is asked to **approve** the Infection Prevention and Control Annual Report for 2012/13.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Infection Prevention and Control Annual Report

2012-2013

Infection Prevention and Control Annual Report
April 2012 to March 2013

Executive Summary

This report summarises the work of the Infection Prevention and Control (IPC) Team during 2012 to 2013, the progress made and the challenges faced by the Trust.

1.0 The annual IPC programme, set in April 2012 was completed with the exception of the full implementation of Saving Lives High Impact Interventions and the expansion of surgical site surveillance to Spinal and foot/ ankle surgery.

2.0 There were 0 cases of MRSA bacteraemia this year, the last attributable case was in May 2008.

3.0 The DH began surveillance of Clostridium *difficile* infection (CDI) infection in January 2004. Acute NHS Trusts in England are required to report all cases of CDI from patients aged two years and over. The total number of CDI attributable to ROHFT for 2011 to 2012 was 6. This was within the trajectory of 7 set locally and is the lowest number of cases since mandatory surveillance was introduced.

4.0 The DH requires all hospitals performing orthopaedic surgical operations to monitor surgical site infections (SSI) for at least a 3 month period every year. As part of this scheme the Trust participated in all 4 quarters and continued to report both inpatient and 30 day SSI data to the Health Protection Agency. At present no other specialist orthopaedic trust undertakes 30 day surveillance so it is not possible to benchmark our data.

5.0 IPC amalgamated with Tissue Viability part way through the year and now provides a joint service. The team comprises of:
1.0 Band 8B - Senior Nurse
0.8 Band 7 – IPC Specialist Nurse
0.5 Band 7 – TV Specialist Nurse
1.0 Band 4 – Administrator
2 PA's - IPC doctor (SLA with UHB)

6.0 The key challenges for 2013 to 2014 are detailed in Appendix 2 on page 26.These will be delivered through the IPC Annual plan for 2013 to 2014.

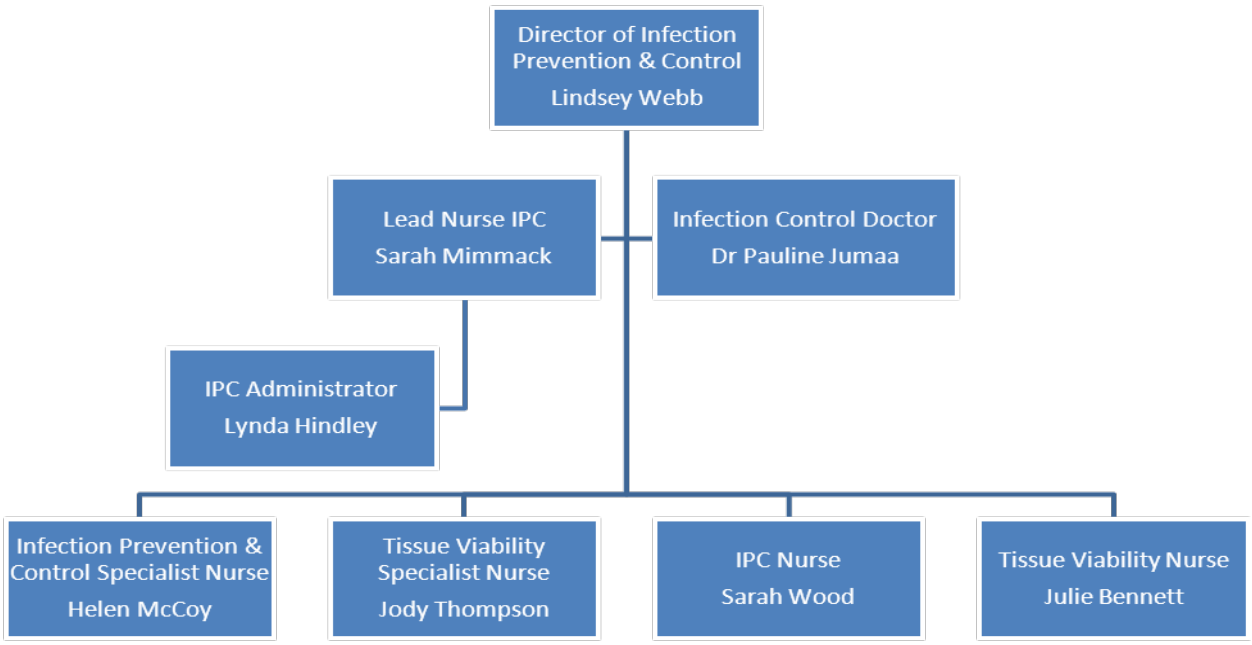
Report Contents: Page No:

1.0 Introduction

This report provides a summary on Infection Prevention and Control Service provision, activities and issues during the period of April 2012 to March 2013.

2.0 Description of Infection Prevention and Control arrangements

2.1 IPC Team structure



2.2 Board support for IPC

Director of Infection Prevention and Control (DIPC)
The Director of Infection Prevention and Control leads the team. The DIPC reports directly to the Chief Executive and is an executive member of the Trust Board.

Non-executive Lead
The DIPC is supported at the board by the Chairman in the role as non-executive lead for IPC.

The Infection Control Committee (ICC) meets every two months and
Members in 2012-13 were:

- Director of Infection Prevention and Control – Lindsey Webb (Chair)
- Clinical Microbiologist – Dr Pauline Jumaa
- Operational Lead / Senior Nurse – Sarah Mimmack
- Consultant Orthopaedic Surgeon – David Dunlop
- Consultant Orthopaedic Surgeon – Seggy Abudu
- Central Midlands CSU, Infection Prevention Practitioner – Jackie Clarke
- Health Protection Agency representative
- Estates Manager
- Facilities Manager
- Clinical Service Manager

The Infection Control Committee reports to the Integrated Governance Committee, a sub-committee of the Board.

2.3 The Operational group is chaired either by Sarah Mimmack the Operational lead or Helen McCoy, the IPC Specialist Nurse and consists of a multidisciplinary link team. The group includes representation from facilities, physiotherapy, imaging and occupational therapy along with a strong nursing contingent. This group report to ICC and meet monthly. They are very active and undertake monthly audits of their areas. Attendance from most areas is very good, and is monitored by the Matrons.

2.4 Links to Drugs and Therapeutics Committee

The DIPC attends this meeting and maintains links; reporting and advising as necessary. The antimicrobial guidelines have been in place since June 2008. They were updated in July 2011 and while cefuroxime is no longer recommended for use as prophylaxis, it is considered appropriate for some spinal operations as it perfuses the cerebral spinal fluid more effectively than other agents.

2.5 Links to Clinical Governance / Risk Management / Patient Safety

The DIPC role is held by the Director of Nursing and Governance who chairs the Infection Control Committee and also the Quality Committee. The DIPC also attends the Integrated Governance Committee.
MRSA bacteraemia and cases of *Clostridium difficile* are reported to the Executive Management Team and the Board of Directors via a monthly report. A more detailed analysis regarding additional aspects of IPC is included in the quarterly clinical governance report which reports to the Integrated Governance Committee. In addition the Infection Control Committee report every 6 months to the Integrated Governance Committee via the DIPC who delivers a full report on the work of the committee.

2.6 On call service

Access to a 24 hour on call Microbiologist is available under the service level agreement held with University Hospitals Birmingham NHS Foundation Trust.

2.7 IT systems

Since the end of October 2007 ROH have received daily (Mon – Fri) lab data reports. This provides the IPCT with a complete picture of any positive specimens received in the UHB lab. Unfortunately the system is not live and requires considerable manual input as there is no interfaced database at present. Money was granted during the business planning process for the implementation of ICNet during 2009-10. Work regarding IT infrastructure was required both at UHB where the laboratory is based and at ROHFT, this work was completed in November 2011. The system went live in March 2012. The full implementation of ICNet will take place during 2012-13.

3.0 Budget Allocation to Infection Prevention and Control.

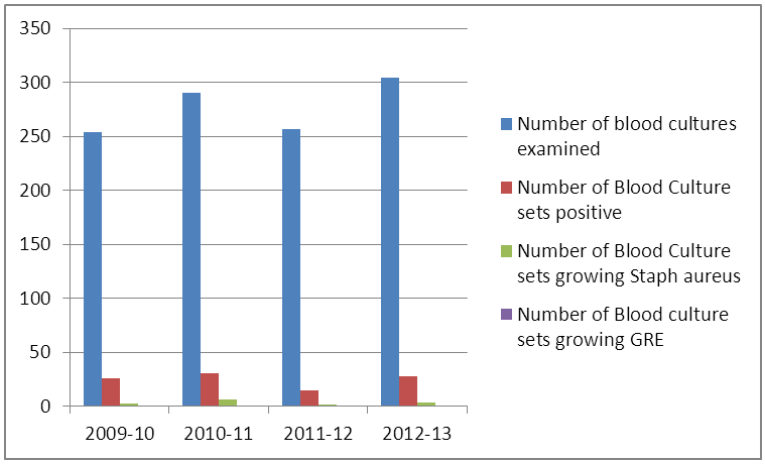
The total budget for Infection Prevention and Control was £334,352. This includes the monies associated with Tissue Viability and the Bone Infection Unit (pay = £264,408 and non-pay = £69,944).

4.0 Mandatory Surveillance

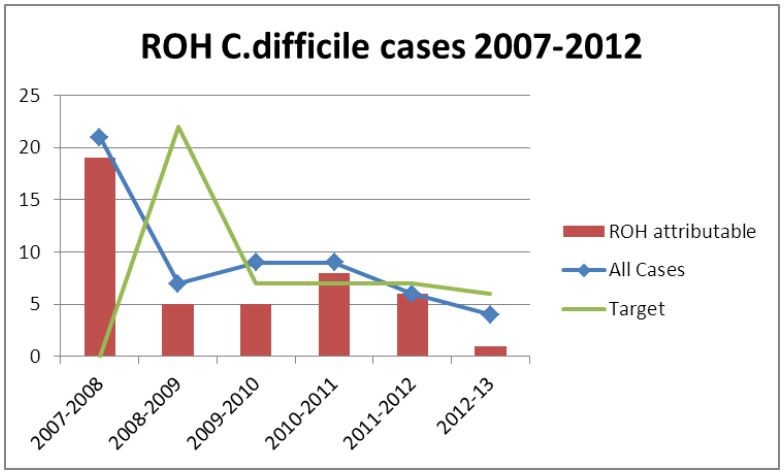
4.1 Rates of Meticillin Resistant Staphylococcus Aureus bacteraemia have been subject to mandatory reporting since 2001. There have been no cases of MRSA bacteraemia at ROH this year. Since 2001 there have been 4 cases, 2 during the summer of 2006 and 2 in 2008 (May and Oct). It is 5 years since an MRSA bacteraemia was attributed to ROHFT.

4.2 Rates of Glycopeptide Resistant Enterococcal bacteraemia (GRE) have been subject to Mandatory reporting since early 2004. There have been no cases at ROH this year.

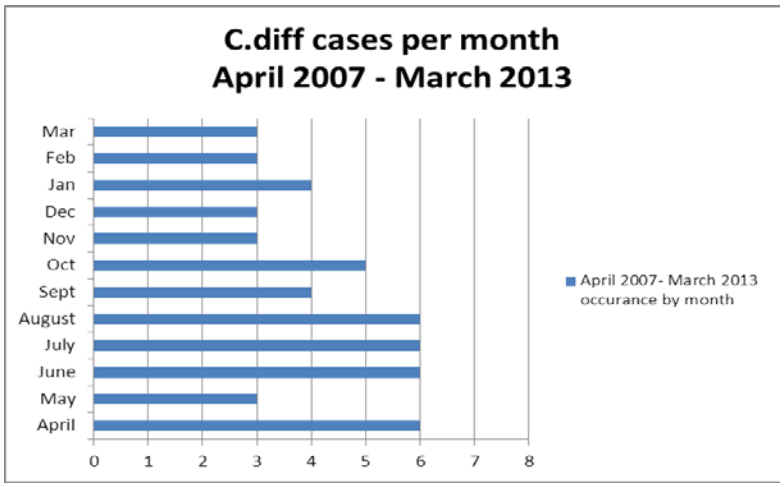
The graph below details the number of blood cultures sent for analysis each year since 2009 - 10 until the end of 2012-13. Contamination rates are monitored and specific training is provided to all those staff taking blood cultures to ensure competency.



4.3 Surveillance of Clostridium difficile – prior to April 2007 mandatory recording related only to cases in patients over 65years. Since April 2007 all cases of Clostridium difficile in patients over 2 years of age are reportable. There was 1 Trust attributable case at ROH this year. This is the lowest figure since mandatory reporting was introduced. The Trust is at an irreducible minimum with no evidence of cross infection since mandatory reporting began.

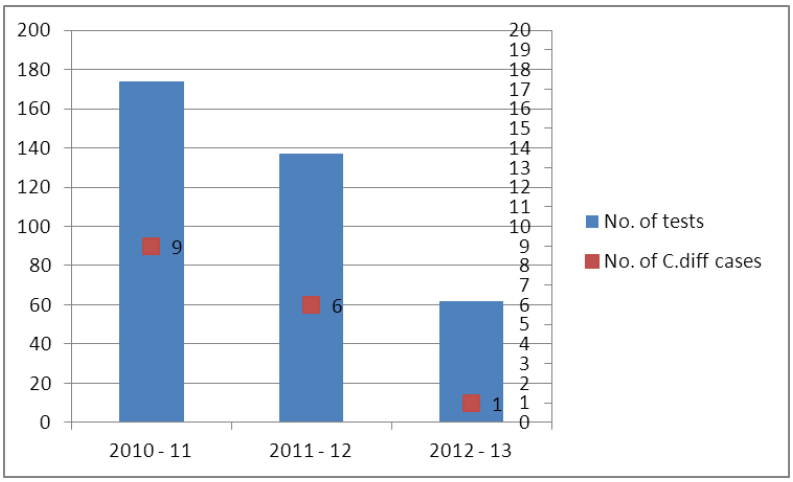


The months in which cases fall are monitored in order to try and identify trends. The numbers of cases at ROHFT are very small and therefore identifying trends is especially difficult. The graph below details in which month each case occurred since the introduction of mandatory surveillance in 2007. From this it identifies April, June, July and August as being the months which have seen the highest number of cases, with October and August following. Interestingly the norovirus season (winter) does not seem to indicate a rise in cases.



A root cause analysis is undertaken into every case and the Consultant in charge asked for his comments. The case identified , 5 were oncology patients (1 paediatric included) and 1 was an orthopaedic patient. There were no breaches of the antimicrobial guidelines identified and there is no evidence of any case being caused by or related to cross infection during 2011 /12.

Below is a graph detailing the number of stool specimens sent for analysis and the number of *C.difficile* toxin positive being requested. This data is part of the mandatory surveillance required by the Health protection agency. Testing is discussed with all clinical staff as part of mandatory training and all cases of diarrhoea are reported to IPC for their specialist input and to ensure close monitoring of the management of such patients. The number of tests has reduced significantly; this is very likely due to the increased level of knowledge amongst nursing staff and the increased input of IPCT on the wards each day.



4.4 Methicillin Sensitive Staphylococcus aureas (MSSA)

There were 2 post 48 hour cases of MSSA identified during the year. Both cases were thoroughly investigated and related to deep joint infections – neither patient had undergone surgery at ROHFT prior to developing the infection, but were referred here for remedial treatment.

2012/13	**MRSA**	**MSSA**	**E.coli**	**C.diff**
Target	0	none	none	6
End of Year position	0	2	1	1

4.5 E.coli bacteraemia

There was 1 post 48 hour case of E.coli bacteraemia in a complex oncology patient, no clear source of sepsis was identified.

4.6 Surgical Site Infection - Reportable to the Health Protection Agency

The infection Prevention and Control team currently monitor arthroplasty although there is a strong desire to add spinal to this work by the end of 2013-14.Mandatory surveillance of Surgical Site Infection (SSI) announced by the Chief Medical Officer in June 2003 commenced 1st April 2004. Every NHS Trust where orthopaedic surgery is performed is expected to carry out a minimum of 3 months (1 quarter) surveillance in at least one of four orthopaedic categories each year:

- Hip replacements
- Knee replacements
- Repair of neck of Femur
- Reduction in long bone fracture

The ROHFT took an early decision to participate for all quarters and collect data continuously rather than the 1 mandatory quarter each year that is required.
The latest data published by Public Health England (formerly the Health Protection Agency) collates infection rates from all hospitals undertaking surveillance and reports the national figures from April 2007 – March 2012:

Operation:	No. of Ops	LOS	SSI %	Time to infection:
Hip prosthesis:	161,482	5	0.7	14
Knee prosthesis:	175,605	5	0.6	15

Of note is the information that shows inpatient length of stay and then the time at which infection was noted; some 9 - 10 days after discharge from hospital.

The following table details the inpatient and readmission SSI rates at 6 specialist orthopaedic hospitals including Sussex Orthopaedic NHS Treatment Centre which is run by a private provider and shows data from 2011-12, this is the most recent data available publically at present. 2 of the hospitals monitor for 1 quarter while the other 4 undertake continuous monitoring. There is no publically available 30 day data to enable comparison.

Inpatient and readmission data 2011-12

Trust	NOC	RNOH	RJAH	ROHFT	Sussex TC*	Wrightington
No of Hip ops	217	308	1495	**1284**	593	1228
% SSI	0.0	0.65	0.67	**0.08**	0.0	0.81
No of Knee ops	No data	304	1386	**981**	524	887
% SSI	No data	0.0	0.43	**0.10**	0.0	0.45
No of Quarters reported	1	3	4	**4**	4	4
* operated by Care UK						

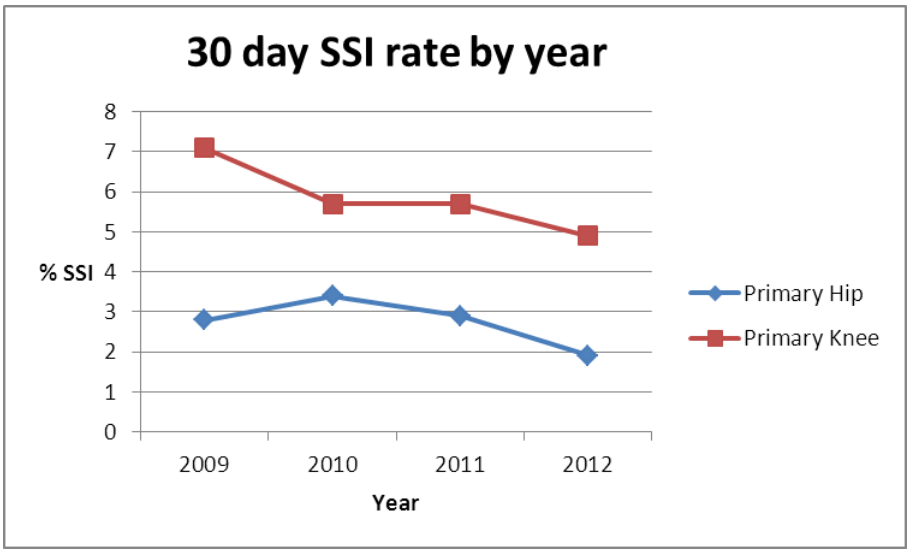
Currently there is no requirement for Trusts to monitor patients following discharge. However length of stay has considerably shortened throughout the NHS since the introduction of mandatory surveillance in 2004. In July 2008 the HPA introduced an optional surveillance method which provided a questionnaire for patients to complete on the 30th day post op.

In January 2009 ROHFT commenced 30 day monitoring of all arthroplasty patients utilising the HPA post discharge surveillance questionnaire.

There are many facets to SSI and its cause; this makes it difficult to interpret the data from the other specialist trusts. Length of stay is a significant factor as it is well documented (as identified above) that a very short length of stay is unlikely to elicit any valuable SSI data as the bacteria are most likely to show themselves at between 5 and 15 days post operatively in superficial infections. It is hoped that several of the other specialist orthopaedic Trusts will submit 30 day data in order for us to benchmark with data that measures SSI over a finite period. The PHE and CDC recommend that patients with a prosthesis should be monitored for 1 year post operatively for infection – this is something ROHFT is working towards.

SSI data by consultant undertaking primary hip and knee surgery is analysed and shared with the surgeons. Revision surgery is monitored but excluded from the report to the surgeons although it is reported to the HPA. The reason for this is the complexity of the revision surgery undertaken at ROHFT; this complexity makes it difficult to use revision surgery as an accurate indicator for infection. Many of the revisions undertaken at ROHFT are referrals from other centres and are patients who are too complex to undergo surgery at their local hospital.

Results:



Monitoring continues and IPC are keen to implement a more robust surveillance system than the current HPA criteria. This will improve the quality of the data currently collected. It is impossible to accurately benchmark with other trusts if the Trust moves away from the HPA / PHE surveillance at 30 days although augmenting this data collection with additional information as requested by the CDC will enhance the information currently available. This forms a significant part of our annual plan for 2013-14.
Telephone follow up for all those patients who fail to return their questionnaire was introduced mid-way through 2012-13 and so far has not shown any improvement in the data collection as those who fail to report very rarely have an issue with their wound. However, the wound infection helpline has ensured access straight back to the Trust for any patient with a concern about their wound post operatively. This ensures a small team of specialist orthopaedic practitioners review the wounds rather than GP's and district nurses who may not be as ofay with the post-operative complications associated with arthroplasty surgery.

The last 4 years has seen the spotlight on SSI at the Trust. The introduction of the wound care helpline has reduced some of the erroneous data that was previously reported by patients who had seen their GP with post-operative concern regarding their wounds; many of whom were being given 'precautionary' antibiotics. By ensuring they are seen by an orthopaedic specialist much of this unnecessary use of antibiotics has been eliminated and a truer picture of SSI is now known.

4.7 MRSA Screening

From March 2009 all Trusts are required to report their MRSA screening figures. 100% of elective admissions, whether day case or inpatients were screened prior to admission. From March 2010 all emergency admissions have also been included in this target. The Trust has met this target throughout the year.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Number of patients screened	956	1145	882	840	699	696	859	871	657		792	735
Emergencies	24	42	39	36	44	29	35	32	30	26	32	29
daycase			541	560	445	530	466	569	487	440	540	506
Elective Inpatient	908	1090	462	628	486	464	533	527	409	537	553	614
Total excluding day cases			580	664	530	493	568	559	439	563	585	643
Total	932	1132	1042	1224	975	1023	1034	1128	926	1003	1125	1149
% screened	102.5	105	152	126	131.8	141.1	151%	151.2	149.6	138.7	135.5	114.3
No of Positives	6	3	3	2	1	2	3	5	1	5	6	0

The cost of MRSA screening all patients at ROH during 2011/12 at £6.75 per swab (with most patients requiring 2 swabs – nose and groin) was £183,600.

An assessment tool based on data collected in the preceding 2 years was introduced in June 2012. This is a risk based screening method to try and eliminate unnecessary screening while maintaining the DH requirements. It was anticipated that savings of approximately £100,000 per year could be made. The tool errs on the side of caution and any patient staying overnight is automatically screened, along with those having any metal work inserted. It considers their social circumstances and all other risk factors. This resulted in a reduction in the number of patients being screened by around 4,500 which equates to a saving of £60,318 in the 9 months following its introduction which if extrapolated equates to annual savings of £80,424. The number of patients being screened remains slightly higher than expected at present although IPC would prefer the staff take a cautious approach and screen if there is any uncertainty.

There has been no evidence of acquisition of MRSA or MRSA bacteraemia's being an issue since the introduction of the screening tool and these markers are closely monitored by IPCT.

4.8 Outbreak Surveillance

There were no outbreaks during 2012-13.

5.0 Influenza – H1N1

There were no confirmed cases of H1N1influenza among patients and a low incidence of staff sickness relating to influenza.

Last year's new approach to the Trust's vaccination programme was repeated this year utilising the IPC team who undertook the necessary training and visited each area of the hospital on several occasions and had 'open access' for all staff wishing to have the vaccination in the IPC office. This year's program elicited a slightly poorer response which may be partly due to the absence of any national campaign. 40.9% of staff were vaccinated (compared to only 18.4% 2010/11). Nationally 45% of healthcare workers were vaccinated although within West Midlands SHA 42% of frontline staff were vaccinated. The table below shows comparison with other local Trusts.

Hospital	**% Uptake 2011/12**	**% Uptake 2012/13**
RNOH	28.3	33.5
RJAH	50.1	57.7
ROH	**46.7**	**40.9**

WMAS	17.2	27.8
Worcs Acute	51.8	32.6
Sandwell & w B'ham (City)	41.7	49
UHB	23.4	23.4

6.0 Hygiene Code

There have been no hygiene code inspections during 2012-13. Although Birmingham Cross City CCG undertook an unannounced inspection on 7th March 2013 - an excerpt from their report is included here (different font):

Identified good practice

2.7.4 The environment was found to be clean, tidy and well organised.

2.7.5 A good standard of infection prevention and control was observed.

4 inpatient wards were visited along with the High Dependency Unit, Theatres, recovery, outpatients department and Physiotherapy.

The team did not highlight any specific IPC issues in their recommendations.

The Conclusions from the report are included below:

3. CONCLUSIONS

3.1 Overall the visiting team felt that this visit provided significant assurance around the quality of services at Royal Orthopaedic Hospital. Patient experience was consistently found to be good or excellent.

3.2 A number of specific issues were identified during the visit and these are detailed above. These were fed back to the provider on the day, and the senior management team agreed to review this report in detail when received.

3.3 The visiting team would like to thank the staff at all levels of Royal Orthopaedic for their openness and welcoming approach.

3.4 Birmingham Cross City CCG would also like to thank those from other organisations for the time, effort and expertise they contributed to this visit.

7.0 Saving Lives High Impact Interventions

Saving Lives was introduced by the Department of health in June 2005. The High Impact Intervention tools are based upon a 'care bundle' concept, integrating the latest evidence based guidelines and providing a means for staff to measure compliance in key clinical procedures. Every clinician has the potential to significantly reduce the risk of infection by ensuring they consistently comply with evidence-based practice. All elements are equally endorsed and none is regarded as optional. The HII that apply to the Royal Orthopaedic Hospital are;

- **HII1:** Central Venous Catheter Care Bundle
- **HII2:** Peripheral Intravenous Care Bundle
- **HII4:** Care Bundle to Prevent Surgical Site Infection
- **HII6:** Urinary Catheter Care Bundle
- **HII7:** Care Bundle to Reduce the Risk from *Clostridium difficile*

Advice is available from IPC although actions and enforcement of the Saving Lives High Impact Interventions lies in the clinical areas with the Matrons and Ward Managers. Scores are reported to the Quality Committee and monitored during performance reviews each month. Uptake throughout the year has improved and all areas have now implemented Saving Lives.

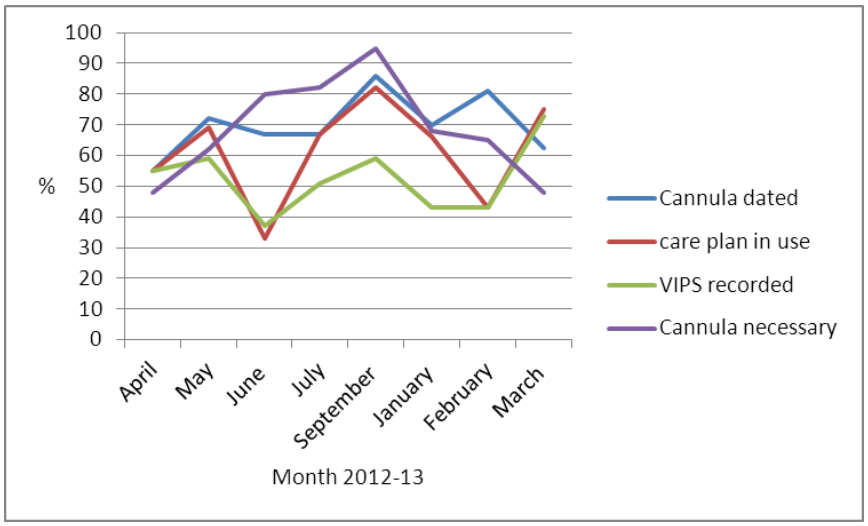
Below is an example of the reports sent to ICC:

Compliance Score for Saving Lives			0-70	71-94	95-100			
HII No	**1**	**1**	**2**	**2**	**6**	**6**	**7**	**8**
	CVC Insertion	CVC On-going care	PVC Insertion	PCV on-going care	Urinary Catheter Care Insertion	Urinary Catheter Care on-going	Reducing the risk from Clostridium difficile	Cleaning & Decontamination
Compliance		★ **100% - 34 observations**	★ **100% - 32 observations**	★ **100% - 140 observations**	★ **100% - 17 observations**	★ **100% - 60 observations**	**None recorded**	
Barriers		All elements were fully compliant	All elements were fully compliant	All elements were fully compliant	All elements were fully compliant	All elements were fully compliant	**Is this a true reflection of clinical activity across the trust**	

No Data from ward 1

The efficacy of Saving Lives audit results in improving practice has been variable. The results are 'cross-checked' by independent cannula audits undertaken by the IPCT and the clinical nurse tutor. The results of these audits rarely correspond with the saving lives results. This is likely to be due to the way in which the audits are performed and the methods used.

While saving Lives audits outline best practice, the actual data collection is undertaken by the ward or clinical area themselves and is less robust that the data collected independently by IPCT. Saving Lives was introduced in 2007 however our internal monitoring mechanisms are much improved from 2007 and the usefulness of the audit results is debateable.



8.0 Antimicrobial Stewardship

Antimicrobial stewardship is now a well embedded part of the trust's governance. A pharmacist attends the weekly Bone Infection MDT and participates on the ward round. The prescribing of antimicrobials has been more stringently regulated to ensure rational prescribing of antibiotics. There is now a list of antibiotics that a microbiologist must approve before doctors at ward level

can prescribe. Some antibiotics may only be prescribed by the Bone Infection Unit – this control is monitored closely by the pharmacy department.
Audits that have been carried out this year include:

- Antibiotic Prophylaxis – Adherence to Guidelines
- Point Prevalence Study on general prescribing
- Linezolid
- And general usage of specific antibiotics eg cefuroxime

9.0 Education and Training

Infection Prevention and Control Training continues to be a key role for the team. Specialist training is included in the Trust Induction, clinical and non-clinical mandatory training, Consultant training and junior doctor induction. A comprehensive teaching programme has been developed to rationalize training across the Trust.

The Training programme is attached in Appendix 1

10.0 Audit

Assurance is an integral part of healthcare and is taken very seriously at the Royal Orthopaedic Hospital NHS Foundation Trust. Audit takes place using various tools, including credits for cleaning which monitors the environment; Lewisham Hand Hygiene audit tool which is utilised in conjunction with the World Health organisation's 5 Moments. Specific tools relating to clinical practice are also utilised monthly; this is a combination of saving Lives High Impact Interventions (HII) and Infection Prevention Society (ICNA) audit tools.

Audit is an intrinsic part of the Infection Prevention and Control Team's function at the Royal Orthopaedic Hospital NHS Function. It serves several purposes, firstly to provide assurance and evidence of our capacity to set and maintain high standards across all areas. Secondly to drive improvement as required. Clear expectations are set and the adherence to these standards is then monitored and reported via the Ward Managers key performance indicators and the monthly IPC reports, both internally and externally.

The inpatient areas have sustained the levels expected for environmental standards and hand hygiene throughout the year, theatres is making excellent progress and via the audit process this improvement has been sustained and the completion rate of audits has vastly improved.

The link team are expected to complete 3 specific audits each month along with a continuous programme of Saving Lives audits. Completion of these audits, along with their scores is reported to the Department Managers and Directorate Managers monthly. Action plans are produced by the link nurses in response to the audits they undertake. These are given to the Ward managers in order for them to ensure the changes required are implemented. The scores and compliance are monitored through ICC and the Ward Managers Key Performance Indicators.

Shared audits are also undertaken, a joint inspection of all inpatient areas is undertaken monthly by IPC and Facilities utilising the Credits for Cleaning tool, this ensures any issues are accurately placed with the responsible staff group - facilities, estates or nursing. It also ensures speedy resolution of any difficulties along with an appreciation of each other's responsibilities and pressures. A written report is then sent to the department manager within a week of the audit taking place.

10.1 ICNA Audits

Below is an example of the information provided to the Ward Managers each month:

2012- 13		Area											
Measure	Target	Ward 1	Ward 2	Ward 3	Ward 7	Ward 10	Ward 11	SSW	HDU	Recovery	DU	POAC	OPD
C.diff pre 48hr		0	0	0	0	0	0	0	0	0	0	0	0
C.diff post 48hr	6	0	0	0	0	0	0	0	0	0	0	0	0
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers	Target	Ward 1	Ward 2	Ward 3	Ward 7	Ward 10	Ward 11	SSW	HDU	Recovery	DU	POAC	OPD
Avoidable		0	0	G 2	0	0	G 2	G 2	0	0	0	0	0
Unavoidable		G 2	0	0	0	0	G 2 x2	0	0	0	0	0	0
		0	0	0	0	0	0	0	0	0	0	0	0
Narrative:	Ward 11 grade 2 patient came back from Theatre with two Grade 2 sores due to 6 hours on the table reported by Ward 11 - unavoidable Ward 11 grade 2 outer aspect of foot from pushing up on the bed - avoidable Ward 3 grade 2 to buttocks once precautions put in place the sores healed - avoidable Short Stay grade 2 to heel may have been stocking - avoidable Patient from theatres- arrived on ward 1 with a grade 2 - all measures in place - unavoidable												
Audit	Target	Ward 1	Ward 2	Ward 3	Ward 7	Ward 10	Ward 11	SSW	HDU	Recovery	DU	POAC	OPD
Hand Hygiene	> 85%	96%	95%	95%	94%	100%	76%	82%	87%	89%	83%	99%	100%
Environment	> 85%	95%	97%	98%	89%	93%	89%	81%	94%	96%	85%	96%	100%
C4C		92%	96%	92%	0%	96%	96%	95%	94%	95%	98%	93%	0%
Commode	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
Action plan received		100%	100%		100%	100%	0%	100%	0%		100%	100%	
IPC Attendance													
Saving Lives PVC	compliance - 95%	100%	100%	0%	0%	100%	78%	0%	100%	0%			
No. of Obs	20 per ward	14	19	0	0	19	11	0	85	0			

Theatres		Th1	Th2	Th3	Th4	Th5	Th6	Th7	Th8	Th9	Th10
Environment	> 85%	95%	83%	100%	83%	84%	86%	90%	82%	95%	100%
Hand Hygiene	>85%	100%	98%	97%	98%	100%	100%	99%	98%	100%	100%
Action plan			100%		100%	100%	100%	100%	100%	100%	100%
C4C		95	95	95	95	94	94	94	94	95	95
Compliance:	Green	≥85%	Amber	76-84%	Red	≤75%	No audit	0			

New hand hygiene signage was implemented throughout the Trust following the staff survey results which highlighted an apparent lack of hand washing facilities. A questionnaire was sent to all staff asking for more detailed responses in order to enable us to understand exactly where the issues lay. Following analysis of the responses, new signage was ordered and facilities agreed to increase the number of times stocks of paper towels and soap were checked each day. The overall view was that there were plenty of facilities although they were not always stocked – this has now been rectified.

10.2 Snapshot audits

In addition to the audits reported earlier in this document, snapshot audits are undertaken within the Trust. Occasionally these take place in response to a Root Cause Analysis or Incident Report; sometimes they are planned in order to monitor compliance with documentation or policy. Snapshot audits were undertaken within ROH on the following topics during 2012-13:

- Adherence to Antibiotic Prescribing guidelines.
- Care of Central Venous Access Devices
- Care of cannulae (including Visual Inflammation and Phlebitis scores - VIPS)
- Mattress integrity
- Catheter associated UTI prevalance
- Commode condition and cleanliness

The results of these audits are reported to ICC and actions implemented as necessary. The results of the cannulae audits have led to the introduction of monthly audits undertaken by IPC in conjunction with the Clinical Nurse Tutor.

10.3 Theatre audits

Every theatre is expected to complete a hand hygiene audit in addition to an environmental audit and report these back to ICC along with an action plan to address any issues identified during the audit. Compliance and scores are reported by IPC and challenged by the Theatre Manager and ICC.

In addition a monthly unannounced inspection of the theatre complex is undertaken by IPC with a member of the Theatre management team with concerns being addressed as they arise.

Work is required to ensure adequate close down periods are instigated in order to facilitate estates and facilities management of the area.

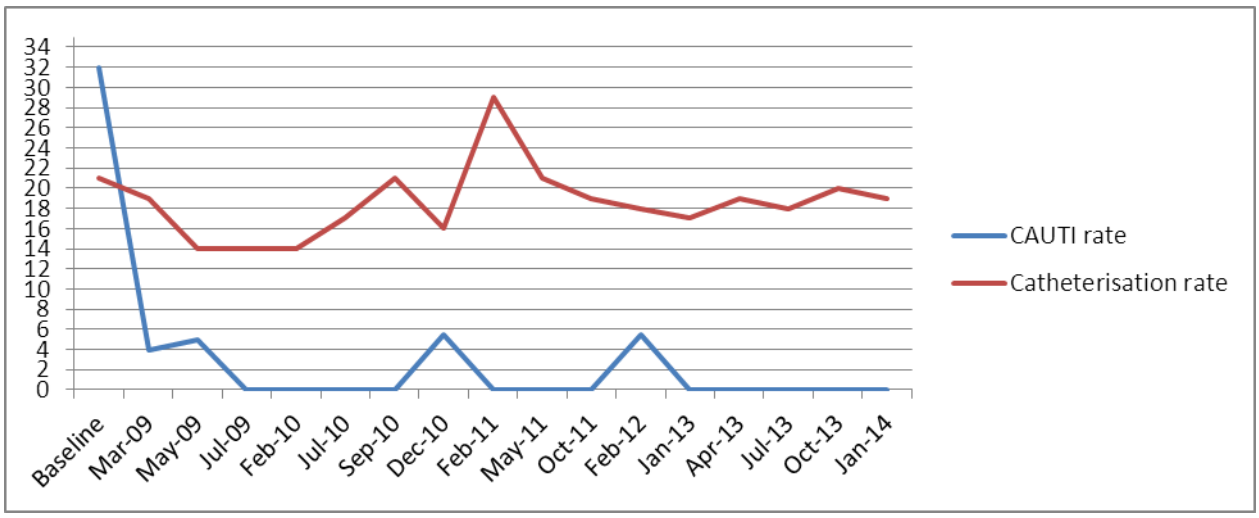
10.4 CAUTI Rate

The Bardex silver alloy urinary catheter was introduced to ROHFT in March 2009 following a trial. This level 1 endorsed device was combined with a Trust-wide Aseptic Non Touch Technique (ANTT) training programme.

CAUTI rates are monitored via the safety thermometer and also monitored during the daily walk round of all inpatient areas that is undertaken by IPC. Snapshot audits are also undertaken every 3 months.

All CAUTI reports are investigated by IPC and any cases reported via the safety thermometer are verified by IPC. The rate remains very low since the introduction of the Bardex silver alloy catheters in 2009.

The graph below shows the success of the implementation of the Bardex IC and the on-going maintenance of a very low CAUTI rate, something the Trust is proud of and is very keen to maintain.



11.0 Environmental improvements

11.1 Estates Projects
The Trust has continued to invest through the capital programme in its Estate which has covered both backlog maintenance and strategic developments. The main areas of focus for 2012/13 being:

- The development of the Admissions and Day Case Unit, which includes a decontamination suite and the refurbishment of medical records and central stores

The Trust has also committed to the following developments which will be completed in future years:

- New paediatric facilities
- Replacement operating theatres and extension to the theatre department.

The Estates Department has undertaken minor estates works which has included the replacement of flooring coverings, fixtures and fittings, suspended ceilings and decoration to a number of areas of the site including our main theatre complex.

12.0 Annual plan review 2012-13

The annual plan for 2012-13 is included in appendix 2 of this report and each element has been graded red, amber or green according to the degree of completion during the year. Most of the

plan is green and has been completed or targets met. However, the plans below are either not yet implemented or fell below target.

2.Limited surveillance reporting reduces drive for change and improvement – extend to include SSI for all specialities
Status end 2012-13:
Business case submitted December 2012 in order to expand surveillance – awaiting decision end of year – due to go through business planning in June 2013.
30 day SSI surveillance for arthroplasty well embedded throughout the organisation.

5.Avoidable exposure to influenza due to low levels of vaccination
Status end 2012-13:
Mass vaccination programme undertaken – unfortunately uptake not as high as plan due to lack of media profile. Staff were reluctant to have vaccination as the perceived risk was low. 40.9% of staff were vaccinated; this was comparable with other Trusts within the region. It is difficult to see how this could have been improved.

13.0 Appendices

13.1 Appendix 1: Education and Training Plan 2012-13

Name of Course	Training Audience	Content	Rationale	Attendance Required	How Often Run	Review Date
Clinical Skills Registered Practitioners	Staff nurses Ward managers Senior Nurses	Aseptic Non-Touch Technique Visual Inflammation and Phlebitis Score NPSA Clean Your Hands	DOH NINSS EPIC2 Saving Lives NICE Guidance WHO	Annual	Bi-Monthly	**July 2013**
Clinical Skills Healthcare Assistants	Healthcare Assistants B Grades	Aseptic Non-Touch Technique Visual Inflammation and Phlebitis Score NPSA Clean Your Hands	DOH NINSS EPIC2 Saving Lives NICE Guidance WHO	Annual	Bi-Monthly	**July 2013**
Clinical Mandatory	Staff nurses Ward managers A + B grades X-ray MRI Physiotherapy Theatre practitioners	Infection Rates ROH Waste Management Hand Hygiene NPSA Bacteria Isolation precautions VIPS Pandemic Influenza Communication with IPC Transfer	DOH EPIC2 Saving Lives NICE Guidance WHO	Annual	Monthly	**July 2014**
Medics/SHOs	Senior House Officers Medics	Infection Rates ROH VIPS ANTT Pandemic Influenza Clinical Dress Code Isolation Precautions Communication with IPC Pandemic flu	DOH NINSS EPIC2 Saving Lives NICE WHO HPA: SSI	Induction	Bi-Annually	**February 2014**
Non-Clinical Mandatory	Housekeepers Secretaries Ancillary staff Porters Laundry Kitchens Estates	Infection Rates ROH Waste Management Hand hygiene NPSA Bacteria Pandemic Influenza Environmental Cleaning Isolation Precautions Communication with IPC	DOH EPIC2 WHO	Annual	Monthly	**July 2014**

Name of Course	Training Audience	Content	Rationale	Attendance Required	How Often Run	Review Date
Non-Clinical Training	Members Volunteers	Hand cleansing Isolation Precautions Infection Rates ROH Communication with IPC Pandemic Influenza	DOH EPIC2 WHO	Annual	Six Monthly	**May 2014**
Students	Nursing	Infection Rates ROH Waste Management Hand Hygiene NPSA Bacteria Isolation precautions VIPS Pandemic Influenza Communication with IPC Inter-departmental Transfer	DOH EPIC2 Saving Lives WHO NICE	According to Practice Placement Manager	6 weekly	**July 2014**
Central Venous Access Devices	Registered Practitioners Ward Nurses Theatre Staff High Dependency Clinical Staff	Aseptic Non-touch Technique Theoretical Framework Hand Hygiene NPSA	DOH EPIC2 Saving Lives WHO NICE	Annual	Bi-Monthly	**May 2013**

13.2 Appendix 2:

Primary Objective:
Minimise harm to patients and to protect staff by eradication of all avoidable healthcare associated infections within the Royal Orthopaedic Hospital NHS Foundation Trust.

Trust Objective:
Ensure safety and deliver outstanding performance for patients.
Deliver all CQC existing and national targets including reducing the incidence of avoidable infections

Principal risks	Intended outcome	Controls (In addition to IPC policies)	Local assurance	Board assurance	Action Plan	Lead	Due date	Initial RAG status
1.Variation in clinical practice leads to variable quality service – saving lives results static	To achieve green status on saving lives audits (over 90%)	1.Saving Lives programme 2.IPC training at induction 3.Actions implemented from RCA's	Saving lives results reported at Ward managers' performance / KPI meetings with exception reports to ICC for close scrutiny.	Bi monthly ICC report to Quality Committee and Trust Board.	Each Ward to develop a plan to ensure completion of audits and improvement in practice to an acceptable level (>95%) Contract requirement by end Q4 2012-13.	CSM's / Senior Nurses	End March 2013	
Status end 2012-13: Saving Lives now being undertaken by all wards and compliance is improving. Reported monthly internally and externally – target for compliance agreed at 90%								End of Q4.
2.Limited surveillance reporting reduces drive for change and improvement – extend to include SSI for all specialities	To establish baseline rates in areas not currently observed.	1.ICNet implemented 2. Baseline data collated for Spinal and foot surgery initially – then rolled out further. 3.Continued surveillance of arthroplasty – 100% of SSI forms submitted correctly	Results reported at ICC and to Consultants at audit every 6 months.	Quarterly reports to ICC regarding 30 day data and baseline data as it become available	Embed SSI surveillance for arthroplasty within theatres.	Theatre Manager		
					Extend SSI surveillance to include spinal surgery and foot surgery.	Lead IPC Nurse		
					Establish accurate links with NJR data to ensure arthroplasty activity data is correct	Lead IPC Nurse		
					Review and expand current HPA questionnaire – tailor questions to ROH	Lead IPC Nurse / Surgical IPC lead		
Status end 2012-13: Business case submitted December 2012 in order to expand surveillance – awaiting decision end of year – due to go through business planning in June 2013. SSI surveillance for arthroplasty well embedded throughout the organisation.								End of Q4

3.Risk of missing target of 6 post 48hr cases of Clostridium *difficile* 2012/13	To have no avoidable cases	1.Training of all staff regarding use of Bristol Stool Chart and CD saving lives HII 2. Review of all RCA's at ICC to establish cause and further work. 3. All cases reported as complications at audit. 4. SIRI's for outbreaks or linked cases.	Daily Lab report RCA's reviewed at ICC	RCA's reported at ICC – presented by Consultant and Ward Manager	RCA's to be completed by Consultant and Ward Manager – advice available from IPC.	WM's/ Consultants	on-going	
					Implement *C.difficile* High Impact Intervention	IPCT/ WM's	On-going-each case	
					Education for nursing and junior medical staff regarding stool sampling to be provided – update mandatory training.	IPCT	On-going	
Status end 2012-13: 1 case reported in June 2012. Vigilant monitoring of patients with diarrhoea introduced by IPCT. Education included for all staff on mandatory training								End of Q4
4.Risk of missing target of 0 MRSA bacteraemias 2012/13	To have no avoidable MRSA bacteraemias	1. MRSA screening – adherence to policy. 2.RCA / SIRI investigations 3.ANTT training and competencies	Daily Lab report. RCA reports reviewed at ICC.	RCA's reported at ICC – presented by Consultant and Ward Manager	RCA's to be completed by Consultant and Ward Manager – advice available from IPC.	WM's/ Consultants	Ongoing	
Status end 2012-13: 0 cases reported. Last Trust apportioned MRSA bacteraemia reported in May 2008								End of Q4
5.Avoidable exposure to influenza due to low levels of vaccination	To implement a robust vaccination programme and increase uptake to 50% of all staff.	1.annual flu vaccination campaign	Progress reported to and monitored by Emergency Planning Committee	Uptake reported to Integrated Governance Committee	Set up specific vaccination programme for ROH	SN/SM	Commence Oct 2012	
					Mobile vaccination clinic to visit all clinical areas to ease access for all staff.			
					IPC to report uptake to Immform or other database as directed by the PCT			
Status end 2012-13: Mass vaccination programme undertaken – unfortunately uptake not as high as plan due to lack of media profile. Staff reluctant to have vaccination as perceived risk was low. 40.9% of staff vaccinated – comparable with other Trusts within the region. Difficult to see how this could have been improved.								End Q4

6. Poor compliance with hand hygiene policy	Improve hand hygiene across all staff groups to >85%	1.Bi-monthly reporting of results to ICC 2.Monthly reporting to PCT via minimum dataset	Monthly link nurse audits. Monthly reports to WM's Bi monthly reports to ICC.	Monthly performance reports on WM's KPI's – to Director of Nursing	Monthly Link Nurse audits – reported to ICC / WM's Monthly results displayed on ward 'Bug board'. Improve signage across all areas Specific staff targeted if compliance falls below 85%.	IPCT/ WM's IPCT/ WM's SM/ IPCT Senior Nurses	On-going	
Status end 2012-13: Hand hygiene compliance reported internally and externally monthly. Weekly audits undertaken by area and staff group utilising WHO 5 moments. Compliance maintained above 90% all year. Significant improvements made. New signage introduced – well received.								End of Q4
7.Failure to maintain standards ready for next CQC inspection	To maintain compliance with Hygiene Code	1. Policy update monitored by IPCT and ICC 2. audit results and IPC reports monitored and action plans in place	ICC bi-monthly meetings	Bi monthly ICC report to Quality Committee and Trust Board.	Audit calendars in place for all clinical areas – results reported monthly to WM's and bi – monthly to ICC. Non-compliance managed formally by Senior Nurses and CSM's	Lead IPC Nurse/ SN's and CSM's	On-going	
Status end 2012-13: Standards maintained – regular audits undertaken by facilities, IPCT and Ward Managers / Matrons.								End of Q4.
8. Maintain compliance with antimicrobial guidelines	Improve compliance	1.Antimicrobial audits undertaken by pharmacy 2.Policy available on Intranet 3.Pocket guides provided to all prescribers 4. Effective and compliant prescribing included in Dr's induction training. 5. All prescribers including Non-Medical	Antimicrobial audits reported to ICC	Bi monthly ICC report to Quality Committee and Trust Board.	Pocket guide for all prescribers Relaunch guidelines with letter from DIPC Re audit every 4 months Mandatory training is attended by all staff including pharmacists, non-medical prescribers etc. Presentation includes specific prescribing information and discussion around Trust guidelines. Doctor's induction also includes these topics.	SM SM/ LW MM SM	On-going from May 2011	

<table>
<tr><td></td><td></td><td>Prescribers and pharmacists to be provided with written information regarding Abx prescribing.</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="8">Status end 2012-13:
Audits undertaken by pharmacy. Compliance adhered to, training provided to all doctors at induction.</td><td>End of Q4</td></tr>
<tr><td rowspan="4">9. Surgical site Infection rates – aim to reduce rates in primary arthroplasty</td><td rowspan="4">Reduce SSI rate in primary arthroplasty by rate agreed at ICC</td><td rowspan="4">1. Enhanced surveillance to be introduced by IPCT.
2. Reported quarterly to ICC.</td><td rowspan="4">Results reported to ICC / clinical outcomes every year.</td><td rowspan="4">Quarterly reports to ICC.</td><td>All patients failing to return questionnaire or those reporting a problem to be followed up by IPC/ ROCS.</td><td>SM / IPC</td><td rowspan="4">On-going from July 2012</td><td rowspan="4"></td></tr>
<tr><td>Criteria for SSI to be investigated</td><td>SM / DD</td></tr>
<tr><td>Agree internal measure for greater scrutiny within ROHFT</td><td>SM/ DD / LW</td></tr>
<tr><td>Continue to report external measure (HPA Questionnaire) to allow benchmarking.</td><td>SM</td></tr>
<tr><td colspan="8">Status end 2012-13:
SSI closely monitored and reported to ICC and Medical Director for action where necessary. Rate has improved since 30 day surveillance commenced in 2009. Rate now:
30 day SSI rate by Year
<table>
<tr><th></th><th>2009</th><th>2010</th><th>2011</th><th>2012</th></tr>
<tr><td>Primary Hip</td><td>2.8</td><td>3.4</td><td>2.9</td><td>1.9</td></tr>
<tr><td>Primary Knee</td><td>7.1</td><td>5.7</td><td>5.7</td><td>4.9</td></tr>
</table></td><td>End of Q4</td></tr>
<tr><td rowspan="2">10. Elicit baseline outcome data from Bone Infection Unit – new service therefore outcomes not previously known.</td><td rowspan="2">To set up a database and elicit 1st year outcome data.</td><td rowspan="2">1. Outcomes to be discussed at clinical audit.</td><td rowspan="2">Results reported to ICC and audit.</td><td rowspan="2">1st report due after the service has been in place for 12 months (October 2012)</td><td>Set up database according to criteria set by lead clinicians</td><td>SM/PJ/AP</td><td rowspan="2">End March 2013</td><td rowspan="2"></td></tr>
<tr><td>Report to consultant body at the end of the first year and then review the service.</td><td>SM/PJ/AP</td></tr>
<tr><td colspan="8">Status end 2012-13:
BIU successful new service – now considered ‘normal business’ for ROHFT. Over-performed during 2012-13 and provided assistance to 179 patients. Outcomes collected but too early to collate – will be available end March 2014.</td><td>End of Q4</td></tr>
</table>

13.3 <u>Appendix 3:</u>

The Royal Orthopaedic Hospital NHS Trust Infection and Prevention and Control Annual Plan 2013/14

Primary Objective:
Minimise harm to patients and to protect staff by eradication of all avoidable healthcare associated infections within the Royal Orthopaedic Hospital NHS Foundation Trust.

Trust Strategy:
By 2016 our ability to provide the best care, by the best people, in the best hospital will ensure our future as an independent organisation.
Ensure safety and deliver outstanding performance for patients.
Deliver all CQC existing and national targets including reducing the incidence of avoidable infections

Principal risks	Intended outcome	Controls (In addition to IPC policies)	Local assurance	Board assurance	Action Plan	Lead	Due date	Risk Status April 13
1.Limited surveillance reporting reduces drive for change and improvement – extend to include SSI for all specialities	To establish baseline rates in areas not currently observed.	1.ICNet implemented 2. Baseline data collated for Spinal and foot surgery initially – then rolled out further. 3.Continued surveillance of arthroplasty – 100% of SSI forms submitted correctly	Results reported at ICC and to Consultants at audit every 6 months.	Quarterly reports to ICC regarding 30 day data and baseline data as it becomes available	Submit business case in order to expand surveillance across all specialities.	Lead IPC Nurse	July 2013	
					<u>If business case is agreed</u>: Extend SSI surveillance to include spinal surgery and foot surgery.	Lead IPC Nurse	Within 3 months of case being agreed.	
					Contact all non-returns by telephone in order to increase accuracy of arthroplasty surveillance.	Lead IPC Nurse	Commence July 2013	
					Review and expand current HPA questionnaire – tailor questions to ROH	Lead IPC Nurse / Surgical IPC lead	September 2013	
Status Update - end Q1 2013-14:								
2.Risk of missing target of 2 post 48hr cases of Clostridium *difficile* 2013/14	To have no avoidable cases	1.Training of all staff regarding use of Bristol Stool Chart and CD saving lives HII 2. Review of all RCA's at ICC to establish cause and further work. 3. All cases reported as complications at audit. 4. SIRI's for outbreaks or linked cases.	Daily Lab report RCA's reviewed at ICC	RCA's reported at ICC – presented by Consultant and Ward Manager	RCA's to be completed by Consultant and Ward Manager – advice available from IPC.	WM's/ Consultants	on-going	
					Education for nursing and junior medical staff regarding stool sampling to be provided – mandatory training.	IPCT/	On-going-each case	

Status Update - end Q1 2013-14:								
3.Risk of missing target of 0 MRSA bacteraemias 2013/14	To have no avoidable MRSA bacteraemias	1. MRSA screening – adherence to policy. 2.RCA / SIRI investigations 3.ANTT training and competencies	Daily Lab report. RCA reports reviewed at ICC.	RCA's reported at ICC – presented by Consultant and Ward Manager	RCA's to be completed by Consultant and Ward Manager – advice available from IPC.	WM's/ Consultants	Ongoing	
Status Update - end Q1 2013-14:								
4.Avoidable exposure to influenza due to low levels of vaccination	To implement a robust vaccination programme and increase uptake to 50% of all staff.	1.annual flu vaccination campaign	Progress reported to and monitored by Emergency Planning Committee	Uptake reported to Integrated Governance Committee	Set up specific vaccination programme for ROH Mobile vaccination clinic to visit all clinical areas to ease access for all staff. IPC to report uptake to Immform or other database as directed by the PCT	SN/SM	Commence Sept 2013	
Status Update - end Q1 2013-14:								
5. Implement AFPP standards throughout theatres	To assist the theatre management team to introduce and embed the AFPP standards.	1.Theatre management action plan	Progress to be reported to ICC for monitoring and assistance with enforcement if necessary.	CQC workshops and ICC scrutiny	Theatre management to ensure reports to ICC are submitted in a timely manner Theatre management team to source advice and support from AFPP, IPC and outside sources if required Discussions to be held with theatre team and Consultant staff to raise awareness Set up an 'Infection' study day within ROH to increase knowledge base regarding SSI and BIU	MP/LP/SM/PJ/ AP	Ongoing	
Status Update - end Q1 2013-14:								

6.Failure to maintain standards ready for next CQC inspection	To maintain compliance with Hygiene Code	1. Policy update monitored by IPCT and ICC 2. audit results and IPC reports monitored and action plans in place	ICC bi-monthly meetings	Bi monthly ICC report to Quality Committee and Trust Board.	Audit calendars in place for all clinical areas – results reported monthly to WM's and bi – monthly to ICC. Non-compliance managed formally by Senior Nurses and CSM's	Lead IPC Nurse/ SN's and CSM's	On-going	
Status Update - end Q1 2013-14:								
7. Surgical site Infection rates – aim to reduce rates in primary arthroplasty	Reduce SSI rate in primary arthroplasty by rate agreed at ICC	1. Enhanced surveillance to be introduced by IPCT. 2. Reported quarterly to ICC.	Results reported to ICC / clinical outcomes every year.	Quarterly reports to ICC.	All patients failing to return questionnaire or those reporting a problem to be followed up by IPC/ ROCS.	SM / IPC	On-going	
					Criteria for SSI to be investigated	SM / DD		
					Agree internal measure for greater scrutiny within ROHFT	SM/ DD / LW		
					Continue to report external measure (HPA Questionnaire) to allow benchmarking.	SM		
Status Update - end Q1 2013-14:								
8. Bone Infection Unit outcome monitoring	To set up a database and elicit outcome data.	1. Outcomes to be discussed at clinical audit.	Results reported to ICC and audit.	Report due annually – March	Set up database according to criteria set by lead clinicians	SM/PJ/AP	March 2014	
					Report to consultant body annually	SM/PJ/AP		
Status Update - end Q1 2013-14:								

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 25th September 2013 **Enclosure Number: 11**

REPORT TO TRUST BOARD

AUTHOR	**Tauny Southwood / Lindsey Webb** **NED, Chair of IGC / Director of Nursing and Governance**
TITLE	**Feedback from the Integrated Governance Committee (IGC) meeting of 20th September 2013**

SUMMARY

1. COEC and PROMS: Mr Tillman reported that discussions were ongoing between specialist Orthopaedic Trusts to ensure that the PROMS data are fit for purpose. For example, the ROH performs much better when compared to its peer group rather than the wider community of orthopaedics in general NHS Trusts, due to mismatch in the numbers of complex procedures such as joint replacement revisions. A further report from a meeting of the Specialist Orthopaedic Alliance was expected soon. Additionally, IGC were assured that the ROH was responding to the need to improve patient experiences and outcomes by planning more specialist physiotherapy post op rehabilitation, by considering changes in the post op clinical pathway including discharge timing and by investigating cultural influences on outcome factors such as post operative pain.

2. IGC asked that Mr Tillman conveyed IGC support for Mr McBride's leadership and plans for the Clinical Audit Committee, and would ask for an update after Mr McBride's first 6 months in post, particularly around numbers of robustly designed clinical audits, inclusion of cross- and multi- disciplinary audits from anaesthetics, radiology and histopathology, and changes in clinical audit meeting reporting. There was concern that the Annual Anaesthetic Audit Plan comprised a list of patient surveys and service evaluations rather than clinical audits, and that the report did not contain a plan. A paper from NRES 2007 was tabled detailing the differences between clinical audit, research and service evaluation.

3. IGC noted with concern that there was no report from the Drug and Therapeutics Committee and asked Mr Tillman to follow this up.

4. Reports from the Emergency Planning Group and Infection Control Committee were noted. Ms Mimmack's excellent report to the Clinical Audit Meeting was noted, and further discussion centred on ensuring that her recommendations for improving the infection risk areas of the operating theatres were completely implemented. Ms Webb assured IGC that a regular program of theatre shut down for essential estates maintenance has been instituted. The Medical Director, Mr Pearson will be taking on the role of Director of Infection Prevention and Control and therefore taking up the Infection Committee chair position, a move that was welcomed by IGC.

5. IGC noted that the new Corporate Risk Register system was being implemented and Ulysses was being populated with the relevant data.

6. A report on the Members Council Patient Experience Group indicated that more information on the patient experience was being sought and that future meetings would also discuss ROH generated data on patient experiences including complaints, delays, falls, surveys, etc. This was welcomed by IGC as part of the implementation of the recommendations of the Francis Report.

7. IGC was concerned that the new NHSLA system, being implemented in order to improve efficiency and minimise costs, might actually have the reverse effect. Francis Kirkham agreed to work with the incoming Director of Nursing to evaluate the potential impact on the ROH.

8. Finally, proposed changes to the Board Committee structure were discussed, and the idea of a revised Clinical Governance Committee (CGC) concentrating on patient safety and clinical effectiveness were considered in some detail. Of the existing IGC tasks, it was felt that Workforce, review of performance management structures and the Staff Survey warranted a unique reporting stream via EMT to the Board. A number of other tasks were not felt to be appropriate in the re-focussed CGC, including IM&T, Emergency planning, compliance with mandatory services and membership, and some aspects of the Quarterly Declaration. Ensuring that the revised "Audit Committee" be renamed and separated from CGC in reporting requirements. Additionally, it was suggested that each CGC meeting might consider at least one topic in more detail on a rolling, annual basis, perhaps accompanied by a "walkabout" component.

RECOMMENDATIONS

The Audit Committee / Board are asked to;

- **Note** the assurances provided by the IGC meeting
- **Recommend** changes to future reports
- **Identify** any further areas that they would wish IGC to provide assurance on

Date of Trust Board: 25 September 2013 **ENCLOSURE NO: 12**

REPORT TO THE AUDIT COMMITTEE

NAME OF DIRECTOR PRESENTING	Andrew Meehan
AUTHOR(S)	Paul Athey

TITLE	Audit Committee Annual Report to the Trust Board

SUMMARY

This annual report is the culmination of the work of the Audit Committee in relation to the 2012/13 financial year and formalises our conclusions in terms of the following areas:

- Committee annual work plan;
- Assurance to the Trust Board;
- The financial statements;
- Liaison with Internal and External Auditors;
- The Assurance Framework and control arrangements; and
- Ad-hoc reviews.

The Audit Committee has provided assurance to the Trust Board quarterly and in summary for the 2012/13 financial year the committee concluded:

- The financial statements for the year ending 31st March 2013 reflect a true and fair position and there are no significant issues within the external auditors report to those charged with governance that need to be reported to the Trust Board;
- The Annual Governance Statement reflected the Committee's knowledge of the Trust and no further disclosures were required;
- The Committee regularly visited the Trusts Programme Management Office (PMO) and assured the Board that links between the CIP and quality measures are made and that every effort is taken to manage the patient safety and experience risks on each scheme
- There were no major issues reported in ad-hoc reviews to the Committee and there are not any significant matters arising from the discussions and reports that have not already been brought to the attention of the Trust Board by the Chair of the Audit Committee during in-year reports
- Following concerns raised in Quarter 2 around the classification of risk on the Board Assurance Framework, actions were put in place to ensure that robust assurance could be obtained in Quarters 3 and 4 of the identification and management of the Trust's key risks.
- Recent concerns were raised about the relationship between Audit Committee and IGC, and these concerns are in the process of being addressed by the Trust Board.

RISK & IMPLICATIONS

There are no risks from this report.

RECOMMENDATIONS

The Board are asked to note this report.

:

Audit Committee Annual Report to the Trust Board

Introduction

The Audit Committee provides a vital scrutiny role, upon which the Board of Directors should be able to rely on in discharging its duties.

The Committee Chair provides a report after each meeting and a Quarterly Assurance Statement to form part of the quarterly Trust Board assurance process. This annual report is the culmination of the work of the Audit Committee in relation to the 2012/13 financial year and formalises our conclusions in terms of the following areas:

- Committee annual work plan;
- Assurance to the Trust Board;
- The financial statements;
- Liaison with and gaining assurance from the Integrated Governance Committee (IGC)
- Liaison with Internal and External Auditors;
- The Assurance Framework and control arrangements; and
- Ad-hoc reviews.

Detail

The committee developed a formal work plan which is attached in Appendix A. The committee is satisfied that this plan covers the key areas that it is required to provide assurance to the Trust Board and discharge its responsibilities.

The summary assurance statements are shown in Appendix B and it can be seen that the committee has been able to assure the Trust Board over the adequacy if the control environment and financial statements.

The Committee meets privately with the Trust's internal and external auditors and debates areas of concerns of Committee members and audit colleagues. There were no significant matters arising from those discussions that have not already been brought to the attention of the Trust Board by the Chair of the Audit Committee during in-year reports. The Committee is satisfied that it has appropriate access to and a relationship with both internal and external auditors.

The Committee has raised recent concerns about the relationship between Audit Committee and IGC, in particular the lack of clarity about lines of responsibility and the potential for issues either being duplication or missed. These concerns have been discussed via a Board workshop, and a review of the Board Committees structure and responsibilities is currently being undertaken. This review will incorporate the shared views of the Chairs of Audit Committee and IGC.

Attendance at the Committee is shown in Appendix C.

Conclusion

The Audit Committee has provided assurance to the Trust Board quarterly and in summary for the 2012/13 financial year the committee concluded:

- The financial statements for the year ending 31st March 2013 reflect a true and fair position and there are no significant issues within the external auditors report to those charged with governance that need to be reported to the Trust Board;
- The Annual Governance Statement reflected the Committee's knowledge of the Trust and no further disclosures were required;
- The Committee regularly visited the Trusts Programme Management Office (PMO) and assured the Board that links between the CIP and quality measures are made and that every effort is taken to manage the patient safety and experience risks on each scheme
- There were no major issues reported in ad-hoc reviews to the Committee and there are not any significant matters arising from the discussions and reports that have not already been brought to the attention of the Trust Board by the Chair of the Audit Committee during in-year reports
- Following concerns raised in Quarter 2 around the classification of risk on the Board Assurance Framework, actions were put in place to ensure that robust assurance could be obtained in Quarters 3 and 4 of the identification and management of the Trust's key risks.
- Recent concerns were raised about the relationship between Audit Committee and IGC, and these concerns are in the process of being addressed by the Trust Board.

APPENDIX A

Audit Committee Work Plan for the 2012/13

	18 Apr 2013	28 May 2013	16 July 2013	15 Oct 2013	10 Dec 2013	Feb 2014	Apr 2014
Action Points	√	√	√	√	√	√	√
Assurance Framework - Review of	√	√	√	√	√	√	√
Integrated Governance Committee - feedback	√	√	√	√	√	√	√
External Audit – Progress Report	√		√	√	√	√	√
Internal Audit - Progress Report	√		√	√	√	√	√
Internal Audit - Outstanding Audit Recommendations	√		√		√		√
External Audit - Outstanding Audit Recommendations	√		√		√		√
Counter Fraud – Outstanding Audit Recommendations		√	√		√		
Losses and Compensations	√		√	√		√	√
Hospitality Register - review of			√		√		
Accounting Policies - Review of					√		
Counter Fraud - Progress Report				√		√	
Breeches and Waivers of SFIs			√		√		
Counter Fraud - CFSMS Qualitative Assessment				√			
Counter Fraud - Approval of plan						√	
External Audit - Approval of plan and agree fees				√			
Internal Audit - Approval of plan						√	
Counter Fraud - Annual Report		√					
Annual Accounts - Draft Annual Report	√						√
Annual Accounts - Draft DoF Commentary on Accounts	√						√
Annual Accounts - Review of Draft Accounts	√						√
Annual Accounts - Annual Report		√					
Annual Accounts - DoF Commentary on Accounts		√					
Annual Accounts - Review of		√					
External Audit - Governance Statement		√					
Internal Audit - Head of Internal Audit Opinion - Draft	√						√
- Final		√					
Review of Audit Committee work plan	√			√			√
Annual Risk Report - review of	√						√
Audit Committee - Annual Report			√				
Contract Risk Review				√			
Audit Committee - Terms of Reference review of				√			
Audit Committee - Self Assessment					√		

APPENDIX B

SUMMARY ASSURANCE STATEMENTS

Statement	Evidence and Assurance
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.	The Committee received, reviewed and challenged the Board Assurance Framework regularly during the year. Concerns were raised in Quarter 2 around the categorisation of risks, specifically questioning whether risks were scored in an overly cautious manner, whether they were recognised too early and whether long-standing red risks we being appropriately reviewed and managed. Actions were put in place by the Executive Management Team to address these concerns, and the Committee reported in Quarters 3 and 4 that they were happy with the progress being made against these actions. The committee received regular reports from the Integrated Governance and was assured by its progress. The Committee regularly visited the Trusts Programme Management Office (PMO) and assured the Board that links between the CIP and quality measures are made and that every effort is taken to manage the patient safety and experience risks on each scheme .
The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.	The Committee receives regular presentations and update from the Trust's Internal Auditors and reviewed the completed audit reports and recommendation tracking. The Committee received positive assurance from the Head of Internal Audit that there are robust internal controls in place within the organisation.

Statement	Evidence and Assurance
The Committee shall review the work and findings of the External Auditor appointed by the Foundation Trust and consider the implications and management's responses to their work.	The Committee also received an unqualified opinion on the Trusts financial statements from the External Auditor and were happy that the financial statements represent a true and fair view of the financial position. The Committee debated fully and in detail the key areas of management decisions and assumptions and were satisfied that these were reasonable. The Committee was satisfied and ratified the non-material unchanged errors in the financial statements and ratified the actions of the Director of Finance.
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.	The Committee regularly received assurances from the Director of Nursing and Governance on the Board Assurance Framework in terms of process and content. The Committee also met with Trust managers to go through areas of risk in detail and gain assurance that appropriate progress was being made to manage or address the risks appropriately. The Committee reviewed the Annual Governance Statement which reflected the Committee's knowledge of the Trust and no further disclosures were required.
The Audit Committee shall review the Annual Report and Financial Statements (wherever practical) before submission to the Board,	Using its delegated authority the Committee approved the 2011/12 accounts, having received presentations from the Director of Finance and External Audit, for submission to Monitor. The Committee was pleased to note the positive feedback received from External Audit.

Statement	Evidence and Assurance
The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.	The Committee reviewed all internal audit reports noting positive levels of assurance given for all of the key financial systems. The overall opinion given in the annual audit of the General Ledger & Budgetary Control was amber/green, reflecting the need for the Trust to update its Standing Financial Instructions and Standing Orders in line with its new service line management structure.
The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.	The Committee received assurance of the Trust's Counter Fraud service having received an external scoring assessment from NHS Protect which shows an increase in the score to the higher level of 3. The Committee received regular reports updating them on recent developments in the healthcare field for review and also discussed areas where further assurance could be gained by management. The Committee was satisfied that where assurance was asked for it was received.

APPENDIX C

MEETING ATTENDANCE 2012-13

TITLE	NAME	19/04/12	29/05/12	17/07/12	16/10/12	11/12/12	14/02/13
Non-Executive Director (Chairman)	R Otto	Y	Y	A	Y	Y	Y
Non-Executive Director	A Meehan						A
Non-Executive Director (Vice Chairman)	E Hensel	Y	Y	Y	Y	A	
Non-Executive Director	R Millinship	Y	A	Y	Y	Y	Y
Non-Executive Director	C Monk	A	A	Y	Y		
Non-Executive Director	E Mountford						Y
Non-Executive Director	T Pile						A
Director of Finance	S Bloomer	Y	Y	Y	Y		
Interim Director of Finance	P Taylor					Y	Y
Internal Audit	G Palethorpe	Y	Y	Y	A	Y	Y
Internal Audit	P Kaur						
Internal Audit	S Mallinson				Y		
Internal Audit	A Hussain				Y		
External Audit	G Miah	Y	Y	A		Y	A
External Audit	M Ramzan				Y		A

TITLE	NAME	19/04/12	29/05/12	17/07/12	16/10/12	11/12/12	14/02/13
External Audit	A Gilder		Y	Y		Y	Y
External Audit	C Malone						Y
External Audit	J Bingham		Y				
External Audit	A Claybrook		Y				
Counter Fraud Specialist	G Ball		Y		A	Y	A
Counter Fraud Specialist	M Elcock						
Director of Nursing & Governance	L Webb	Y					Y
Company Secretary	J Street	Y					
Chief Executive	D O'Donoghue		Y				
Deputy Director of Finance	P Athey	Y	Y		Y	Y	
Head of Financial Accounting	K Poole	Y	Y				
Deputy Director of Nursing	H Peakman	Y	Y		Y		
Head of Commissioning	G Hyland				Y		
Head of Facilities	E Bridge				Y		

KEY: A = Apologies Y = Did attend

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 25th September 2013 **ENCLOSURE NUMBER: 13**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Lindsey Webb** **Director of Nursing and Governance**
AUTHOR:	**Lisa Pim** **Interim Deputy Director of Nursing and Governance**
SUBJECT:	**Board Assurance Framework Risks 2013/14**

SUMMARY

The attached report gives details the one Board Assurance Framework Risk managed via Trust Board. It has recently been updated and transferred to the electronic risk register database ('Ulysses Risk Register').

IMPLICATIONS

Scrutiny and challenge of BAF risks is essential to ensure that any risks are identified and managed.

RECOMMENDATIONS

The Board is asked to:

- **Note** the attached risk paying particular attention to the current risk score and progress with planned additional assurances (actions plan) associated with this risk
- **Identify** any additional risks for inclusion onto the BAF/ CRR

.

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Risk Number & Version			
Risk Number & Version:	11 Ver 1	**Risk Level:**	2. BAF Prinicpal Risk

Risk Details			
Opened:	/ /		
Status:	Static	**Strategic Objective:**	2.3 Manage People To Enable To
Risk Type:		**Source Of Risk:**	
Team/Project:		**Risk Category:**	
Directorate:		**Risk Owner:**	Bryan Jackson
Monitoring Committee:		**Operational Lead:**	Joy Street

Details of the Risk	
Risk Description:	Executive Director Continuity and Corporate Memory
Causes:	Executive Director Continuity and Corporate Memory. Old ref: 155
Consequences:	3.0

Initial Risk Rating

Likelihood	***Consequence***				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	***Score : 16***	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	Score : 4	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Initial Risk Rating:	High (Red)
Initial Risk Score:	16

Current Controls & Assurances

Control Details:	Board turnover very high from November 2012 to October 2013. Regularly reviewed by Board and mitigated by prompt recruitment, appropriate and timely interim arrangements and effective handovers
Adequacy of Controls:	Adequate
Independent Assurance:	Regular review by remuneration committee of board Review of risk at each board meeting

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Current Risk Rating

Likelihood	*Consequence*				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	***Score : 12***	Score : 15
2 Minor	Score : 2	Score : 4	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Current Risk Rating:	Moderate (Orange)
Current Risk Score:	12

Additional Controls & Assurances

Priority:	
Action Lead:	Joy Street
Person Accountable:	

Action Details:

Progress:

Outcome:	Closed	**Completion Date:**	20/09/2013

Priority:		**Start Date:**	16/09/2013
Action Lead:	Bryan Jackson	**Target Date:**	25/09/2013
Person Accountable:	Joy Street	**Reminder Date:**	22/09/2013

Action Details:

Appointment of new CEO september 2013 - start dat early 2014
Interim Director of Nursing appointed end September 13
NED continuity for two ends of term being recommended to governors

Progress:

Target Risk Rating

Likelihood	*Consequence*				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	***Score : 4***	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Target Risk Rating:	Low (Yellow)
Target Risk Score:	4

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notifications			
Date:	**Notification Group:**	**Notified Staff Member:**	**Info Only:**
16/09/2013	Additonal Notification	Joy Street	N

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 25th September 2013 Enclosure Number: 14

REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Frances Kirkham**
AUTHOR:	**Graham Bragg**

TITLE: Trust Board Feedback From The Charitable Funds Committee

The new style committee including the additional representatives:-

Mr Joe Blackledge	Governor
Mrs Lynn Russell	Patient Facing member of staff
Mrs Yvonne Scott	Patient Representative

Met on Monday 16th September. The following key items were covered:-

- Frances Kirkham kindly agreed to chair this and future meetings of the Committee.

- The Committee reviewed the Charitable Funds Terms of Reference and made one amendment regarding the review period and agreed that they would recommend these Terms of Reference to the Trust Board for approval.

- The Committee considered the Business Plan as a frame work for operating on behalf of the Trust Board and agreed that this document would be recommended to the Trust Board.

- The Committee considered the Draft Work Plan for the period to May 2016, made some additions and agreed to recommend the revised Work Plan to the Trust Board.

- The Committee considered the Annual Report and Accounts and Auditors opinion on the accounts for 2012/13 and with some minor changes agreed that the Chair would approve the letter of representation and sign off the accounts for submission.

- A discussion was held regarding the schedule of funds noting their purpose and the current fund balances and it was agreed that a small number of these funds needed to be reviewed as to their activity and signatories.

- The committee considered five requests for use of Charitable Funds

    1. They agreed subject to discussions with the supplier of dressings that £20,000 would be allocated to enable a 12 month pilot to take place, to identify whether these new dressings would cut down surgical site infection.

    2. It was felt inappropriate that Charitable Funds be used for staff retirement gifts and consideration should be given to the recognition of staff whilst they were still employed for their contribution and this would be a main hospital issue. It was agreed that the Chief Executive would write to all the members of staff on their retirement.

    3. An outline proposal was put forward regarding the development of the Research and Teaching Centre. Members of the Committee requested that a presentation be given by the Medical and Executive leads on research at the next meeting to fully understand how this fitted into the long term strategy and how we could measure success of the significant investment.

    4. Discussion was held around putting forward proposals to support training for certain bands of staff that are unable to access funds currently and a proposal to refurbish the staff gym. Members wished that these proposals be developed further for consideration at the next meeting.

5. A request was made for improvement to the administrative building which was not supported.

- Members received the Investment Brokers Market update and a document from the Charities Commission relating to the role of the Trustee.

- It was agreed that the next meeting would be held in November at a date to be agreed.

RISKS AND IMPLICATIONS

There were none.

RECOMMENDATIONS

The Board asked to approve:-

The amended Terms of Reference – Appendix 1

The proposed Annual Plan – Appendix 2

The proposed Committee Work Plan – Appendix 3

Enclosure 1

Royal Orthopaedic Hospital NHS Trust

Charitable Funds Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as The Charitable Funds Committee.

1.1 The Trust Board is the corporate trustee and as such cannot delegate responsibility for the charity's overall priorities, strategy, budget and reporting responsibilities.

1.2 The Committee is a non-executive committee and as such has no delegated authority other than that specified in these Terms of Reference.

2. Delegate Authority

2.1 The Authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee.

2.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,

2.3 The Committee may act with such authority delegated to it by the Trust Board from time to time and in accordance with the legislation pertaining to the role of Trustees of Charitable Funds.

3. Accountability

3.1 The Trust Board

4. Reporting Line

4.1 The Trust Board

5. Objective

5.1 On behalf of all voting members of the Trust Board (being the Corporate Trustee In law under the Terms of the Charities Acts) oversee the day to day activities of the Charitable Funds in accordance with the Committee Terms of Reference.

6. Duties

6.1 On behalf of all Members of the Trust Board (being the corporate Trustee in law under the terms of the Charities Acts) the Committee will:-

- Develop and recommend for approval to the Trust Board (as the corporate Trustees) on an annual basis a business plan that sets out the strategy for the charity, its priorities for expenditure and how these priorities link with the business plan for the current year.

- Develop an annual work plan for the committee to be approved by the Board
- Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.
- Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds.
- Develop and recommend to the Trust Board a fundraising policy for the Charitable Funds.
- Develop and recommend to the Trust Board an investment strategy for charitable funds.
- Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds.
- Receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds and to review the regular investment reports supplied by the Trust's investment brokers if appointed.
- Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds
- Receive regular budgetary information in respect of each fund.
- Consider and approve the Annual Charitable Funds accounts and the Annual Report to the Charities Commission.
- Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance.
- Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds.
- To approve all individual items of expenditure within limits delegated by the Trust Board in accordance with the Charitable Funds Standing Financial Instructions.
- To consider all business cases involving the use of Charitable Funds.

7. Permanency

7.1 The Committee is Permanent

8. Membership

8.1 The Chairman of the Committee will be a non-executive director.

8.2 Other members

- A governor representative
- A patient representative

- A patient facing staff member
- All voting members of the Trust Board

8.3 At any meeting of the Committee, the Chairman if present shall preside. If the Chairman is absent from the meeting then another Non-Executive Director

9. Quorum

9.1 Four members of which one must be a Non-Executive Director and either Chief Executive Officer or Director of Finance

Secretariat

Head of Financial Accounting

Internal Executive Lead

Director of Finance

Frequency of Meetings

Meetings will be held four times a year.

Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

Minutes of the meetings will record conflicts of interest and what steps were taken to manage them.

Reporting

A report of the proceedings will be given by the Chair at the next Trust Board.

Review

The Terms of Reference of the Committee will be reviewed by the Trust Board every 1 year.

Enclosure 2

The Royal Orthopaedic Hospital NHS
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Report To	**Charitable Funds Committee**
Report Of	**Graham Bragg, Acting CEO**
Purpose of the Report	Annual Plan for the use of Charitable Funds for 2013/14
Recommendation	Members of the Charitable Funds Committee consider the Annual Plan for recommendation to the Trust Board for the current financial year.

1.00 1.01	**Detail** The charity's key purpose is to use its resources to support the NHS and specifically the services provided by the Royal Orthopaedic Hospital NHS Foundation Trust. The type of activities that the charity funds are training and research, provision of specialist medical equipment, staff development and services that would not normally be provided from NHS resources but enhance the patients' experience.
2.00	**Business Plan 2013/2014** The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Funds are available for supporting the activities of the hospital in line with the various requests from the donors of such funds. The Trust's strategic direction is as follows:- **"to provide the best care, by the best people, in the best hospital which will ensure our future as an independent organisation".** It is proposed that the use of charitable funds by the committee should support this strategic direction and the detailed strategic objectives. The members of the charitable funds sub-committee wish to encourage greater utilisation of the funds during 2013/14 recognising that any use should be for the use of the improvement of the services provided by the hospital for patients and to enhance its reputation. It is proposed that individual fund managers should be encouraged to put forward proposals to utilise the resources available to them in line with the donor's wishes. Members propose that schemes should focus on:- • The research and development of services and facilities to improve patients' experience and outcomes. • The development of staff to enable them to reach their career potential and provide first class service to patients.

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	• To improve physical facilities around the hospital to benefit patients and their relatives. • To consider projects which will enhance the reputation of the hospital
2.01	**Working Arrangements** It is intended that the Charitable Funds Committee would meet four times a year. In addition to considering proposals for the use of funds in excess of £5,000 per project, the committee would review the day to day management of the charitable funds in line with the work plan included at Enclosure 2
3.00	**Recommendation** Members of the Charitable Funds Committee are asked to consider this document and propose amendments in order that it can be forwarded to the Trust Board for ratification as the framework for activities during 2013/14.

Enclosure 3

The Royal Orthopaedic Hospital NHS
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CHARITABLE FUND COMMITTEE WORK PLAN

	COMMITTEE MEETING DATES											
DUTIES	**Sep-13**	**Nov-13**	**Feb-14**	**May-14**	**Sep-14**	**Nov-14**	**Feb-15**	**May-15**	**Sep-15**	**Nov-15**	**Feb-16**	**May-16**
Agree terms of reference for approval by the Trust Board.	✓											
Develop and annual work plan for the committee to be approved by the Trust Board.	✓											
Develop and recommend for approval to the Trust Board (as the corporate Trustees) on an annual basis a business plan that sets out the strategy for the charity, its priorities for expenditure and how these priorities link with the business plan for the current year.	✓			✓				✓				✓
Monitor the safeguarding of those assets donated or bequested, in cash or other form to the Trust's Charitable Fund.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Develop and recommend to the Trust Board a fundraising policy for the Charitable Funds.				✓								
Advise on the appointment of investment brokers to provide professional advice on the investment of Charitable Funds.			✓									
Receive and consider regular reports on income and expenditure from the Trust's Charitable Funds and to review the regular investment reports supplied by the Trust's investment brokers if appointed.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Monitor and review the banking, accounting and audit arrangements made in respect of the Charitable Fund.		✓										
Receive and review regular budgetary information in respect of each Charitable Fund.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consider and approve the Annual Charitable Fund Accounts and Annual Report to the Charities Commission.	✓				✓				✓			
Review Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of Charitable Funds within the Trust and, as far as practicable, ensure compliance.		✓										
To approval all individual items of expenditure within limits delegated by the Trust Board in accordance with the Charitable Funds Standing Financial Instructions.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
To consider all business cases involving Charitable Funds.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review arrangements and cover of Indemnity Insurance		✓								✓		
Annual review of administration charge			✓				✓				✓	
Annual Review of non-active funds			✓				✓				✓	

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PUBLIC TRUST BOARD MEETING
Notice of the Public Trust Board meeting to be held on Wednesday 25th September 2013 at 8.30 am in the Board Room

AGENDA

Apologies for absence: Tauny Southwood			To note	Time
Introductions & welcome			To note	08.30
Declarations of Interest	Register available on request from Company Secretary			
Minutes of the Trust Board meeting held on Wednesday 31st July 2013		Enc. 1	**For Board approval**	
Action Points		Enc. 2	To note	
Chairman's & Chief Executive's Updates	Bryan Jackson & Graham Bragg	Verbal	To note	08.45
Medical Director's Mid-Year Update Report	Andrew Pearson	Enc. 3	To note	09.00
Medical Staff Committee Report (no meeting held)	Graham Bragg			
Nursing Staff Report	Lindsey Webb			
Strategy and Organisation Development				
Capital Programme & Site Development	Amanda Markall/ Graham Bragg	Enc. 4	**For Board Approval**	09.15
Carbon Reduction Strategy Annual Report	Amanda Markall	Enc. 5	To note	09.30
Risk Assessment Framework	Joy Street	Enc. 6	To note	09.40
Quality Governance Framework	Lindsey Webb	Enc. 7	**For Board Approval**	09.50
Break				10.10

Performance Management/ Assurance Reports				
Corporate Performance Report & PMO	Paul Athey	Enc. 8 - to follow & presentation	For discussion	10.20
Director of Nursing & Governance Patient Safety Report	Lindsey Webb	Enc. 9	For discussion	10.45
Infection Control Annual Report	Lindsey Webb	Enc. 10 – to follow	To note	11.00
Integrated Governance Committee Report – 20th September 2013	Elizabeth Mountford	Enc. 11 – to follow	To note	11.10
Audit Committee Annual Report 2012/13	Andrew Meehan	Enc. 12	To note	11.25
Trust Board Risks	Bryan Jackson	Enc. 13	For Discussion	11.35
Board Committees & ad-hoc Groups not covered elsewhere				
Remuneration Committee – 31 July 2013	Bryan Jackson	Verbal	For discussion	11.45
Charitable Funds Committee – 16 September 2013	Frances Kirkham	Enc. 14	For discussion	12.00
Items for Executive Question Time/ CEO Bulletin				
Any Other Business				12.15
Date and Time of Next Meeting Wednesday 30th October 2013 Joint Council of Governors'/Trust Board Meeting				
Exclusion of the Press and Public The Board is asked to resolve 'that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.'	Chairman			
Private Trust Board Meeting				12.30

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Minutes of the Trust Board Meeting
held in public on Wednesday 25th September 2013 in the Boardroom

Present:
Dr Bryan Jackson, Chairman (Chair)
Mr Graham Bragg, Acting Chief Executive
Mrs Lindsey Webb, Deputy CEO & Director of Nursing, Governance & Strategy
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Mrs Amanda Markall, Director of Operations
Mr Robert Millinship, Non-Executive Director
Mr Tim Pile, Non-Executive Director
Mr Andrew Meehan, Non-Executive Director
Ms Elizabeth Mountford, Non-Executive Director
HH Mrs Frances Kirkham, Non-Executive Director
Professor Tauny Southwood

In attendance:
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Roger Tillman, Interim Deputy Medical Director
Ms Helen Shoker, Interim Director of Nursing and Governance

ACTION

09/13/1460 **Apologies and welcomes**
None

09/13/1461 **Introductions & Welcome**
None

09/13/1462 **Declarations of Interest**
No other Declarations of Interest than those registered previously.

09/13/1463 **Minutes of the Trust Board meeting held on 31st July 2013**
The minutes were approved as a correct record subject to the following amendements:

Agenda item 07/13/1450, Patient Safety Report, third bullet point should read, 'There had been a failure to undertake pregnancy testing in a patient who subsequently was exposed to radiation and who did not disclose their condition. The incidence morphine overdose had caused no adverse long term effect on the patient'.

09/13/1464 **Action Points**

The action notes were updated (see separate sheet).

09/13/1465 **Chairman's & Chief Executive's Update**

- BJ advised that interviews had taken place and a preferred candidate had been identified for approval by the Council of Governors.
- Lisa Pim had been appointed as Interim Deputy Director of Nursing & Governance
- Helen Shoker had been appointed as Interim Director of Nursing & Governance
- Andrew Pearson had been appointed substantively as Medical Director
- MSB, the organisation which had conducted work on staff engagement had presented findings to contributing staff and the interactive session allowed validation of their findings. EM reinforced this. RM felt it had been a really good piece of work.
- 22nd October is a development day for directorate leaders and this will consider MSB recommendations
- ADCU opened in August and minor snagging issues were being resolved as they occurred and patients were very happy. Official opening is on Friday 27th September at 12.45pm.
- A bid for £500k to support E-Prescribing had been made and was through the first stage. A conference call will take place on 26th September.
- PA, AP and GB had attended a Specialist Orthopaedic Alliance meeting on the 19th September where PROMS had been discussed (to be followed up by IGC and COEC). This connected with tariff implications.

09/13/1466 **Medical Director's Mid-Year Report**

AP presented a mid-year Medical Director's Report and highlighted the following issues:-

- Junior doctor rotas and cover at night as well as resultant cost pressures through use of locums.
- As a result of the revalidation requirements, letters (sent on four occasions) had gone to nine doctors yet to be appraised and after this they will receive correspondence from the GMC. There is potential impact on revalidation. AC felt that half of these will come through with a date by the end of September. ADM expressed concern at the risk this posed and AP explained that this could ultimately mean doctors who fail to be revalidated cannot practice although none of the nine are due for revalidation this autumn. BJ asked if appraisals were contractually required and AC confirmed they were not. AM asked if it could be made part of the contract and AC advised this would be possible. AP commented that doctors felt that

they were so important to the organisation that a sanction such as this would not apply to them. TS refined the argument by saying that with doctors it was always hard to replace the skills and this further fuelled the problem. RM congratulated AP for the efforts so far. LW commented that this was just one example of a firmer line being taken and AP acknowledged that the MSB work had highlighted staff concerns at differential treatment of staff groups in such regard. EM felt that the trick was to turn it from 'you have to' to 'you want to'. EM asked if there was any help needed and AP felt that he had further steps through the employment liaison advisor of the GMC. Elsewhere this had triggered action. **GB agreed to write to the chair of the Medical Staff Committee**. **GB**

The Board noted the update.

09/13/1467 **Medical Staff Committee Update Report**

No meeting had been held and no response had been received about medical records which GB had raised with the committee.

09/13/1468 **Nursing Staff Report**

Nothing to report – quarterly only

Strategy and Organisation Development

09/13/1469 **Capital Programme & Site Development**

AM presented the Site Development paper which includes the procurement strategy for the next phase of the site development plan including site demolitions.

FK advised that she had met Stuart Lovack and that it was technically possible to extend the contract and she would support any drafting necessary subject to her availability, but had yet to hear from him about this.

FK advised that staff procuring work should be made fully aware of the impact of their changing decisions on the cost of works.

ADM was concerned about value for money and asked for assurance that the hospital negotiated strongly. GB advised that the contract had originally been competitively tendered and in this instance 2010 fees had been agreed which the quantity surveyor advised was competitive.

TP asked when the Board would discuss the overall capital programme – as prompted by the demolition. AM advised that the site planning was underway and that the Trust needed to balance the phasing of capital spend on IT and buildings.

PA advised that a longer term view on capital was being prepared and BJ commented that the Trust should consider its phased financial investment. The low cost of capital results in low depreciation and this needs to be accounted for. **A full plan detailing planned capital spend should be presented in November under a business as usual arrangement, this could then be overlain with income projections.** **PA**

The Board approved the continuation of the established Design Team and main Contractor for the departmental relocations, site demolitions and refurbishment of the Short Stay Ward.

The Board approved the variation of the existing ADCU Contract to include site demolitions, car park works, departmental relocations and refurbishment of the Short Stay Ward.

09/13/1470 **Carbon Reduction Strategy Annual Report**

AM presented the carbon reduction end of year position 2012/13

The Trust's strategy is to meet the government's target for carbon reduction by reducing its carbon footprint from our base year in 2006 by 10% by the year 2015.

Chris Monk had been the Non-Executive Trust Board nomination and the Good Corporate Citizen's Group (GCCG) is the management group to oversee the delivery of the strategy. **ADM agreed to be the Non-Executive Director on the group.**

The strategy and targets for 2013/14 will be discussed and proposed at the next GCCG meeting which takes place in July 2013. BJ suggested that solar power should be explored.

The Board noted the report.

09/13/1471 **Risk Assessment Framework**

JS presented the Risk Assessment Framework. The Trust Board received a report at the end of the last financial year giving information on the draft Risk Assessment Framework (RAF) being proposed by Monitor to replace the Compliance Framework. The final version was published on 27th August 2013 and the paper provides the Board with assurance on the Trust's readiness to comply with this when it comes into effect on the 1st October 2013.

LW advised that the big issue was the unknown outcome of the CQC changes.

IGC had considered the report and advised the Board on the Trust's anticipated compliance with the terms of the RAF. Executive recommendations are that the Trust will maintain compliance with the requirements of the RAF.

09/13/1472 **Quality Governance Framework**

LW presented the Quality Governance Framework (QGF). At the Board workshop in August 2013 to undertake the self-assessment against Monitor's QGF Board members:

- Received a presentation from colleagues at Monitor on the QGF
- Reviewed the QGF and previous self-assessments
- Discussed and identified assurances and areas for further work
- Requested the Executive Team undertake a more detailed piece of work that would enable all Board members to have a better understanding of the assurances and areas for further work during 2013/14

This piece of work has now been completed, the output of which had been provided in the paper.

BJ and TP were concerned at the score of red for item 4b being overly affected by the current lack of IT. PA felt that this had been derived also from the effectiveness of feedback loops. TS suggested that rather than 4b being red, 4c should be red as the deficiencies were in effective usage. ADM felt that although systems were not yet perfect the information used was validated.

TS gave an example of the data available on clinical audit still not being sufficiently refined and robust to give real assurance. FK advised that the issue could be divided into one of external perspective and internal focus and that amber would always indicate the imperative for executive action.

The Board approved the self-assessment score against the QGF subject to the amendment of 4b to amber green; noted the associated action plan; and agreed to continue the quarterly review process by IGC for presentation to the Board to inform each declaration. **HS**

The Board clearly expected that all amber scores would be subject of executive attention to move towards green. **Execs**

Performance Management/Assurance Reports

09/13/1473 **Corporate Performance Report & PMO**

PA and AM gave a presentation on the August 2013 Corporate Performance Report. The presentation highlighted Monitor considerations on cancer targets and capital re-profiling; finance and CIPs; and the financial position to date.

AM explained the cancer treatment targets and alerted the Board to the possibility that the Trust might fail its 62 day cancer target in September. This was in part due to having had low numbers of patients and high incidents. In September there had been two breaches. The Trust often receives very late referrals from other Trusts and on occasion a Trust to which ROH refers then delays treatment resulting in both cases in ROH sharing breaches. The ROH always writes to late referring hospitals to ask that this be avoided in future. There is scope for Chief Executives to agree a re-allocation of breaches but this is not usually exercised in the interests of good partnership working.

GB explained that the specialist commissioners had adopted a positive approach to satellite provision in local Trusts as well as in the major centres of expertise and RT provided evidence of ROH receiving very late referrals from those Trusts too. BJ suggested that using data that has an impact on patients, the Trust should write to the commissioning group and cite examples. PA advised that the Local Area Team now handled this area and should be the focus of such communication. GB suggested that we join forces with the Royal National Orthopaedic Hospital on this matter.

TP suggested that ROH should run services in other hospitals as a way of enhancing quality and achieving localism. This would be considered by executives as part of the growth strategy.

AM confirmed that she would be working with her team on this over the next few weeks.

PA presented the changes in capital spend profile where spend on the CT scanner was brought forward, E-prescribing, IT schemes and Demolition had been re-profiled such that spend moved to 2014/15 and records scanning schemes had been removed.

PA reported that the overall financial position had worsened due primarily to activity numbers and a change in case mix. With the exception of day case performance, the Trust was now behind the year on year position and well behind the target which was based on the higher activity level of the year before last (2011/12). Encouragingly, first outpatient appointments were significantly up which should convert to surgery in the usual ratio.

Funding for Saturday working on a regular basis had now been approved in order to ensure that this was regularised. New employees would have 6 day week contracts and others would go through the consultation process for change.

Patient cancellations were under review, theatre operational meetings have been revitalised and directorate job planning are all factors being considered in terms of positive impact on performance.

Analysis of GP referral patterns is being used to identify areas for targeting and there appear to be very localised opportunities for this.

The team is accepting referrals from other Trusts and AM/AP are meeting Trusts to discuss opportunities.

ADM commented that Saturday working was always more expensive and asked what targets were set for in week work. PA responded that 90% of sessional utilisation was the target and this was above anything achieved so far. ADM asked if there would be a trackable report on progress towards achieving activity.

BJ asked how visits to GPs were being managed. AP had been developing an idea for a centralised resource who manages and co-ordinates the visits.

PA confirmed that the Trust would achieve a financial risk rating of 4 for the quarter. Directorates had made efforts to reduce agency costs and the executive team will sign off plans to reduce agency usage still further in the next few months. LW reminded the Board that the developments of ADCU had meant that additional staff had been needed to ensure adequate cover during the transitional periods.

The CIP Board was working well and directorate ownership was in evidence. Theatres and clinical support presented the most complex challenges and corporate services was also under-achieving. **It was agreed that a presentation on CIP schemes would be useful in supporting the Board's understanding at its November meeting**. BJ suggested that the team delivering a CIP be the ones to present. **PA/AM**

The Board noted the report and supported the approval of the re-profiling of the capital plan already given by the Chairman (with agreement of the Chair of Audit) in order to meet the Monitor deadline which was ahead of the board meeting.

09/13/1474 **<u>Patient Safety Report</u>**

LW introduced the Patient Safety Report and highlighted the following factors driving red for quality.

- The unexpected death automatically triggers a red score and initial findings suggest the Trust could not have done anything

differently.

- VTE risk assessment under-performance
- A grade 3 pressure ulcer had been identified on Ward 1 and significant steps had been made to change working practices on the ward. All staff involved were experienced and should have performed differently. Ward Managers had now received training in how to give direct messages about performance expectations. The leadership of this ward had now changed and GB asked if this person had sufficient support to support a culture change. LW advised that the matron is actively supporting and a Band 6 vacant post had now been filled. The directorate was also supporting the team with handovers being an example of improved process. AP and LW had visited the ward and spoken to patients and they were very happy. EM asked about the effect on the three staff and LW advised that it was different for each of them. There would be a financial penalty as a result.

The Board noted the Patient Safety Report

09/13/1475 **Infection Control Annual Report**

LW presented the Infection Control Annual Report for 2012/13. AP will become Director of Infection Prevention and Control (DIPC) when LW leaves the Trust.

The Trust work on surgical site infection was outlined and there were opportunities from other Trusts to further develop this work. As a result of the charitable funds investment the Trust will be able to produce papers and evidence which will, in turn, stimulate more demand.

The Board approved the Infection Prevention and Control Annual Report

09/13/1476 **Integrated Governance Committee Report – 20th September 2013**

TS presented the Integrated Governance Committee report following the last meeting held on the 20th September 2013.

Outcomes had been a key discussion area. GB updated that the SOA had looked at these and all specialist Trusts were in a similar position but the ROH should not be complacent. TS reported that RT had advised of several positive things that were happening.

Clinical Audit was now being led by Callum McBride and a clear steer on what audit was and was not, was provided. The report given to surgical audit by the infection control lead had been excellent and the follow-through and embedding of recommendations was something to pursue.

The patient experience group will be receiving more information and will be revamped later in 2013.

The NHSLA had changed its policy and FK will be taking ideas forward with the Interim Director of Nursing & Governance and Alison Braham from the governance team.

The Board noted the update.

09/13/1477 **Audit Committee Annual Report**

ADM presented the annual report of the Audit Committee. The key area outstanding were terms of reference vis a vis clinical governance and the review of risk registers.

The Board approved the Annual Report of the Audit Committee.

09/13/1478 **Trust Board Risks**

The Board approved the risk rating.

Board Committees & ad-hoc Groups not covered elsewhere

09/13/1479 **Remuneration Committee – 31 July 2013**

BJ reported that the Committee had recommended a candidate for appointment as Chief Executive.

09/13/1480 **Charitable Funds Committee – 16th September 2013**

FK reported on the Charitable Funds Committee meeting held on the 16th September 2013.

A governor, staff member and patient had joined the committee.

Requests were for spend were broad propositions rather than worked up proposals. The committee recommends that the Board support funding for dressings and asks Ed Davis to work up further and present a proposal for the research and development facility.

The work of the committee and opportunities for funding should be widely publicised across the hospital. The next meeting will be in November 2013.

The Committee will make recommendations to the Board for ratification after each of its meetings.

09/13/1481 **Items for Executive Question Time/CEO Briefing**

- Staff changes
- Staff engagement
- Charitable funds

09/13/1482 **Any Other Business**

AM reported that the Trust had been approached by the BBC to return on the 11th October to see the progress made within catering. Patient feedback had improved dramatically as had waste. Café Royal is making additional revenue and all staff have development plans.

FK raised concern that the programme would be fair given what the Trust knows. BJ had concern at the reaction of the media if we said no and if there remained substantiated criticism the Trust should address it.

It was felt that the programme's intent was to show that their initial programme's intervention had worked.

The Board agreed that the BBC be invited back to demonstrate the improvements and the staff should be actively involved to prepare and manage the process insofar as this was possible.

The Chairman thanked Bob Millinship and Lindsey Webb for their considerable contribution to the organisation over the last few years.

09/13/1483 **Date and Time of Next Trust Board Meeting**

Wednesday 30th October 2013 (Joint Trust Board/Council of Governors' Meeting)

The Board resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

The Royal Orthopaedic Hospital NHS
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PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 25TH SEPTEMBER 2013

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
07/13/1443	Board Committees Committee's to review ToR and make amendments ready for formal adoption in October.	ADM/TS/ JS/PA	October 2013		
04/13/13 97	Q4 Workforce Report Appraisal forms to be refreshed.	AG	Nov 2013		Part of implementation of new national pay deal in 2013/14.
07/13/1446	Spinal Deformity Presentation GB to review the situation with outcomes data.	GB	September 2013		Meeting arranged 30/9
05/13/1414 09/13/1466	Medical Director's Report Mid-year review to be given to the Board in September. GB to write to the Chair of MSC	AP GB	September 2013 October 2013	√	Discussed at Sep meeting.
05/13/1415	Medical Staff Committee Update Report Executive Directors to consider radiological staffing and to report back to the Board in July. Report to be completed by October.	Execs	October 2013		The Board were updated that a wider project is now being undertaken with input from the Intensive Support Team to understand better both additional workforce and additional equipment (in particular MRI) requirements. It was agreed that a report would be completed by October 2013.

07/13/1440	Destruction of Hospital Notes Chairman to agree any executive proposals with the Acting CEO.	BJ/GB	September 2013	√	On-going
05/13/1420	Capital Programme GB to discuss with AM investment of beds and chairs for ADCU to ensure of a high standard.	GB	October 2013	√	Equipment all supplied.
05/13/1424	National Inpatient Survey Timescale for improvement around food to be determined. The Board noted the results of the 2012 National Inpatient Survey and supported the monitoring of the action plan to address the findings by the Quality Committee.	AM	October 2013	√	Satisfaction standards maintained detailed at Sep meeting. Follow up with James Martin agreed.
05/13/1425	Equality Duty Report Data to be tracked over time in order to ensure that the Trust improved in meeting its diversity obligations.	AC	Feb 2014		Progress to be included in next annual Equality Duty Report
07/13/1438	Marketing AP to provide contact for potential marketing expert. Action plan and timetable to be provided for EMT to consider action.	AP JS	August 2013 August 2013	√ √	EMT Oct.
07/13/1442	Francis Report NED's to contact LW regarding involvement with Francis working groups.	NED's	August 2013	√	Groups established and meeting.
07/13/1444	Council of Governors' Constitution Comments on the constitution to be sent to JS by 15 August. JS to contact lawyers and feedback with their views and a timetable at the September Board meeting.	ALL JS	15 August 2013 September 2013		Lawyers contacted and awaiting a response.
07/13/1445	Board Assurance Framework Finance risk to be added to the BAF.	PA	September 2013	√	

07/13/1447	Proposal for Option Appraisal Commercial Tissue Requests Process to be fully explained to theatre staff.	ED	September 2013		
07/13/1452	Audit Committee Report Annual Report of the Audit Committee to be considered by the Board in September.	JS	September 2013	√	On the September Board agenda.
07/13/1453	Trust Board Risks JS/GB to update the risk treatment action plan.	JS/GB	September 2013	√	On agenda
07/13/1456	Investment Committee Letter of intent to BVT confirming the Trust's aspiration to offer physiotherapy services in the Health & Wellbeing Centre on the site subject to a business case to be actioned. GB/PA to meet to prepare a submission for potential support from charitable funds for work to reduce SSI's.	GB GB/PA	August 2013 September 2013	√ √	Letter of intent approved by legal advisor and sent to BVT. Met with Charitable Funds.
09/13/1469	Capital Programme & Site Development A full plan detailing planned capital spend to be presented in November under a business as usual arrangement, this could then be overlain with income projections.	PA	November 2013		
09/13/1472	Quality Governance Framework 4b to be amended to amber green. All amber scores to be subject of executive attention to move towards green.	HS Execs	October 2013	√	Done
09/13/1473	CPR A presentation on CIP schemes to be provided to the Board's at its November meeting.	PA/AM	November 2013		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enclosure 3

Medical Directors Report to Board
October 2013

During the month of October, as well as my routine medical director work, I have performed the following activities:

Meetings

A. External – Personal Development

1. Case Manager Training Day - Birmingham
Training arranged by NCAS and supported by RST to enable me to lead on investigations bringing expertise to the resolution of concerns about professional practice.

2. Electronic Document Management in Healthcare, Manchester
Meeting to discuss and present solutions to resolving the challenge of a 'paperless' NHS by 2018.

3. Responsible Officer Network – Birmingham
Quarterly meeting of regional ROs.

4. Medical Directors Forum – Birmingham
Regional (NHS England –Midlands & East) forum to support and inform secondary and tertiary care medical directors.

B. Internal

1. Quality Committee

2. Strategic Estates Planning Group

3. Program Board Meeting

4. Trust Board Links
Governance and Theatre links meetings.

5. Cost Improvement Program Meeting

6. Directorates Development Day

7. Joint Clinical Contracting Group

8. Information Governance Group

9. Elderly Patient Francis Task & Finish Group

10. GP Trainee Meeting

11. ADCU problem resolution group

<u>One to One Meetings</u>

CD for Out Patients and Support Services
Chief Executive
Director for Nursing & Clinical Governance
Caldicott Regulator

<u>Miscellaneous</u>

1. Enhanced Recovery Project Group
2. Patient Complaint Meeting
3. Walk-about with Director of Nursing and Clinical Governance

<u>On going Issues</u>

1. Consultant competence investigation – case manager. MDU rep meeting

Andrew Pearson
30th October 2013

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 October 2013 **ENCLOSURE NUMBER: 4**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Graham Bragg**
AUTHOR(S)	**Andrew Thomas**

TITLE	**Medical Staff Committee Report**

SUMMARY

This paper provides an update from the Medical Staff Committee held on 27 September 2013.

RISK & IMPLICATIONS

RECOMMENDATIONS

The Board is asked to note this update.

Medical Staff Committee Report September 2013

This is a summary of discussions held at the Medical Staff Committee held on Friday 27 September 2013. The Chair of the meeting was Mr Andrew Thomas, in the absence of the regular chairs.

The open meeting commenced. Graham Bragg, Acting Chief Executive joined the assembled medical staff and updated the committee on the following issues:

Chief Executive Appointment

The Trust Board have agreed the appointment of Jo Chambers as Chief Executive and Graham gave an overview of Jo's career background.

Deputy Chairman and Senior Independent Director

The Board of Governors have agreed that Tim Pile, Non-Executive Director will take on the role of Deputy Chairman and Senior Independent Director for the Trust.

IT

Graham gave an update with regard to IT and confirmed to the committee that the Chief Information Officer had left the Trust however the IT investment programme would not be stopped. A number of IT programmes are being evaluated and the Trust are keen to implement e-prescribing and have submitted a bid to the NHS England Technology Fund for £500,000 to support this. The Trust should find out if they have been successful at the end of October. The Trust will be looking to appoint a permanent Chief Information Officer. Mr Thomas emphasised the importance of the involvement of clinicians at the heart of IT, which is very much DoH policy. Graham requested support from the medical staff regarding representation at the IT Programme Board and specific IT committees and various clinicians offered their support.

MSB Staff Engagement Feedback

Graham encouraged all staff to attend the staff engagement exercise feedback meeting.

ADCU

Graham reminded staff of the official ADCU opening ceremony. A number of consultants raised issues relating to ADCU there was felt to be a need for clinician involvement in sorting the problems out. Members were advised by the Medical Director to raise these concerns at the ADCU meeting which is held at the end of every day and he also asked for volunteers to join the Theatre User Group meeting where ADCU will be discussed. (Meeting is scheduled for the evening of Tuesday 29th of October)

CT Scanner

Graham advised members that the Executive Management Team had agreed that purchase of a new CT scanner which would be bought before the end of March 2014.

Notes Destruction

Graham noted concerns raised by assembled members regarding the destruction of patient notes. Noted that the issue had been discussed on a number of occasions at the Clinical Directors meeting and that Clinical Directors had been involved in the process, it was however clear that there are concerns by many clinicians about the long-term implications for research and outcome measurements of destroying notes. A long term option to the Trust could be to weed notes following the patient's discharge which would improve overall efficiency by getting rid of excessive paper. There are conflicting views on the legalities of this, further planning is required and Mr Thomas confirmed that he would be happy to be involved in this process.

Graham Bragg left the meeting at this point and Mr Thomas opened the closed session of the meeting.

Digital Dictation

Mr McKenzie updated the committee on the 2 systems being considered by the Trust. It was agreed that a working group, including medical secretaries, would be set up to review the 2 options.

WHO Checklist and Pre-op Pregnancy Testing

Mr Mehta raised this issue following a recent SIRI in the Trust and advised committee members that guidelines had been developed following this incident for patients who may be potentially pregnant or are pregnant. It was noted that pregnancy may be an issue in surprisingly young children and pregnancy testing is required to prevent potential radiation risks during x-ray screening.

Reflections on appraisal process

Mr Stirling gave feedback on the current appraisal documentation and it was agreed that suggestions to improve and optimise the documentation should be forwarded to Mr Pearson. Mr Pearson advised members that the Trust was currently in the process of purchasing a revalidation management system database which should be in the Trust by Christmas.

Charitable Funds

A discussion took place on the rules behind the use of charitable funds and it was confirmed that General Trust Funds could be used to improve the care and experience of patients and staff and protected Trust Funds should be used for a particular projects. The Charitable Funds Committee are streamlining the process for Charitable Fund requests.

There being no other business Mr Thomas closed the meeting noting that the next meeting will be held in two months' time on Friday 22 November. This document is respectfully submitted to the Trust Board for their information, either Mr Thomas or the regular chairs are happy to discuss any of the issues debated with board members if that would be helpful.

Andrew Thomas FRCS
Consultant orthopaedic surgeon

Enclosure 5

Ward Managers Report to Trust Board

Reporting for September 2013

Feedback from issues raised in last Board report

Activity within the Trust: no change felt at ward level in regards to planning of activity and ward staffing. Wards would be able to plan staffing better with more notice about activity.

Lack of support services over the weekend/ out of hours: No change at ward level, an increase in number of reported incidents have been received regarding out of hours services. There have been several incidents whereby there has been a lack of collaborative working between bleep holder/ ward nurses and pharmacy. There is the on-going issue of not being able to dispense enoxaparin out of hours for discharge patients. It is felt this is unsafe practice and the ward nurse is essentially discharging the patient without the appropriate medication with the reliance that the patient or representative will return to the Trust in normal working hours to collect the medication. It raises serious concerns over safety for the patient and protection of the patient against DVT/ PE. There has also been the difficulty of accessing essential support equipment for patients out of hours such as CPM machines, polyslings and cricket pads splints. **Pharmacy are attending next ward managers forum to discuss issues raised (23/10/13)

Recruitment and retention: No change. Ward managers continue to shortlist entire candidate lists (without filters being applied first) and administer literacy test without support if conducting interviews outside assessment centres. An electronic system to support the recruitment process is being implemented and training will be required for the ward managers and sisters/charge nurses.

Department News

Private suite - New entrance to the ward is expected to open this week.

ROCS - Secured a 3 month pilot scheme to work with Sandwell Hospital for all their elective patients.

Short stay ward - Increase in compliance for 24 hours VTE review has been reported. The ward manager has new permanent staff starting imminently to fill outstanding vacancies. Interviewing for additional Band 5 in October.

Ward 2 - Establishment of ward rounds: 5 Consultants have agreed a time with the ward manager to conduct a formal ward round to review their patients. They are assisted by nursing staff and this is to improve medical engagement with patients and staff and consistency of care.

Ward 3 - Very positive feedback has been received from the cancer patient satisfaction survey relating to in-patient care. A donation of 5 Dyson fans has been received from a patient to acknowledge their recent episode of care on ward 3. Additional patient chairs have been purchased, the ward now has a full complement of DBO patient chairs which are fully compliant with IP&C regulations.

Ward 11 - Refurbishment of the play area, pre-op space and outpatient area is planned. New staff have been recruited to support the pre-op assessment of the different patient groups and a new outpatient manager has been appointed.

Issues to raise:

The group wishes to raise our concerns about the increasing amount of non-nursing tasks that are being required/expected of front line nursing staff, with little consultation. These include: tap flushing, keeping a live PAS register and associated paperwork, menu distribution and tallying, room temperature checks, fridge temperature checks, monkey pole checks, electrical equipment assessments. This is coupled with ever increasing clinical tasks that have been historically undertaken by medical staff (venepuncture, cannulation and male catheterisation). Certainly the non-clinical tasks are taking nursing staff away from delivering high standards of care and completing the necessary documentation that supports such care.

We are all too aware of all the recent press reports surrounding the lack of basic care that some patients have received within the NHS. We are concerned about the amount of time nurses have to care for patients with this recent trend of task allocation. We feel it is undermining the importance of the nurse's role in delivering care to patients and could jeopardise the patient's experiences of being nursed at the ROH.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th October 2013 **ENCLOSURE NUMBER: 6**

SUMMARY OF REPORT TO Trust Board

NAME OF DIRECTOR:	**Paul Athey**
SUBJECT:	**External Auditor Contract 2013/14 & 2014/15**

SUMMARY

The attached paper describes the recommended process for appointing the Trust's External Auditors for 2013/14 and for the period from 2014/15 onwards

IMPLICATIONS

The Trust is required to appoint External Auditors to independently audit its Annual Report & Accounts, the Quality Account and the Charitable Funds Accounts

RECOMMENDATIONS

The Trust Board is asked to recommend to the Council of Governors that:

- The current external audit contract with Deloitte LLP is extended for a further year, in line with the existing contract option.
- A "mini-competition" process, utilising the audit service frameworks hosted by either Health Trust Europe or the Government Procurement Service, is used to award a new contract from 2014/15 onwards.

External Auditor Contract 2013/14 & 2014/15

Background

It is the responsibility of the Council of Governors to approve the appointment of the Trust's External Auditors. In 2009/10, the Trust completed a formal tender exercise for the provision of External Audit services relating to the Trusts Annual Report & Accounts, the Quality Account and the audit of the Charitable Funds accounts.

Following this competitive process, the Trust awarded a control to Deloitte LLP for 3 years, with an option to extend for a further year if both parties were in agreement. The initial 3 year element of the contract concluded with the presentation of the Annual Report and Accounts to the 2013 Annual General Meeting.

Proposal

It is proposed that the Trust Board recommend to the Council of Governors that the option to extend the current contract for a further year is approved.

Over the last 3 years, the Trust has built up an excellent working relationship with Deloitte, and this has facilitated the efficient production of our annual accounts in ever tightening timescales. Deloitte have been active in supporting the organisation through their involvement in the Audit Committee, and have made a valuable contribution to this body.

The Trust have undertaken some high level benchmarking of our external audit fees against similar local organisations and we can confirm that the current fee continues to represent good value for money, standing at 20% less than the fee paid by Robert Jones and Agnes Hunt NHSFT and 33% less than the fee paid by Birmingham Women's Hospital NHST.

For 2014/15 onwards, it is recommended that the Trust undertakes a competitive procurement process to award its new External Audit contract. We are able to access procurement frameworks on audit services hosted by both Health Trust Europe (HTE) and the Government Procurement Service (GPS). These procurement hubs have already run full tender exercises on behalf of their members, and the ROH is able to access the commercial information provided through these tenders. Based on this information, we are able to shortlist a pool of preferred suppliers with whom we run a "mini-competition" process to determine the final contract award.

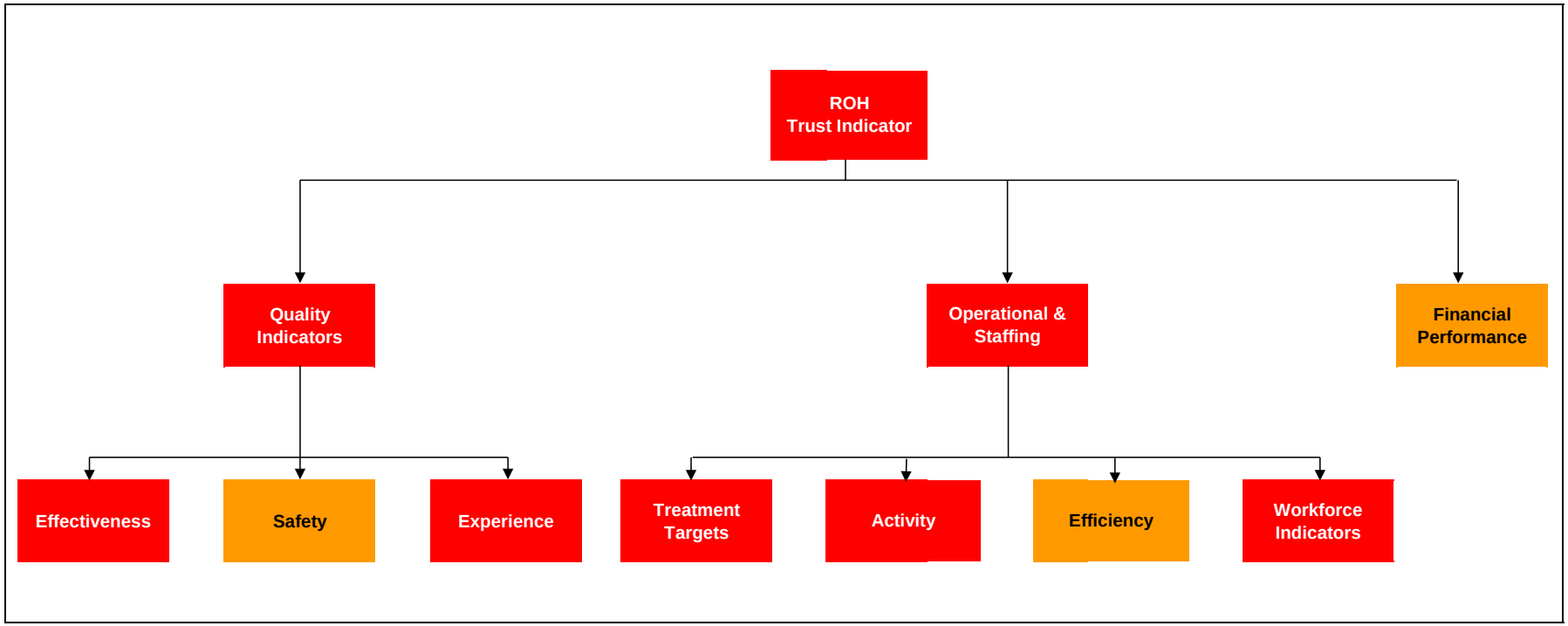
It is recommended that this process takes place in Summer 2014, and that the award panel is chaired by a representative from the Council of Governors and includes the Chair of Audit Committee, the Director of Finance and the Director of Nursing or an appropriate professional representative.

Recommendation

The Trust Board is asked to recommend to the Council of Governors that:

- The current external audit contract with Deloitte LLP is extended for a further year, in line with the existing contract option.
- A “mini-competition” process, utilising the audit service frameworks hosted by either Health Trust Europe or the Government Procurement Service, is used to award a new contract from 2014/15 onwards.

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending September 2013



Quarterly Detailed Report

Executive Summary as at September 2013

Headlines

- An overall red for quality has been identified as a result of an unexpected death, an increase in complaints and PALs contacts and the non-achievement of the VTE target.
- The Trust has breached the 62 day cancer waiting target for the quarter. This is likely to lead to an Amber/Green Monitor Governance Risk Rating.
- The Trust's surplus for the first 6 months of the year stands at £978,000 against a planned target of £1,378,000. Despite this underperformance, the Trust has still has a forecast Financial Risk Rating of 4.

Monitor Compliance Framework Targets	September 2013 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.4%	95.5%	0	6
Referral to treatment time - Admitted %	90%	90.2%	90.9%	0	6
Referral to treatment time - Incomplete Pathways %	92%	93.3%	93.7%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	80%*	81%*	1	6
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%*	100%*	0	6
Cancer 31 day wait from diagnosis to first treatment	96%	100%*	100%*	0	6
Cancer 2 week (all cancers)	93%	100%*	100%*	0	6
Clostridium Difficile cases	2 (Full Year)	0	0	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating	None				

* The current month's cancer outturns are provisional position only. The cancer position for the quarter is based on provisional in-month and confirmed previous months data.

Indicative Monitor Governance Risk Rating	**Amber /Green**
Indicative Monitor Financial Risk Rating	**4**

Key Trust Targets		September 2013 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	1	↓	3
	Complaints	<=12	22	↑	4
	CQUINS	100%	90%	→	11
	Total Unexpected Hospital Deaths	0	1	↑	5
Efficiency & Workforce	Total Backlog Patients	<400	472	↑	6
	Incomplete 14 - 18 Week Waiters	<500	654	↑	6
	Total Inpatient Activity vs Plan	100%	82.3%	↑	7
	Unused Theatre Sessions	<44	67	↓	8
	Sickness	4.1%	3.9%	↑	9
Financial	Surplus	£1,378k	£978k	↑	10
	CIP	£1,627k	£1,378k	↑	12
	Agency Expenditure	£91k	£138k	→	11
	Locum Doctor Expenditure	£46k	£68k	→	11

Trust Summary

The Trust is Red rated for September, with key concerns relating to quality, workforce, activity, finance and treatment targets.

An overall red for quality has been identified as a result of an unexpected death, an increase in complaints and PALs contacts and the non-achievement of the VTE target. More detail is provided in the Safety Report.

Workforce continues to be rated as red due to concerns around training and appraisal levels but performance in both areas continue to improve. Staff turnover and the level of agency staffing remain of concern. More detail is provided in the Quarterly HR Report

The gap between staff in post and establishment reduced in September by 7 wte meaning total vacancies of c52wte or 6% of the funded establishment.

For the month of September the Trust made a surplus of £249,000 against a planned surplus of £300,000. This was however supported by the receipt of a one off £181,000 insurance pay-out from claims in previous years. The Trust now has a year to date surplus of £978,000 against a plan of £1,378,000 which is a shortfall of £400,000. It is forecast that the Trust has a Monitor Financial Risk Rating of 4 for the year to date. Some cost pressures do exist particularly around agency pay, outsourced MRI and unmet cost improvement targets but much of the variance against plan is caused by the underperformance against inpatient activity.

Inpatient activity has now underperformed for 4 successive months and the level delivered in September was particularly disappointing at 82% of plan. A continuation of this level of activity will pose a significant risk to the delivery of this year financial plan and the level of contracted activity and income for the Trust in future years.

All 18 week RTT targets achieved for the seventh successive month however the backlog of patients waiting over 18 weeks has increased to 472 from 450. There remain a small number of patients who have been waiting for 52 weeks or longer for their care however it is anticipated that all patients will be treated by the end of October.

Due to the low numbers of accountable patients treated on a 62 day pathway combined with late tertiary referrals we will have failed to meet the 85% compliance target for September and therefore Quarter 2. This is likely to lead to an Amber/Green Monitor Governance Risk Rating.

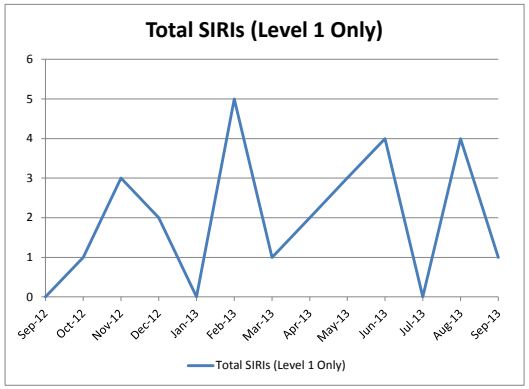
One cancellation was not rebooked within 28 days. This is being investigated and commissioners have been made aware via an exception report.

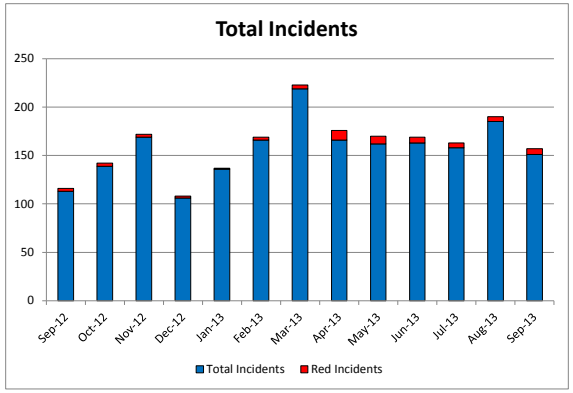
Quarterly Detailed Report
Safety Indicators as at September 2013

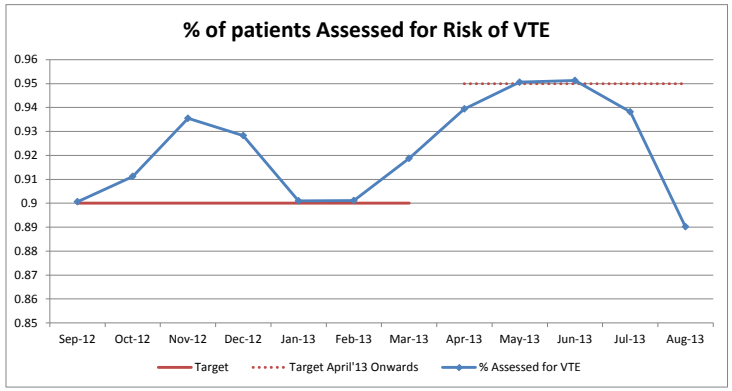
Headlines

- There has been a reduction from 4 serious incidents in August to 1 in September
- There were only 2 inpatient falls recorded in September
- VTE Risk Assessment is reported one month in arrears and the target was not achieved in August with a further fall in performance

	Monitor	National	CQC Standard		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	0	1	3	2	0	5	1	2	3	4	0	4	1	14
			4,16	SIRI per 1000 bed days	1.03	0.33	0.98	0.84	0.00	1.36	0.34	0.62	1.12	1.32	0.00	1.27	0.43	0.79
			4,16	Total Incidents	113	139	169	106	136	166	219	166	162	163	158	185	151	985
			4,16	Incidents per 1000 bed days	38.66	45.26	55.08	44.41	46.31	56.23	74.19	51.83	60.23	53.95	47.07	58.96	64.25	55.47
			4,16	Red Incidents	3	3	3	2	1	3	4	10	8	6	5	5	6	40
			9,16	Total Drug Errors	6	9	26	15	17	19	66	31	21	15	15	23	18	123
			9,16	Drug Errors per 1000 bed days	2.05	2.93	8.47	6.28	5.79	6.44	22.36	9.68	7.81	4.96	4.47	7.33	7.66	6.93
		N	1	Mixed Sex Occurrences	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			9	% Patients Assessed for Risk of VTE	90.06%	91.12%	93.55%	92.83%	90.10%	90.11%	91.88%	93.94%	95.06%	95.13%	93.82%	89.02%		93.50%
			9	Incidence of Hospital Related VTE	0	3	1	0	0	1	1	0	0	1	1	0	1	3
			4	Patient Falls - Inpatients	8	8	5	8	0	6	7	4	7	6	4	9	2	32
			4	Patient Falls per 1000 bed days	2.74	2.61	1.63	3.35	0.00	2.03	2.37	1.25	2.60	1.99	1.19	2.87	0.85	1.79
			4,16	% Harm Free Care	98.82%	97.96%	98.85%	92.86%	97.22%	93.26%	93.26%	97.89%	96.19%	97.94%	98.90%	97.85%	98.70%	97.85%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears. The CQUIN target has not been achieved in August with three areas not meeting the required 95% target; ADCU, Ward 10 and Ward 1.

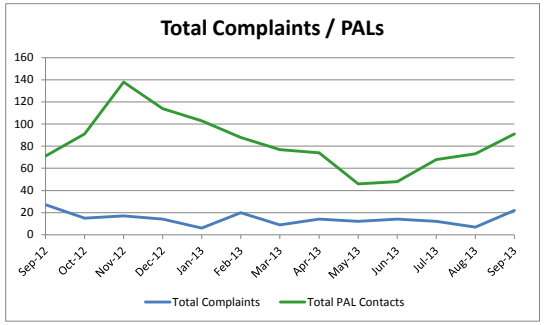
There has been a reduction in the number of reportable inpatient adult falls . 2 reportable falls both occurring on Ward 3 (patient independently mobilised without assistance). happened in September

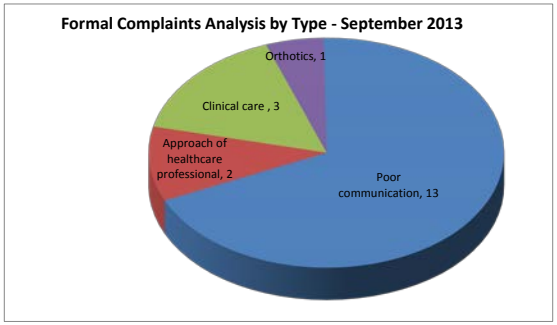
Quarterly Detailed Report
Experience Indicators as at September 2013

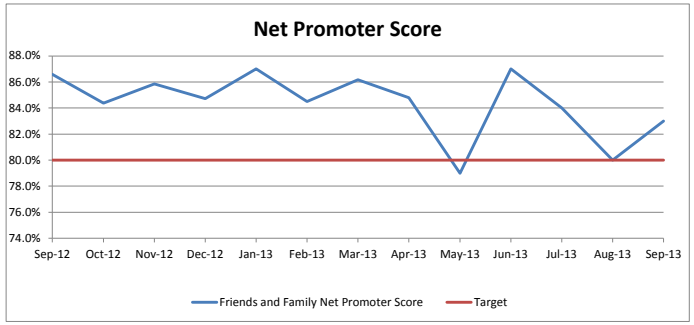
Headlines

- There has been a marked increase in the volume of complaints received this month from 7 (4 formal) to 22 (19 formal) representing an increase of 214%.
- PALS contacts rose also this month to 91 from 73 (+25%) last month.
- The Friends and Family Net Promoter score has increased following a decline in the past 2 months

	Monitor	National	CQC Standard		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Full Year Position
Experience			17	Complaints to Complements Ratio	1:9	1:28	1:13	1:33	1:63	1:20	1:46	1:25	1:25	1:29	1:32	1:46	1:14	1:25
			17	Total Complaints	27	15	17	14	6	20	9	14	12	14	12	7	22	81
			17	Complaints reverted to informal <48 hrs	10	7	3	0	0	1	0	1	0	1	1	3	3	9
			17	Formal	17	8	14	14	6	19	9	13	12	13	11	4	19	72
			17	Complaints per 1000 bed days	9.24	4.88	5.54	5.87	2.04	6.78	3.05	4.37	4.46	4.63	3.57	2.23	9.36	4.56
			17	Total PAL Contacts	71	91	138	114	103	88	77	74	46	48	68	73	91	400
			17	PALS Contacts per 1000 bed days	24.29	29.63	44.98	47.76	35.07	29.81	26.08	23.11	17.10	15.89	20.26	23.27	38.72	22.53
			17	Total Compliments	239	419	223	456	380	404	414	347	295	404	386	320	298	2050
			17	Compliments per 1000 bed days	81.77	136.44	72.69	191.03	129.38	136.86	140.24	108.35	109.69	133.72	114.99	101.99	126.80	115.44
				Food - Real Time Patient Survey	62.37%	63.36%	72.19%	66.07%	75.00%	69.75%	77.54%	77.50%	85.43%	86.67%	90.48%	92.40%	90.00%	85.02%
			17	Friends and Family Net Promoter Score	86.58%	84.37%	85.86%	84.73%	87.00%	84.50%	86.18%	84.8%	79.00%	87.0%	84.0%	80.0%	83.0%	83.7







COMPLAINTS
There has been a marked increase in the volume of complaints received this month from 7 (4 formal) to 22 (19 formal) representing an increase of 214%. Expectation was that a busier month would follow however this is a greater increase in volume than had been anticipated and certainly is well above the mean volume per month received in 2012/13 which was 13.3.

Number of complaints responded to in agreed timescale in September is 7/7 (100%) which is above agreed KPI of 80%.

PALS:
PALS contacts rose also this month to 91 from 73 (+25%) last month. Numbers of PALS received by Directorate:

Corporate 11
Small Joint 0
Large Joint 17
Oncology 5
Clinical Support 31
Paediatrics 3
Spinal 22
Theatres 2

COMPLIMENTS
The number of Compliments received was 298 (7% down on last month's total of 320)

Quarterly Detailed Report
Effectiveness Indicators as at September 2013

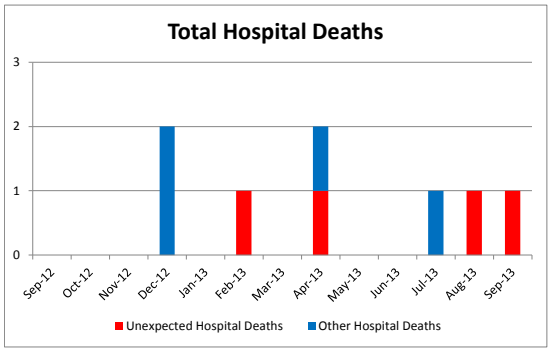
Headlines

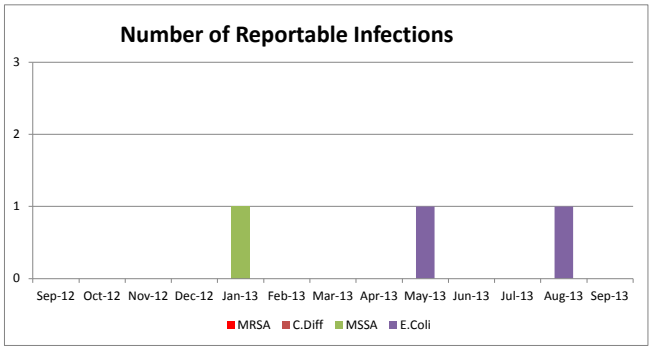
There was 1 unexpected death in September

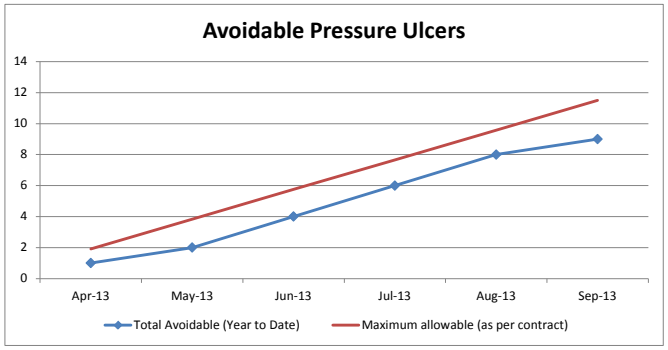
There was 1 avoidable grade 2 pressure ulcer in September

There were no cases of reportable infections in September

	Monitor	National	CQC Standard		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	0	0	2	0	1	0	2	0	0	1	1	1	5
			4,18	Hospital Deaths per 1000 bed days	0.00	0.00	0.00	0.84	0.00	0.34	0.00	0.62	0.00	0.00	0.30	0.32	0.43	0.28
			4,18	Unexpected Hospital Deaths	0	0	0	0	0	1	0	1	0	0	0	1	1	3
				Other Hospital Deaths	0	0	0	2	0	0	0	1	0	0	1	0	0	
			8	MRSA % Screened	150.0%	161.2%	165.3%	149.7%	138.7%	135.5%	114.3%	129.56%	129.13%	140.59%	145.53%	127.51%	146.00%	114.15%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	M	N	8	Total ROH CDIF	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH MSSA	0	0	0	0	1	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	0	0	0	0	0	0	1	0	0	1	0	2
			8	HCAIs not attributable to ROH	0	1	1	2	0	1	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	0	0	0	0	0	0	1	0	1
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	3	7	3	3	5	5	5	1	1	2	2	1	1	8
			4	Avoidable Pressure Ulcers per 1000 bed days	1.03	2.28	0.98	1.26	1.70	1.69	1.60	0.31	0.37	0.66	0.60	0.64	1.49	0.62







Effectiveness Commentary

There was 1 unexpected death of a male patient who died at home after having recently been discharged. The patient had been undergoing treatment for Sarcoma, however the cause of death is currently unknown. The family have been fully informed of the subsequent investigation, in line with our duty of candour.

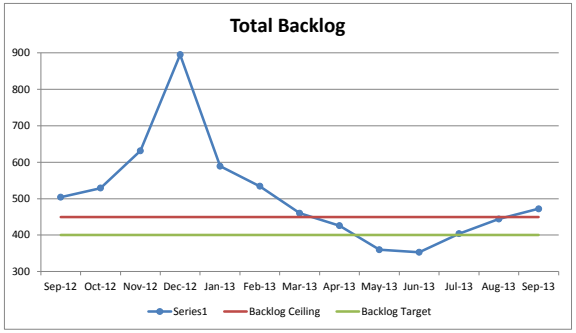
In September one grade 3 hospital acquired avoidable pressure ulcer was noted . All appropriate actions have been taken as a result of the avoidable ulcer.

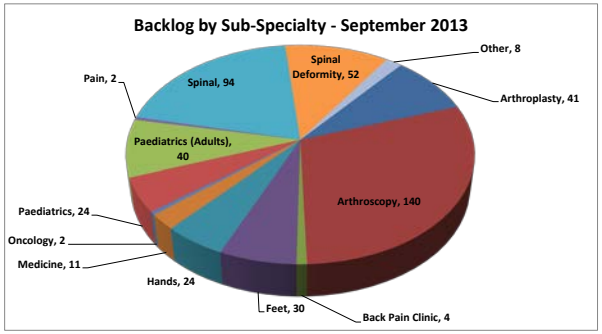
Quarterly Detailed Report
Treatment Targets as at September 2013

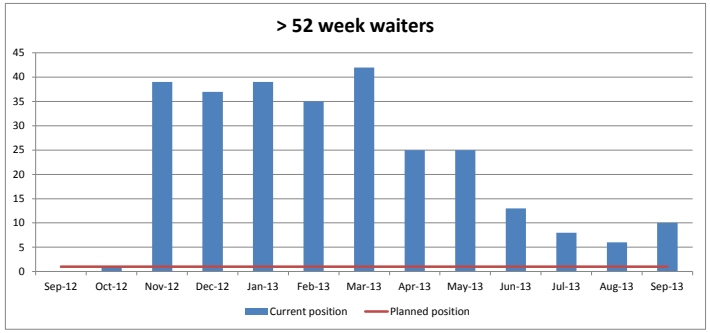
Headlines

- All of the RTT targets have been achieved in month however the backlog of patients has increased to 472
- 1 cancellation was not rebooked within 28 days
- 52 week waiters increased to 10 in September

	Monitor	National	CQC Standard		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13		13/14 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	0	1	39	37	39	35	42	25	25	13	8	6	10		10
	M	N	4	Referral to treatment time - Non Admitted %	96.22%	95.06%	95.28%	95.09%	95.03%	95.07%	95.18%	95.24%	95.08%	95.35%	95.29%	95.78%	95.42%		95.35%
	M	N	4	Referral to treatment time - Admitted %	90.49%	90.07%	90.38%	90.59%	90.42%	90.37%	90.00%	90.22%	90.39%	91.37%	92.05%	90.33%	90.19%		90.92%
	M	N	4	Referral to treatment time - Incomplete Pathways %	92.46%	92.02%	90.56%	90.52%	90.68%	91.09%	92.01%	92.77%	94.36%	94.77%	94.18%	93.71%	93.34%		93.99%
			4	Non admitted Backlog - Pathways waiting >18 wks	198	118	208	438	221	199	187	155	121	110	131	159	163		163
			4	Admitted Backlog - Pathways waiting >18 wks	306	411	423	457	368	335	273	271	239	243	273	285	309		309
			4	Total Backlog - 18 week pathways waiting >18 wks	504	529	631	895	589	534	460	426	360	353	404	444	472		472
			4	Incomplete 14 -18 Week Waiters	561	740	698	717	610	629	535	388	411	504	477	630	654		654
	M	N	4	Cancer 2 week (all cancers)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.33%	100.00%	100.00%	100.00%	100.00%	100.00%	*	
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.00%	100.00%	66.67%	80.00%	100.00%	80.00%	*	
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	100.00%	100.00%	100.00%	100.00%	99.98%	100.00%	100.00%	99.24%	100.00%	99.52%	99.20%	99.09%	99.70%		99.49%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	1		1
			1,21	Data Quality on Ethnic Group - Inpatients	95.32%	95.11%	100.00%	95.12%	95.20%	95.11%	91.99%	97.64%	95.29%	96.44%	94.86%	95.30%	96.97%		96.30%







Treatment Targets Commentary

All of the RTT targets have been achieved in month however the backlog of patients has increased to 472 , an increase from last month of 28 patients largely related to the Arthroscopy service.

Due to the low numbers of accountable patients treated on a 62 day pathway combined with late tertiary referrals we will have failed to meet the 85% compliance target for September and therefore Quarter 2. This is likely to lead to an Amber/Green Monitor Governance Risk Rating.

There remain a small number of patients who have waiting for 52 weeks or longer for their care however it is anticipated that all patients will be treated by the end of October. This in part will be achieved by transfer of 6 patients to the Cromwell in October. Unfortunately although the success of reducing the number of patients >52 weeks is well recognised by the SCG, from October 1st a £5k fine per patient will be incurred for all patients who wait >52 weeks for their treatment.

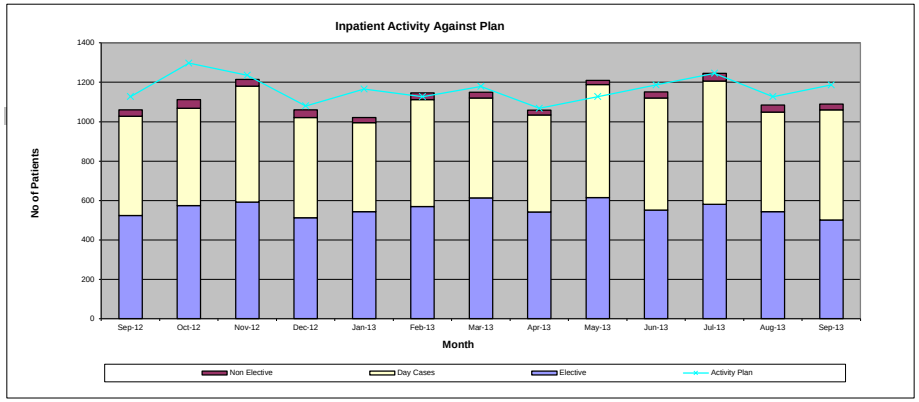
1 cancellation was not rebooked within 28 days. This is being investigated and commissioners will be made aware via an exception report.

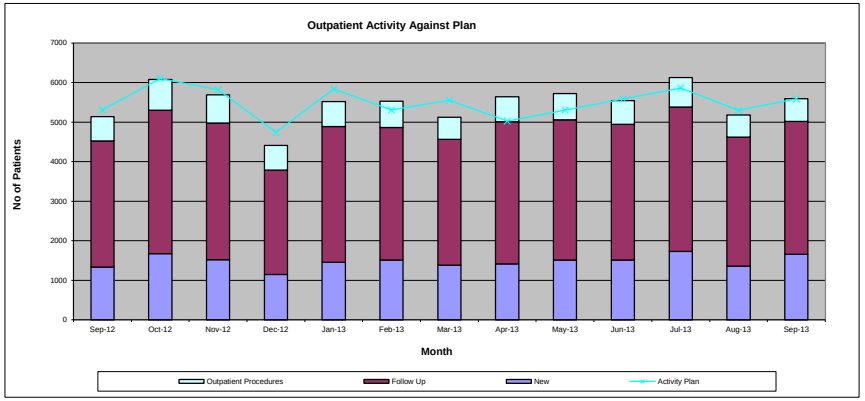
Quarterly Detailed Report
Activity Targets as at September 2013

Headlines

- Elective inpatients underperformed by 104 cases or 17% in September
- Non electives continue to underperform
- Outpatient procedures have underperformed for the 2nd month running

	Monitor	National	CQC Standard		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Full Year Position
Activity			4	Total Discharged Elective Patients	524	575	592	513	544	570	614	541	615	551	580	543	501	3331
			4	Total Discharged Non Elective Patients	34	44	34	39	27	35	29	25	20	30	38	35	28	176
			4	Total Discharged Day Cases	503	494	588	508	451	542	506	493	574	570	627	506	560	3330
			4	Total New Outpatients	1330	1674	1517	1146	1455	1510	1381	1416	1513	1508	1728	1359	1660	9184
			4	Total Follow Up Outpatients	3196	3628	3458	2641	3435	3356	3179	3590	3548	3438	3653	3264	3357	20850
			4	Outpatient Procedures	609	774	716	622	631	662	562	635	662	594	743	560	575	3769
			4	Elective as % Against Plan	92.4%	88.1%	95.2%	94.4%	92.8%	100.5%	108.3%	99.43%	107.1%	91.1%	91.4%	94.5%	82.9%	94.18%
			4	Non Elective as % Against Plan	88.8%	99.9%	81.0%	106.3%	68.2%	91.4%	75.8%	72.4%	54.8%	78.1%	94.3%	96.0%	72.9%	78.37%
			4	Day Cases as % Against Plan	96.3%	82.2%	102.7%	101.5%	83.5%	103.8%	96.9%	100.7%	111.1%	104.8%	109.8%	97.9%	103.0%	104.66%
			4	% New Outpatients Against Plan	97.8%	107.0%	101.7%	94.3%	97.3%	111.0%	101.5%	111.1%	112.5%	106.5%	116.2%	101.0%	117.2%	110.88%
			4	% Follow Up Outpatients Against Plan	98.3%	97.0%	97.1%	91.0%	96.2%	103.3%	97.8%	113.6%	106.3%	97.9%	99.0%	97.8%	95.6%	101.47%
			4	% Outpatient Procedures Against Plan	87.3%	96.4%	93.6%	99.8%	82.3%	94.9%	80.6%	107.6%	106.3%	90.6%	108.0%	89.9%	87.7%	98.30%





Activity Commentary

For the 2nd consecutive month the Trust underachieved against admitted activity targets, with elective and emergency being below plan and a small over performance against DC activity.

New OP activity remains high however which indicates a strong order book which is further reflected in the number of patients currently on a pathway which is around 200 higher than historically normal.

Directorates have been tasked with increasing their activity and improving theatre list utilisation and have been provided with data to support these efforts in a focused manner.

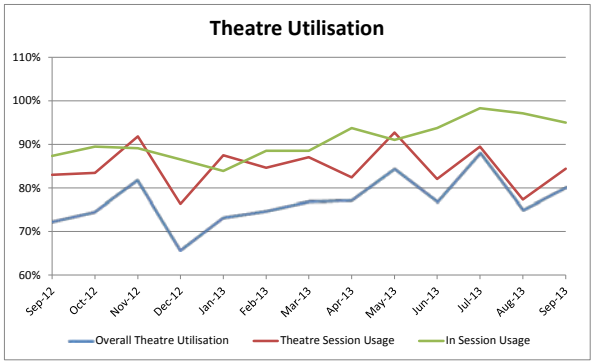
This remains a significant risk to the organisation and one that should not be underestimated by all teams.

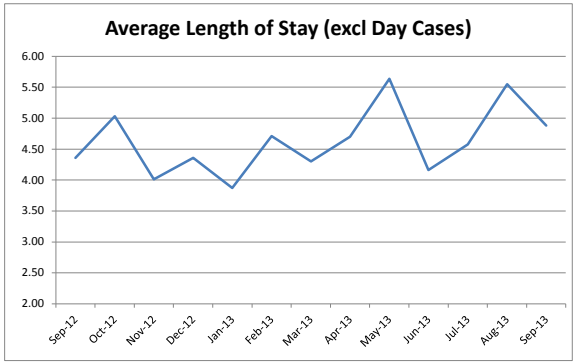
Quarterly Detailed Report
Efficiency Indicators as at September 2013

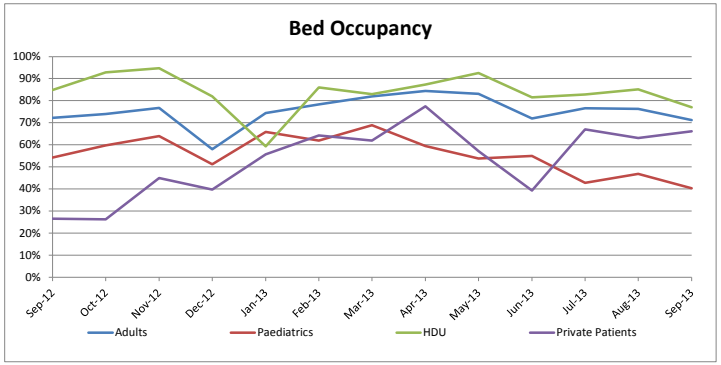
Headlines

- Theatre utilisation and usage remains low and there were 67 unused theatre sessions.
- Overall bed occupancy remains low which is consistent with inpatient activity levels.
- The number of cancelled operations on the day reduced to 4 in September

	Monitor	National	CQC Standard		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Full Year Position
Efficiency			4	Overall Theatre Utilisation	72.5%	74.7%	81.8%	66.0%	73.4%	74.9%	77.0%	77.30%	84.41%	76.95%	87.98%	75.15%	80.19%	80.80%
			4	Theatre Session Usage	83.01%	83.47%	91.85%	76.30%	87.50%	84.60%	87.07%	82.45%	92.72%	82.09%	89.50%	77.38%	84.42%	84.86%
			4	In Session Usage	87.3%	89.5%	89.1%	86.5%	83.9%	88.5%	88.5%	93.76%	91.04%	93.73%	98.31%	97.11%	94.99%	95.21%
			4	Unused Theatre Sessions	70	79	37	92	57	63	53	76	30	77	50	102	67	233
			4	Number of Cases per Theatre Session	2.82	2.60	2.79	3.45	2.46	3.13	3.11	2.82	3.01	3.08	2.79	2.94	2.90	2.92
			4	Total Cancelled Operations (On Day or Day Before)	90	95	91	95	108	78	52	91	72	63	88	58	62	314
			4	Total Cancelled Operations (On Day or Day Before) - Avoidable														
			4	Total Cancelled Operations (On Day or Day Before) - Unavoidable														
			4	Total Cancelled Operations by Hospital (On Day)	7	7	6	6	5	4	2	4	5	5	11	14	4	43
			4	% Cancelled Operations by Hospital	0.72%	0.68%	0.52%	0.59%	0.51%	0.37%	0.18%	0.40%	0.43%	0.46%	0.93%	1.36%	0.38%	0.66%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.66	2.37	2.49	2.51	2.63	2.30	2.59	2.76	2.44	2.53	2.24	2.53	2.33	2.48
			4	Pain Review-To-New Ratio	2.89	3.26	3.99	3.83	3.65	3.70	2.99	3.53	4.65	2.90	4.02	4.24	1.89	3.69
			4	Outpatient DNAs	8.78%	8.50%	8.91%	9.37%	10.51%	9.05%	10.52%	7.70%	8.79%	9.23%	8.70%	9.33%	8.60%	8.63%
			4	Bed Occupancy - Adults	72.19%	73.96%	76.67%	57.92%	74.44%	78.34%	81.96%	84.37%	83.16%	71.91%	76.53%	76.26%	71.19%	77.22%
			4	Bed Occupancy - Paediatrics	54.17%	59.68%	63.89%	51.18%	65.86%	61.90%	68.89%	59.44%	53.76%	55.00%	42.71%	46.77%	40.28%	49.59%
			4	Bed Occupancy - HDU	84.77%	92.86%	94.68%	81.99%	59.35%	86.06%	82.89%	87.36%	92.53%	81.44%	82.76%	85.15%	77.01%	87.02%
			4	Bed Occupancy - Private Patients	26.46%	26.27%	44.90%	39.63%	55.64%	64.29%	61.91%	77.47%	57.14%	39.29%	66.96%	63.13%	66.19%	62.24%
			4	Admissions on the Day of Surgery	365	383	429	357	384	400	457	381	433	403	417	372	368	1634
			4	AVLOS for APC (excl day cases)	4.36	5.03	4.01	4.36	3.87	4.71	4.30	4.70	5.63	4.16	4.58	5.55	4.88	4.75







Efficiency Commentary

Theatre session utilisation in month was poor in part due to TBALD (18 sessions).

The number of cancelled operations remains high at 62 in month, this is a high priority area of focus for the organisation and one of the 6 key initiatives that will be monitored via the Programme Board.

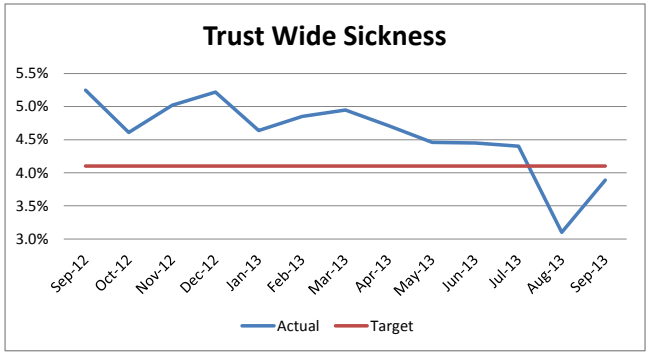
Average LOS continues to underperform against target however it is hoped that the introduction of evening physiotherapy from mid October will assist in reducing LOS. Enhanced Recovery Programme is another of our 6 key initiatives which when implemented will assist in reducing LOS and improving clinical outcomes.

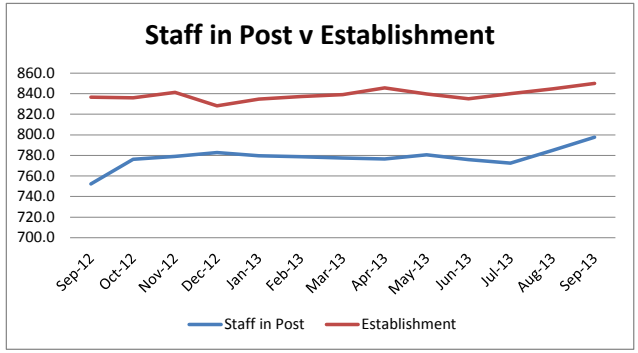
Monthly Report
Workforce Indicators as at September 13

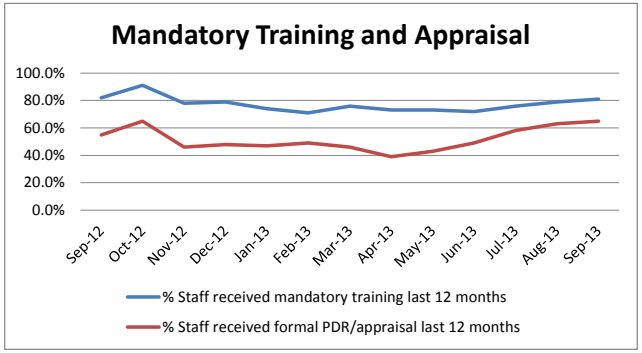
Headlines

- The number of staff employed has increased and the level of vacancies reduced
- Sickness remains below target but has increased in month
- Mandatory Training and Appraisal rates have improved but do remain below target

	Monitor	National	CQC Standard		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Full Year Position
Workforce			13	Total WTE Employed	752.3	776.2	779.0	782.6	779.6	778.6	777.5	776.5	780.5	775.8	772.5	784.9	797.7	781.3
			13	Total WTE Employed as % of Establishment	89.9%	92.9%	92.6%	94.5%	93.4%	93.0%	92.7%	91.8%	93.0%	92.9%	92.0%	92.9%	93.8%	92.7%
			13	Staff Turnover (%)	10.4%	10.3%	10.4%	10.4%	11.1%	12.6%	12.7%	11.6%	12.0%	12.6%	12.5%	12.5%	12.7%	12.3%
			13	% of Sickness - Trust wide	5.3%	4.6%	5.0%	5.2%	4.6%	4.9%	5.0%	4.7%	4.5%	4.5%	4.4%	3.1%	3.9%	4.2%
			13	Agency % of Staff Cost	5.4%	5.4%	4.2%	4.2%	5.6%	6.4%	8.7%	6.1%	8.0%	8.4%	6.1%	6.5%	6.4%	6.9%
			13	Temporary staffing hours as a % of establishment														
			13	% Staff received mandatory training last 12 months	82%	91%	78%	79%	74%	71%	76%	73%	73%	72%	76%	79%	81%	76%
			13	% Staff received formal PDR/appraisal last 12 months	55%	65%	46%	48%	47%	49%	46%	39%	43%	49%	58%	63%	65%	53%
			13	% of required staff receiving safeguarding training								33%	30%	21%	51%	51%		37%
			13	Qualified Nurse / Bed ratio														
			13	Staff Net Promoter score								3.84						







Workforce Commentary

There has been a net growth of 12.6WTE in September. Recruitment to substantive posts has reduced in all directorates except Clinical Support Services and Theatres

Sickness has continued to reduce during the quarter and the moving annual average is now 0.63% lower than last year. The areas with high absence rates are ADCU (25%), Catering (19%) and Pharmacy (21%). Absence in catering and pharmacy has improved during October.

Staff turnover has increased by 0.17% during the quarter with the largest increases in the nursing workforce (registered and HCA). The review of the exit questionnaire has now been completed and all staff who have left in the last four months will be surveyed to ascertain any underlying trends and lessons for the future.

Agency expenditure has reduced by £65,000 pcm during the quarter, predominantly driven by reduced usage in corporate departments. The areas of highest usage continue in Medical staff, Wards (HDU and ADCU) and Pharmacy.

Mandatory training and appraisal levels continue to rise, but remain below 95%. Attendance at mandatory training sessions in October has continued to be high and therefore further improvements are expected in November.

Quarterly Detailed Report
Financial Performance as at September 13

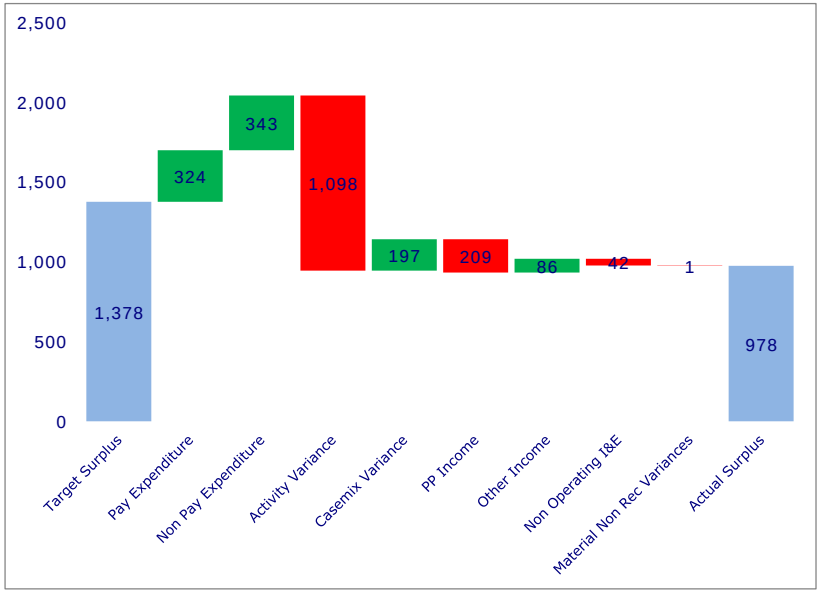
Headlines

- The Trust has a year to date surplus of £978,000 against a plan of £1,378,000 which is a shortfall of £400,000.
- The Trust continues to under recover in healthcare income compared to plan. The primary driver for this is an underperformance in elective inpatient activity.
- CIP achievement currently sits at £1,378,000 of which 93% is recurrent. This is £249,000 behind the target after Month 6.

Trust Financial Metrics

	Year to Date		
	Actual	Plan	Risk Rating
EBITDA Margin	7.4%	8.6%	3
EBITDA Achieved (%)	83.4%		3
Net Return after Financing	3.4%	4.7%	5
I&E Margin	2.7%	3.7%	4
Liquidity Risk (Days)	82.9	80.3	5
Overall Risk Rating			4

Trust Performance Bridge Graph



Executive Financial Summary

Overall Performance
For the month of September the Trust made a surplus of £249,000 against a planned surplus of £300,000. This was however supported by the receipt of a one off £181,000 insurance pay-out from claims in previous years . Excluding this the Trust is £232,000 behind plan for the month.

The Trust therefore now has a year to date surplus of £978,000 against a plan of £1,378,000 which is a shortfall of £400,000 . This is now (following receipt of the insurance pay-out) in line with the normalised position having excluded material non recurrent income and expenditure.

It is forecast that the Trust has a Monitor Financial Risk Rating of 4 for the year to date.

Income
We continue to under recover healthcare income compared to plan. The primary driver for this is an underperformance in elective inpatient activity which in September was 104 cases or 17% behind plan for the month. In addition the elective inpatient activity undertaken in the month was 61 cases lower than the average year to date indicating a worsening trend.

On the positive side were have seen an increase in the average price of inpatient and day case episodes and have not been required to pay fines to commissioners for over 52 week waiters for the first 2 quarters which has partly mitigated elective inpatient underperformance.

Private patients remain a concern and are now under recovering by £209,000 or 39%.

Pay
The paybill has reduced for the second month running but still remains above that expected given the levels of activity and is £46,000 or 2% higher than 12 month average. Agency staffing costs have reduced for the 4 successive month which is encouraging . Consultant ADHs are in line with the average for the past 12 months as opposed to the reduction that would be hoped for given reduced activity levels in September.

Compared to the Monitor plan we are spending less on pay than predicated. When the Monitor plan was set we were anticipating activity over performance to meet the £1.1m income CIP target. This and the associated costs are yet to materialise which shows as a negative activity variance and a positive pay variance on the Performance Bridge Graph.

Non Pay
Non pay spend was low for the month (£187,000 less that the average for the first 5months) driven by the reduced activity in September and underperformance in elective inpatient activity which tend to have high non pay costs (particularly in prosthesis). As with pay we are now showing a positive variance which is driven by the general underperformance plus not achieving planned activity growth.

CIP
Achievement currently sits at £1,378,000 of which 93% is recurrent. This is £249,000 behind the target after Month 6 .

Balance Sheet & Cash Flow
The Statement of Position is broadly in line with plan as month end. Cash balances remain healthily but is £2.7m behind plan which continues to be predominantly driven by delays in payments from newly established commissioning organisations of £1.0m (down from £1.3m) of which £0.7m has been paid by mid October and lower than planned creditor accrual levels of £1.6m (was £2m).

Quarterly Detailed Report

Financial Efficiency Indicators as at September 13

Headlines

- The paybill has reduced for the second month running but still remains above that expected given the levels of activity and is £46,000 or 2% higher than 12 month average.
- ADH and agency costs remain high particularly in the context of low activity levels
- Both the Trust surplus and CIP performance remain below planned levels

		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Cost of Staffing	Total Paybill	£3,075,000	£3,138,000	£3,071,000	£3,069,000	£3,168,095	£3,247,000	£3,388,000	£3,216,996	£3,313,000	£3,259,000	£3,324,000	£3,252,000	£3,233,418
	Substantive Pay	£2,652,000	£2,737,000	£2,723,000	£2,713,000	£2,800,783	£2,813,000	£2,841,000	£2,809,592	£2,852,000	£2,822,000	£2,864,000	£2,806,000	£2,805,483
	Bank Pay	£251,000	£227,000	£214,000	£222,000	£183,483	£226,000	£246,000	£203,441	£187,000	£197,000	£252,000	£230,000	£213,956
	Overtime Pay	£6,000	£4,000	£4,000	£5,000	£5,665	£4,000	£5,000	£9,915	£4,000	£4,000	£4,000	£5,000	£7,612
	Agency Pay (excluding Medical Locums)	£137,000	£108,000	£66,000	£75,000	£140,543	£123,000	£234,000	£139,565	£241,000	£191,000	£150,000	£144,000	£138,048
	Medical Locum Pay	£29,000	£62,000	£64,000	£54,000	£37,621	£80,000	£62,000	£54,484	£28,000	£81,000	£54,000	£67,000	£68,319
	ADH Payments - Surgical	£30,000	£16,500	£20,000	£25,000	£28,000	£45,000	£40,000	£26,000	£38,000	£20,000	£17,000	£26,000	£23,000
	ADH Payments - Clinics	£11,000	£15,000	£10,000	£7,000	£14,000	£20,000	£17,000	£11,000	£14,000	£7,000	£17,000	£9,000	£13,000
	ADH Payments - Anaesthetics	£21,000	£22,000	£25,000	£27,000	£35,000	£48,000	£84,000	£46,000	£47,000	£48,000	£63,000	£46,000	£53,000
	ADH Payments - Spot Work & Strategy	£1,000	£2,000	£1,000	£1,000	£1,000	£1,000	£0	£0	£0	£0	£0	£0	£0
Income & Efficiency	Trust Surplus	£1,716,000	£2,057,000	£2,485,000	£2,350,000	£2,033,000	£2,074,000	£2,203,000	-£66,000	£250,000	£305,000	£602,000	£729,000	£978,000
	Normalised Surplus	£960,000	£1,301,000	£1,740,000	£1,605,000	£1,397,000	£1,409,000	£1,853,000	-£66,000	£250,000	£443,000	£891,000	£912,000	£977,000
	Total Income	£5,540,000	£6,110,000	£6,032,000	£5,815,000	£5,395,000	£5,727,000	£6,409,000	£5,910,000	£6,135,000	£5,914,000	£6,575,000	£5,515,000	£5,884,000
	CIP	£3,244,000	£3,309,000	£3,531,000	£3,579,326	£3,630,122	£3,679,000	£3,820,000	-	£339,000	£561,000	£869,000	£1,125,000	£1,378,000

Summary

The paybill has reduced for the second month running but still remains above that expected given the levels of activity and is £46,000 or 2% higher than 12 month average. This continues to be driven by the on-going cost of agency staffing and the premium cost out of hours work which are both in line with the average for the past 12 months as opposed to the reduction that would be hoped for given reduced activity levels in September.

The Trust therefore has a year to date surplus of £978,000 against a plan of £1,378,000 which is a shortfall of £400,000 . This is now (following receipt of the insurance pay-out) in line with the normalised position. having excluded material non recurrent income and expenditure.

CIP achievement currently sits at £1,378,000 of which 93% is recurrent. This is £249,000 behind the target after Month 6

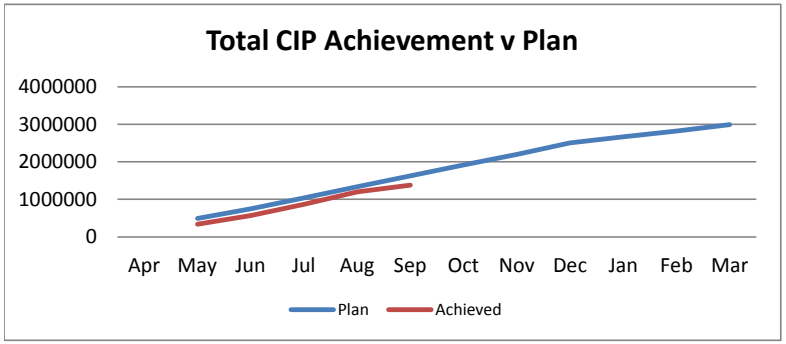
Monthly Report

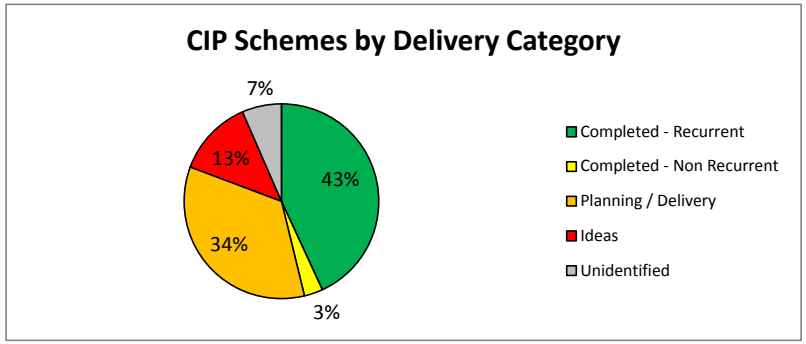
Cost Improvement Programme as at September 13

Headlines

- Achievement currently sits at £1,378,000 of which 93% is recurrent. This is £249,000 behind the target after Month 6
- To date only 46% of the required CIP value is completed and implemented. 20% is not identified or ideas at this stage
- No medium of high risk quality issues have been raised or identified

Cost Improvement Programme	%age Achieved	Target £'000	C/F £'000	Revised £'000	Completed - Recurrent £'000	Completed - Non Recurrent £'000	Planning / Delivery £'000	Ideas £'000	Unidentified £'000
Clinical Directorates	46%	1,119	(11)	1,108	464	47	76	314	207
Corporate Areas	72%	774	0	774	511	45	165	66	(12)
Income	28%	1,100	0	1,100	311	0	789	0	0
Total	**46%**	**2,993**	**(11)**	**2,982**	**1,286**	**92**	**1,030**	**380**	**195**
						1,378			



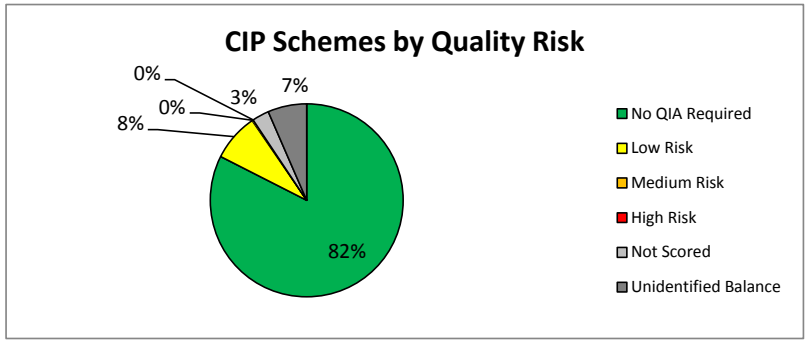


Significant Exceptions

Theatres & Anaesthetics. To date only 16% of the £473k target has been implemented. 32% requires further significant reduction in agency spend and 43% is unidentified at this stage.

Income. To date only 28% of the £1.1m plan has been implemented. The remaining requires the Trust to deliver activity levels over and above baseline contract which we are failing to achieve.

Clinical Support, Paediatrics & Management all have delivery percentages of between 50% and 65%. Delivery in these areas has been slower than planned but 92% of the requirement has been identified.



Quarterly Detailed Report
Statement of Position as at September 13

Headlines

The Trust finished quarter 2 with a Statement of Position £0.4m behind plan, with the main variances relating to higher than anticipated closing debtor and creditor balances and a lower than planned cash balance

The Trust finished quarter 2 with a Statement of Position £0.4m behind plan. It is important to note that this report has been based on the original plan submitted to Monitor at the start of the financial year. Following our Q1 submission Monitor requested that we resubmitted our capital plan as we were materially behind plan at Q1.

Based on the original plan capital expenditure still appears to be £1m behind. The capital report later in the pack show performance against the revised plan and this is now showing the Trust as being on target.

As in previous months the debtors balance is higher than expected due to the delay in receiving payment for SLA contracts from some of the new CCG's. As at the end of September this stood at £1.0m (down from £1.3m at the end of August) Of the outstanding £1m balance £0.7m has been paid by mid October with promises of £0.2m to be paid on the 1st November.

The creditors balance is lower than expected due to invoices being received earlier than anticipated in the plan. The plan was based on activity with PCT's and SHA which have now changed to CCG's whose processes are resulting in invoices being issued and therefore due for payment much earlier. In addition the Transaction Team have concentrated on clearing NHS payables so there are limited balances to review as part of the agreement of balances process which is due to take place in October.

The variances in debtors and creditors (plus a shortfall on plan of £400k) has resulted in the cash position being lower than planned by £2.7m. This will improve by c£1m due to the payments from CCG outlined above. Recovery against the financial plan will also contribute to improving this. In addition the Transaction Team have been asked to review their processes to ensure invoices are not paid until the due date and a review of levels of stock held within theatres will be undertaken.

The £693,000 balance in Creditors falling due after more than one year relates to the future liability on the lease for the MRI scanner.

Debtor days: Debtor days currently stands at 29 days
Creditor days: Creditor days currently stands at 46 days

Debtors > 90 days: Total debts over 90 days is £990k at a percentage of 16.37% of the total debtor balance. This percentage reduces to 11.73% when taking into account the CCG payments received in October 2013 and 8.4% based upon the confirmed 1st November payments.

Creditors > 90 days: Total creditors over 90 days is £576k at a percentage of 10.10% of the total creditor balance.

STATEMENT OF POSITION	Actual £000	Plan £000
FIXED ASSETS:		
Intangible assets	51	35
Tangible assets	41,228	42,244
Investments	0	0
TOTAL FIXED ASSETS	**41,279**	**42,279**
CURRENT ASSETS:		
Stocks and work in progress	3,236	2,781
Debtors	6,357	4,863
Investments	0	0
Cash at bank and in hand	17,876	20,556
TOTAL CURRENT ASSETS	**27,469**	**28,200**
CREDITORS:		
Creditors falling due within one year	(9,074)	(10,407)
NET CURRENT ASSETS/(LIABILITIES)	**18,395**	**17,793**
TOTAL ASSETS LESS CURRENT LIABILITIES	**59,674**	**60,072**
CREDITORS:		
Creditors falling due after more than one year	(693)	(693)
PROVISIONS FOR LIABILITIES AND CHARGES	(259)	(259)
TOTAL ASSETS EMPLOYED	**58,722**	**59,120**
FINANCED BY		
TAXPAYER'S EQUITY		
Public dividend capital	38,905	38,905
Revaluation reserve	2,712	2,712
Donated asset reserve	0	0
Available for sale investments reserve	0	0
Other reserves	0	0
Income and expenditure reserve	17,105	17,503
TOTAL TAXPAYERS' EQUITY	**58,722**	**59,120**

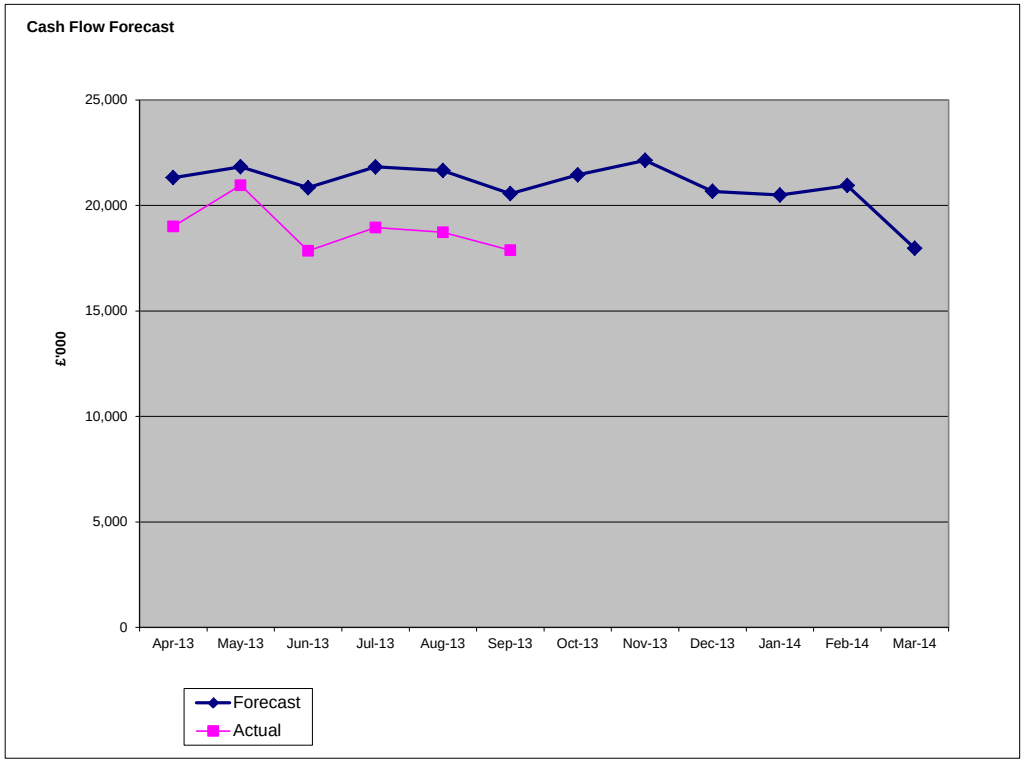
Quarterly Detailed Report
Financial Cash Flow as at September 13

Headlines

The Trust closed Q2 with a cash balance of £17.9m which is £2.7m behind plan. More detailed analysis of the variances is provided in the balance sheet report

CASHFLOW STATEMENT
As at 30th September 2013

	Actual £'000	Plan £'000	Variance £'000
Earnings Before Interest Taxation & Depreciation	2,648	3,201	(553)
Movement in Working Capital			
(Increase) / Decrease in Stock	(395)	60	(455)
(Increase) / Decrease in Debtors	(2,531)	(1,287)	(1,244)
Increase / (Decrease) in Creditors	(1,287)	(356)	(931)
Increase / (Decrease) in Provisions and Liabilities	(1)	1	(2)
Total Movement in Working Capital	**(4,214)**	**(1,582)**	**(2,632)**
Cash flow from Operations			
Capital Payments	(1,384)	(1,797)	413
Cash flow before Financing	**(1,384)**	**(1,797)**	**413**
Financing			
Interest Received	46	11	35
Interest Paid	0	0	0
Capital element of finance lease rental payments	0	0	0
Public Dividend Capital Received	0	0	0
Public Dividend Capital Repaid	0	0	0
Dividend Paid	(695)	(644)	(51)
Loans Received	0	0	0
Loans Paid	0	0	0
Grants Received	0	0	0
Grants Paid	0	0	0
Total Financing	**(649)**	**(633)**	**(16)**
Net Cash Inflow / Outflow	(3,599)	(811)	(2,788)
Opening Cash Balance	21,448	21,448	0
Closing Cash Balance	**17,849**	**20,637**	**(2,788)**

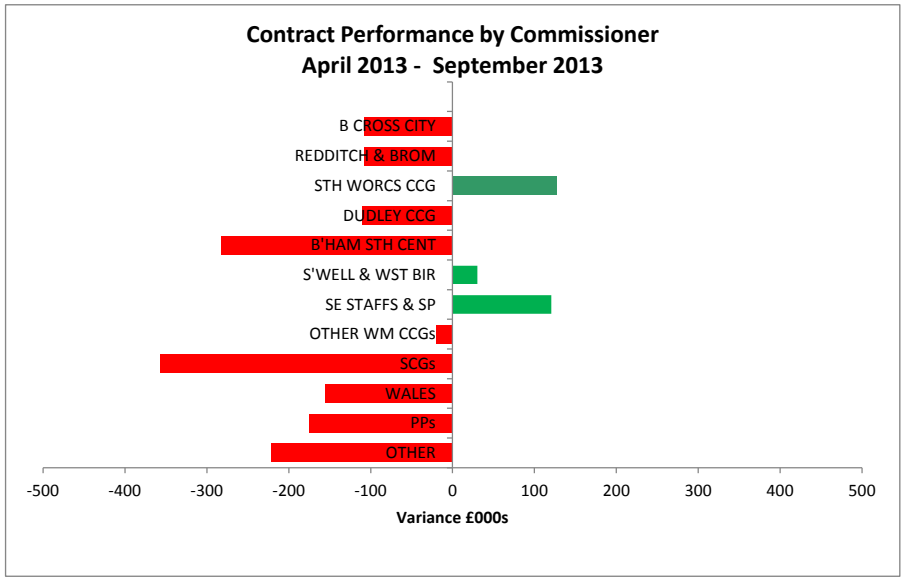


Quarterly Detailed Report
Income and Expenditure Statement as at September 13

Headlines

- The Trust's surplus is £400,000 behind plan at quarter 2
- EBITDA margin is 0.8% behind plan at Quarter 2.
- We are underperforming against the majority of SLAs which is predominantly driven by an underperformance in inpatient activity

	Current Quarter			YTD			FY
	Act	Plan	Var	Act	Plan	Var	Plan
Income	17,959	18,914	(955)	35,884	37,052	(1,168)	74,621
Pay Costs	(9,810)	(9,940)	130	(19,597)	(19,815)	218	(40,204)
Drug Costs	(355)	(375)	20	(761)	(759)	(2)	(1,537)
Other Costs	(6,292)	(6,837)	545	(12,878)	(13,277)	399	(26,709)
EBITDA	**1,502**	**1,762**	**(260)**	**2,648**	**3,201**	**(553)**	**6,171**
Depreciation	(528)	(567)	39	(1,021)	(1,190)	169	(2,740)
Net interest	12	6	6	46	11	35	21
Other	(313)	(327)	14	(695)	(644)	(51)	(1,323)
	673	**874**	**(201)**	**978**	**1,378**	**(400)**	**2,129**
Exceptional Items							
Net surplus / (Deficit)	**673**	**874**	**(201)**	**978**	**1,378**	**(400)**	**2,129**
EBITDA %	8.36%	9.32%		7.38%	8.64%		8.27%
CIP	691	882	(191)	1,261	1,627	(366)	2,993



Finance Commentary

The Trust surplus was behind plan in Q2 by £201k compared to £199k in Q1. Overall the surplus is £400k behind plan after the first 6 months of the year.

The Trust is under recovering total income by £1.2m as at Q2. which is driven predominantly by under recovery in NHS healthcare income of £1m (which includes CIP growth assumptions) and private patients of £0.2m.

The biggest area of underperformance in the year to date has been against contracts with Specialist Commissioning Groups, equating to nearly £357k to the end of Q2. The £1.4m for 52 week waiters has now been reflected in the plan, this is contributing to the underperformance.

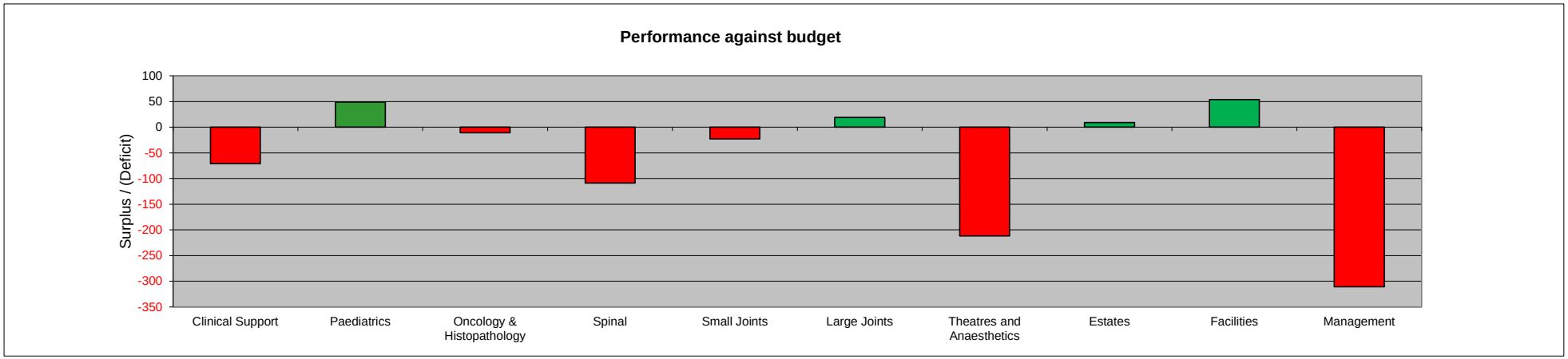
Performance against our local contracts is variable, with underperformance against Birmingham Cross City, Redditch, Dudley, Birmingham Central offset by over performance in South Worcester, Sandwell and West Birmingham and South East Staffordshire. Overall the local contract's income is £18.5m as at month 6 and is under performing against the plan by £332,000.

Compared to the plan we are spending less on pay and non than predicated. When the plan was set we were anticipating activity over performance to meet the £1.1m income CIP target. This and the associated costs are yet to materialise which shows as a positive pay and non pay variance.

Quarterly Detailed Report
Finance Performance by Directorate as at September 13

Headlines

- 6 of the 10 Directorates within the Trust are overspent at the end of Quarter 2
- Spinal, Theatres and Management have significant overspends, please see details below.



Financial Performance Commentary
To help incentivise delivery of CIP unmet Directorate targets have now been devolved to Directorates which has led to an increase in the number and value of Directorate overspends this quarter. Six of ten Directorates are reporting overspends for the year to date. The exceptions are Paediatrics, Large Joints, Estates and Facilities. The key pressure areas are as follows:

Theatres & Anaesthetics
Staffing - Theatres are overspent by £138,000 at month 6 on staffing as a result of continued agency costing £398,000 to date on nursing and technical cover for substantive vacancies, although the on-going recruitment programme has seen reductions in agency use. Non Pay - Theatres are £87,000 underspent on non pay which is to be expected given the large underperformance in inpatient activity. This is however offset by £198,000 unmet CIP to date.

Management
Management Directorate is overspent by £311,000 in total at month 6. Pay is overspent by £298,000 mainly on locums on Trust funded junior doctors. Non pay is overspent by £38,000 which is inclusive of underachieved CIP.

Spinal
Spinal is overspent by £109,000 at month 6. Pay is overspend is £39,000 & non pay is overspent by £70,000. The non pay overspend mainly relates to the treatment of patients in the private sector and EEG /radiology contracts with external providers.

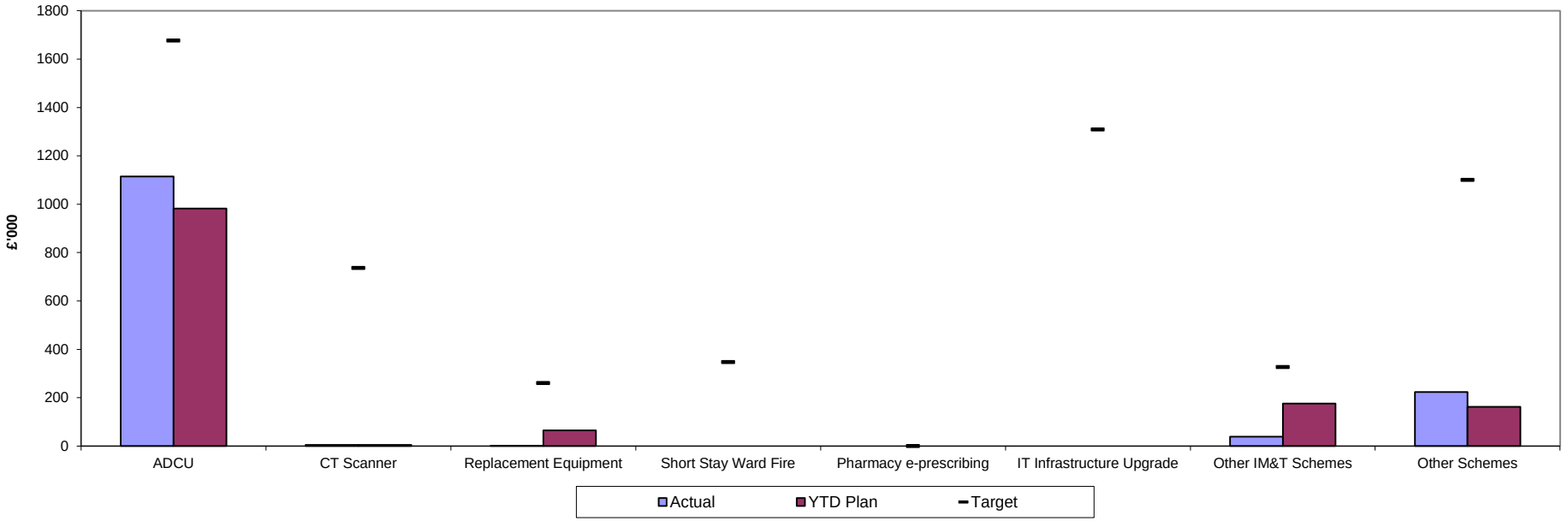
Clinical Support
The overspend is driven by unmet CIP of £62,000 for the first 6 months of the year.

Quarterly Detailed Report
Capital Programme Update as at September 2013

Headlines

The capital plan is £6,000 behind at Q2 based on the revised capital plan submitted to Monitor.

Scheme Analysis



Capital Commentary

At the end of Quarter 1 the capital plan was £354,000 or 28% behind plan. The Trust was therefore asked to resubmit the plan to more accurately reflect the likely capital spend profile for the year. This Capital Programme updated is based upon performance against that updated plan.

ADCU
This scheme is showing a 14% overspend for the first 2 quarters. This is due to phasing of the receipt of invoices which will normalise in Q3

IM&T
Spending against this scheme is minimal until the IM&T Strategy is finalised.

Quarterly Detailed Report
Business Intelligence as at September 13

Headlines

Opportunities to utilise capacity for additional activity due to other Providers failing to meet waiting time standards

Awaiting publication of main commissioners Commissioning Intentions for 2014-15

Risk of financial penalties being levied by Commissioners for breaches of the maximum 52 week wait standard after Q2

Benchmarking - DOH Hospital Activity Statistics Quarter 4

The following tables illustrate the change in activity between Q1 in 2012/13 and 2013/14 reported against the national picture from the DOH Hospital Activity Statistics recently published.
It should be noted that for referral data there will be additional referrals still to be authorised by Consultants that will increase the volume in Q2 2013/14

Table 1 - Comparison of Elective Admissions

	Quarter 2			
Admission Type	**12/13**	**13/14**	**Variance**	**%**
Elective Admissions	1,742	1,624	-118	-6.774%
Day Case	1,544	1,693	+149	+9.65%
Grand Total	**3,286**	**3,317**	**+31**	**+.943%**

Table 2 - Comparison of GP Referrals

	Quarter 2			
GP Referrals	**12/13**	**13/14**	**Variance**	**%**
No of GP Referrals	4,619	4,528	-91	-1.97%

Table 3 - Comparison of Outpatient Attendances

	Quarter 2			
Outpatient Type	**12/13**	**13/14**	**Variance**	**%**
New	4,013	4,047	+34	+.847%
Follow-Up	10,125	10,274	+149	+1.472%
Grand Total	**14,138**	**14,321**	**+183**	**+1.294%**

Table 4 - Market Share Analysis

The table below shows the 'Top 10' GP Practices referring to the Trusts' Services
Quarter 23

		2012-13		2013-14		
Rank	**GP Practice**	**Q3**	**Q4**	**Q1**	**Q2**	**Grand Total**
1	LORDSWOOD HOUSE GROUP	129	157	153	123	**562**
2	M M P SOUTH BIRMINGHAM	98	100	104	84	**386**
3	NORTHFIELD HEALTH CENTRE F	70	99	74	91	**334**
4	WYCHALL LANE SURGERY	82	78	76	92	**328**
5	HALL GREEN HEALTH	66	92	76	88	**322**
6	HOLLYMOOR MEDICAL CENTRE	74	93	79	73	**319**
7	LEACH HEATH MEDICAL CENTRE	74	76	57	67	**274**
8	KINGSFIELD MEDICAL CENTRE	50	79	63	79	**271**
9	MILLENNIUM MEDICAL CENTRE	74	64	61	61	**260**
10	JIGGINS LANE SURGERY	63	64	61	56	**244**

Please note that the latest quarter referral figures will be lower due to data currently being added to the system

Business Opportunities

Market Share Analysis
The Trust has been analysing its market share for local GP Practices (10 mile radius). One aspect of this analysis has focussed on the top 10 Trust procedures for the Hand and Foot service. This has shown that this is a very competitive market with the Trust and its main competitors (Dudley Group, HEFT) within the 10 mile radius having between 20-27% of market share and the Independent Sector having 10%.

Waiting List Initiatives for Local Trusts and Welsh Providers
The Trust has commenced treating long-waiting patients from WHAT. In addition the Trust is expecting to shortly receive patients transferred from SWBH . The Welsh Specialised Services are still reviewing their position, but have expressed a strong preference to use the Trust for transferring some of their long waiting patients from other Providers.

Commissioning Issues
The Trust will be submitting evidence for Q2 CQUIN milestones. The Trust will be reporting that it has failed the VTE Risk Assessment CQUIN in Q2 and is yet to achieve 3 consecutive months Dementia screening to the required level. Although the Trust has breached the Pressure Ulcer target of zero in Q2, the Commissioner is reviewing their position regarding withholding CQUIN payments at the year end .

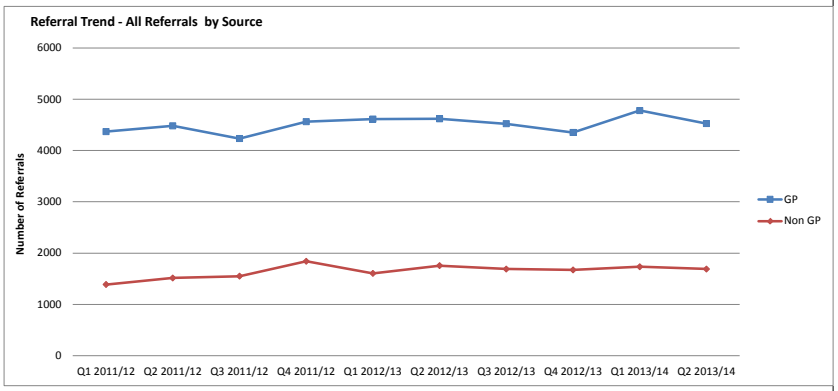
The NHS England Area Team Commissioners for Specialised Services have confirmed that they will be imposing financial penalties for each over 52 week waiter from October 2013. The Trust has made excellent progress in reducing the number o patients waiting over 52 weeks and as a consequence the Commissioners exempted the Trust from financial penalties in Q1 and Q2.

Worcestershire CCG have advised the Trust that they will not fund Electro-Acupuncture treatments from October 2013. The Trust has disputed this action on the basis that there has been no clinical dialogue between the respective parties and the CCG were supposed to be conducting an clinical effectiveness evaluation which has not been shared with the Trust. The Trust has made it explicit to the CCG that it does not except a QIPP deduction based on a cessation of this service without clinical engagement. The Trust is awaiting a response form the CCG.

2014-15 Commissioners Intentions
The Trust is expecting to receive the commissioning intentions from its commissioners over the next few weeks. The Trust understands that the NHS Standard Contract Terms are unlikely to change significantly next year. The Specialised Commissioners have issued their intentions for 2014-15 and the Trust is working through these. The CCGs will be revising the POLCV Commissioning Policies to create a set of universal policies across the Birmingham and Black Country area, however the Trust has been advised the impact on the Trust will be minimal.

Referrals

The number of referrals in Q2 2013-14 is likely to increase due to the time lag between receipt of referral and booking appointments.



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th October 2013 **ENCLOSURE NUMBER: 7**

SUMMARY OF REPORT TO
Trust Board

NAME OF DIRECTOR:	**Paul Athey / Amanda Markall**
SUBJECT:	**Programme Board Update**

SUMMARY

The attached paper provides an overview of the newly formed Programme Board, which has been set up to provide assurance on the delivery of projects operated through the Programme Management Office (PMO)

IMPLICATIONS

The Programme Management Office (PMO) provides a structure to support the delivery of a range of projects designed to improve patient care and experience, increase efficiency and to deliver financial savings.

The Programme Board has been introduced to strengthen the assurance process around this delivery. Without this assurance, there is a risk that important projects will fail to deliver within the required timescales, or will fail to realise the expected benefits upon completion.

RECOMMENDATIONS

The Trust Board is asked to note the contents of this paper

Programme Board Update – October 2013

Background

In October 2013, a Programme Board was introduced to strengthen the assurance process around the delivery of a range of projects operated through the Programme Management Office (PMO).

The Programme Board, which is chaired by the Director of Operations and includes a number of Executive Directors and senior operational managers, is designed to meet the following duties:

- Planning
    - To approve new projects for monitoring through the Programme Board, ensuring robust planning processes are in place prior to the commencement of the project.
- Implementation
    - Hold project leads to account for delivery, tracking key milestones and ensuring that planned benefits are realised and risks mitigated
    - Agree significant changes to deliverables and timescales at project and programme level
    - Own and manage trust-wide programme risks
    - Seek assurance that appropriate engagement has taken place with patients, staff and other stakeholders
- Post-Implementation
    - Gain assurance of project closure arrangements
    - Gain assurance that benefits continue to be delivered post project closure

Detail

The Programme Board met for the first time on 15th October, with the main aims to agree appropriate Terms of Reference for the Board, to agree the principles by which the programme will be managed and to agree an initial programme of work for the remainder of 2013/14 and into 2014/15.

It was agreed that the Programme Board would concentrate on a small number of key initiatives as outlined below:

Initiative	**Project Lead**
Cancellation of surgery	Directorate Manager for Large Joints
Enhanced Recovery	Directorate Manager for Large Joints
Nursing Workforce Review	Deputy Director of Nursing
6/7 Day Working	Director of Operations
CQUINs	Head of Commissioning
Medical Workforce Review	Medical Director

These projects would be monitored on a consistent manner through the use of standardised highlight and exception reports. In addition to these key initiatives, there are a number of ongoing projects that are currently managed through the Programme Management Office, or using PMO principles. These will also be required to provide reports for consideration at the Programme Board, and will be monitored on an exception basis as required. The current projects highlighted at the initial Programme Board meeting are as follows:

Current Projects	
Pre-Operative Pathway	Electronic Document Transfer
Out Patient Pathway	ADCU
Reduction of DNA	RTT Data Quality including electronic WL management
Direct Booking	Capacity Management
Digital Dictation	Increase in market share / growth
Standardisation of letter and copying to patients	Marketing
Medical Records Management	Maximising Procurement
WHH/Model of Care	Patient involvement and experience
ESR	Paediatric refurbishment

Executive Management Team will receive a progress report from the Chair of the Programme Board on a monthly basis, with a summary update provided to the Trust Board.

Recommendation

The Trust Board is asked to note the contents of this paper

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: 30th October 2013 **ENCLOSURE NUMBER: 8**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Anne Cholmondeley** **Director of Workforce & OD**

TITLE	**Quarter Two Workforce Report**

SUMMARY

This is the regular quarterly workforce report for Trust Board. The report focusses on workforce KPIs, recruitment process improvement and feedback from student nurses and doctors in training on their experience in the Trust.

RISK & IMPLICATIONS

The adverse results from the junior doctor surveys are a cause for concern however, there are actions being taken to address the underlying causes.

RECOMMENDATIONS

Trust Board is asked to note the report and actions taken to address the 'red' workforce KPIs.

Quarter Two Workforce Report

1. Key Performance Indicators

Sickness has continued to reduce during the quarter and the moving annual average is now 0.63% lower than last year. This represents a likely financial saving, excluding backfill costs of £145,000 (calculated on the basis of average earnings). The areas with high absence rates are ADCU (25%), Catering (19%) and Pharmacy (21%). Absence in catering and pharmacy has improved during October.

Staff turnover has increased by 0.17% during the quarter with the largest increases in the nursing workforce (registered and HCA). The review of the exit questionnaire has now been completed and all staff who have left in the last four months will be surveyed to ascertain any underlying trends and lessons for the future.

Agency expenditure has reduced by £65,000 pcm during the quarter, predominantly driven by reduced useage in corporate departments. The areas of highest useage continue in Medical staff, Wards (HDU and ADCU) and Pharmacy.

Mandatory training and appraisal levels continue to rise, but remain below 95%. Attendance at mandatory training sessions in October has continued to be high and therefore further improvements are expected in November.

Five key areas where improvements in appraisal are needed (IT, IM, Research and Teaching, Theatres and Medical Secretaries).

All of these areas have been asked to produce their remedy plans by mid-November to their respective directorates.

Consultant appraisals continue to improve and all individuals identified at the last Trust Board as being causes for concern have now booked appraisals during October and November.

2. Recruitment Performance and Process Improvement

The number of posts in active recruitment has reduced to 80 at the end of September (50 substantive staff and 27 bank workers). This is consistent with the 75 new staff starting employment during the quarter (48 substantive and 27 bank workers). The recruitment team have improved performance in month with the proportion of staff cleared within 8 weeks improving 9% to 89%. Subject to this level of performance being sustained, a more stretching target will be agreed with the team.

To support further process improvement two actions are being progressed. Firstly, the pilot for the electronic approval of vacancies for recruitment has now commenced in a number of clinical and corporate directorates. There is a facility for any immediate issues to be recorded and addressed by the HR and IT lead. At the time of writing there were no concerns logged. There will be an evaluation after 4 weeks with further roll out to the remainder of the Trust. Secondly, the availability of the recruitment tracker has been further delayed in implementation due to delivery issues within IT. These are being progressed by the Head of HR Operations.

3. Department of Health Sponsored Health and Wellbeing Project

The Trust is participating in an NHS Employers project to improve staff Health and Wellbeing. This is the second phase of a national programme to support those Trusts that are most challenged to reduce their sickness absence with the focus on implementation of the five high impact changes from the Boorman report:

- Developing local evidence based improvement plans
- With strong visible leadership
- Supported by improved management capability
- With access to high quality local Occupational Health Services
- Where all staff are encouraged and enabled to take more personal responsibility.

The first diagnostic phase of the project has been completed and a multi-professional action planning session took place in early October to identify priorities for action. These initial thoughts will now be developed into a programme of action overseen by the Workforce and OD Committee. The likely areas of priority will be developing the network of Health and Wellbeing champions, taking action on workplace stress and developing the capability of frontline managers.

4. Staff Survey

The 2013 survey is underway with 600 staff receiving a survey. The survey period runs until early December 2013. Two weeks into the survey period the Trust's response rate is 27%.

5. Feedback from Staff in Undergraduate or Post-Graduate Training

Two surveys of staff in training have taken place during the quarter:

a. Student Nurses

The six monthly evaluation report identified the following positive outcomes:

73.5% strongly agreed, 25% agreed they enjoyed their time on placement – no students disagreed

73.5% strongly agreed, 23.5% agreed they felt part of a team no students disagreed

64.7% strongly agreed, 35.2% agreed that they did not take on any responsibilities that were beyond their level of competence without supervision no students disagreed

75% strongly agreed, 23.5% agreed they received on-going support from their practice assessor only 1 student disagreed with this statement

A main area for improvement, raised by students within their feedback related to the working relationship and expectations from Health Care Assistants of Student Nurses and their role whilst on placement. This is being addressed with Ward Managers by the Practice Placement Manager.

b. Junior Doctors in Training

All doctors in training were eligible to participate in the National Training Survey undertaken by the GMC. This is one of the surveys used by the Care Quality Commission as a potential early warning sign of patient safety issues. There were insufficient respondents for Anaesthetics and radiology and therefore these results relate to the GP Trainees, an F2 trainee and SpRs in orthopaedics and histopathology. A summary of the results is attached in appendix one.

The area of good practice (upper quartile) was the regional training for the SpRs in orthopaedics. The areas of particular concern (bottom 25%) were:

- For GP Trainees – poor scores in the areas of adequate experience, local training and overall satisfaction. From feedback received by the Post Graduate Clinical Tutor, these scores relate to two factors – the allocation of one trainee to the spinal directorate for the whole six months (high volume of work with insufficient experience of relevance to a trainee GP) and the overall quality of supervision and training . To address these issues the PGCT has put in place a weekly teaching ward round and teaching session undertaken by the Consultant Physician and has introduced rotation within the spinal placement to create more variety and learning opportunities.

- For SpRs – inadequate experience. It is understood this is caused by trainees in large joints having insufficient practical operating experience. The PGCT is therefore exploring how SpRs can work partially in the Bone Tumour service in order to improve the amount of operating experience.

In order to better engage with junior doctors, the Medical Director will meet informally with the GP trainees and SpRs to discuss their placement in order to identify and resolve and underlying issues.

6. Changes to Learning and Development Funding and Outcome Measurement

EMT discussed the changes to the national funding of Learning for undergraduate and postgraduate training. The new arrangements that came into effect in April, change funding to a tariff approach, similar to that in place for clinical activity. The new model affects learning funding as follows:

- +£147k for non-medical education and training
- +£347k for undergraduate student doctors
- -£320k for junior doctors
  +£174k

This gain is dependent on the number of student placements continuing at current levels. The new tariff arrangements are phased in over fifteen years; however, the Trust has an immediate gain in year of £95k. EMT agreed for this to be invested in learning and development in the following ways:

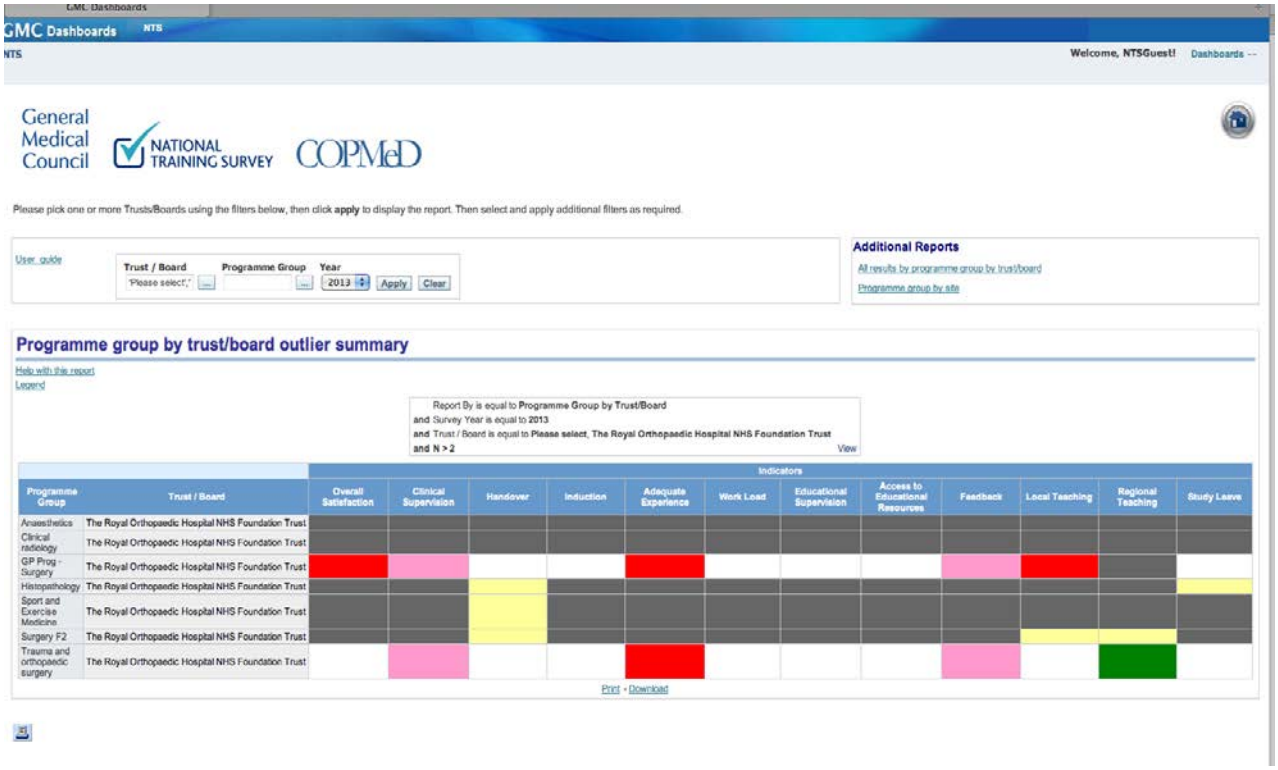
- Invest in a Deputy Head of Academy for undergraduate students
- Invest in a non-Clinical Trainer to support delivery of in-house training and reporting on Educational Outcomes
- Invest in an Educational Fellow to progress inter-professional learning
- Invest in an additional two apprenticeships

Further investment will be made on the basis of learning needs identified from integrated annual planning.

7. Equality and You – Raising Awareness

On 13th September 2013 the Trust held an event to raise awareness around equality and diversity issues and steps to eliminate bullying and harassment.

The event proved to be very popular, with a wide range of staff and patients visiting the stalls and engaging in conversations sharing their experiences, views and what it feels like for them to work in or receive treatment in the Trust. A quiz to test people's knowledge of key elements of the Equality Act 2010 was also provided with 63% of entries achieving 100%. This activity was part of the Trust's Equality Objectives for 2013/14.



Legend: outlier reports

The outlier reports show a grid where one row shows all the outcomes for each report group within that report.

The 'all results' reports show all outcomes for the selected report group(s) with a row for each outcome.

Colour key

Every outcome has a corresponding colour.

Red	Pink	White	Light green	Green
Below outlier	Within the lower quartile (Q1), but not a below outlier	Within the middle quartile (Q2/IQR)	Within the upper quartile (Q3), but not an above outlier	Above outlier

Grey	Yellow
n<3, result not published	n=0, no result

- Red – The score for the indicator is significantly below the national score in the benchmark group. A score is defined as being a below outlier if it meets all of the following criteria.
  - The upper 95% confidence limit associated with the indicator score must be below the lower 95% confidence limit of the benchmark indicator mean score.
  - The mean of the indicator score must be below the lower quartile (Q1) score of the benchmark group.
- Green - The score for the indicator is significantly above the national score in the benchmark group. A score is defined as being an above outlier if it meets all of the following criteria.
  - % confidence limit associated with the indicator score must be above the upper 95% confidence limit of the benchmark indicator mean score.
  - The mean of the indicator score must be above the upper quartile (Q3) score of the benchmark group.
- Light Green – The confidence interval overlaps with the inter quartile range, which could indicate that trainees' perceptions are positive. Result is in the 3rd quartile, but not an above outlier for the indicator result.
- Pink – The confidence interval overlaps with the inter quartile range, which could indicate that trainees' perceptions are negative. Result is in the 1st quartile, but not a below outlier for the indicator result.
- White – Result is within the inter quartile range, suggesting that result for this indicator are average.
- Grey – Insufficient number of respondents for the indicator result, n<3.
- Yellow – There are no respondents for the indicator result.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th October 2013 **ENCLOSURE NUMBER: 9**

SUMMARY OF REPORT TO TRUST BOARD

Director Lead:	**Helen Shoker, Interim Director of Nursing & Governance**
Authors:	**Lisa Pim, Interim Deputy Director of Nursing & Governance** **Alison Braham, Governance Manager**
SUBJECT:	**Patient Safety and Experience Board Report**

SUMMARY

This paper provides an update to the Board in relation to patient safety and patient experience during September 2013.

RISKS

Our patient's safety and their experience are central to the organisations values and is a high priority. This report will assist the Board's understanding and brings together key patient safety and experience issues.

RECOMMENDATIONS

The Board is asked to:

- **discuss** the Patient Safety and Experience report
- **note** areas of good practice
- **identify** areas of risk requiring further assurance
- **identify** any other patient safety and experience issues for inclusion in future reports
- **note** the reporting cycles vary for several safety initiatives

1. Serious Incidents requiring investigation (SIRI)

There has been 1 SIRI recorded in September; a decrease from 4 reported during the previous month (see appendix 1).

2. Deaths

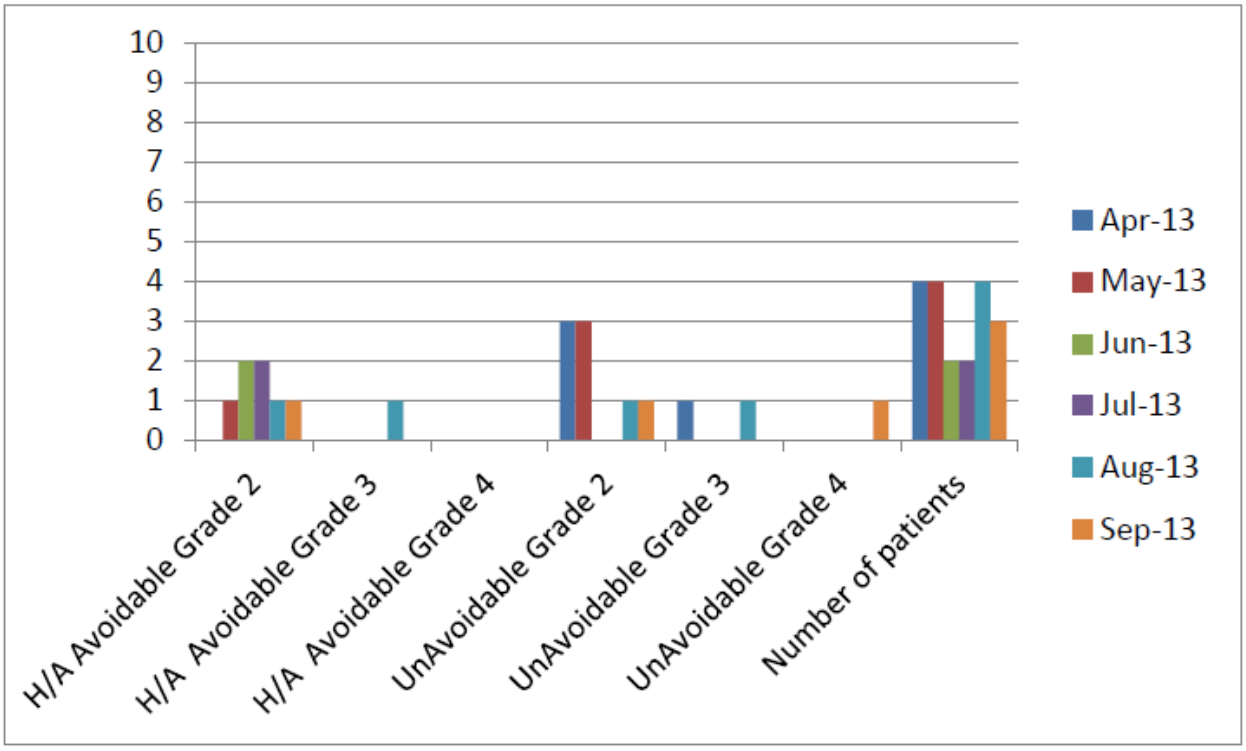
There was 1 unexpected death of a male patient who died at home after having recently been discharged. The patient had been undergoing treatment for Sarcoma, however the cause of death is currently unknown. The family have been fully informed of the subsequent investigation, in line with our duty of candour.

3. Incident trends

There was a rise in medication incidents during the period July to September 2013, with 86% of the reported medication incidents resulting in no harm to the patient, of which 8% of these were reported as near misses.

All medication incidents and RCA reports/action plans continue to be reviewed at the Medicines Safety Group which identifies and takes action on trends and commonly occurring issues. An aggregated 'Medication prescribing' action plan has been drawn up and is regularly reviewed by the group. This action plan will be reviewed in November with a view to closure or escalation if actions remain outstanding.

4. Pressure Ulcers



In September one grade 3 hospital acquired avoidable pressure ulcer was noted and two unavoidable, grade 2 and 4, noted. All appropriate actions have been taken as a result of the avoidable ulcer. The unavoidable pressure ulcers were due to either the general poor condition of the patient and/or non-compliance with preventative strategies/equipment, or a pressure ulcer developing despite all preventative strategies being put in place. It also must be noted as a specialist surgical provider complex orthopaedic surgery is undertaken which can result in lengthy operating times. Any Theatre environment poses challenges in maintaining skin integrity and all actions which could be taken in safety are.

The process of undertaking a Root Cause Analysis for all hospital acquired grade 2 and above ulcers continues. The Patient Harm Meetings are being enhanced from November by the introduction of a monthly ward action plan delivery meeting with the Director of Nursing. This will confirm that actions have been taken and learning transferred into the clinical team and setting.

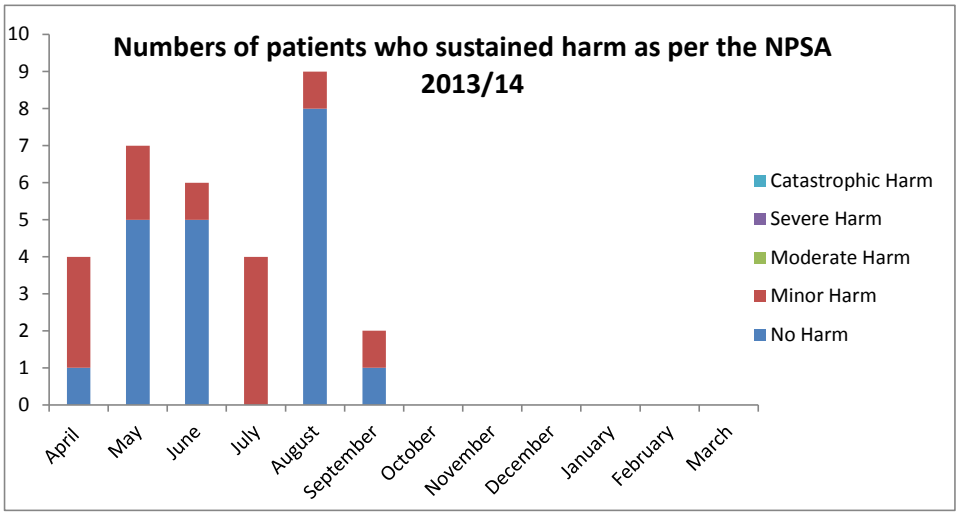
5. VTE risk assessment

The CQUIN target has not been achieved in August with three areas not meeting the required 95% target; ADCU, Ward 10 and Ward 1. A meeting was held with the Ward Leads and their administrative leads by the Deputy Director of Nursing and Clinical Nurse Tutor. Training and support were offered as well as clarification of their understanding of the process. Re-validation of Augusts data is being compiled to ensure patient safety can be assured.

6. Falls

There has been a reduction in the number of reportable inpatient adult falls (excludes assisted falls), table below.
Eight incident forms were received for the month of September categorised as (adult) patient falls, slips or trip. Following review of the incidents only 2 were identified as reportable falls both occurring on Ward 3 (patient independently mobilised without assistance).

<u>The number of patients who have sustained harm as a result of a fall.</u>



<u>Number of falls reported by area</u>

Location of Falls	Number of falls per area
Ward 1	3
Ward 2	0
Ward 3	2
Ward 10	0
Ward 12	1
Theatre	1
Corridor	1

All adult in-patient wards continue auditing falls assessment, care plan and patient management compliance. Low compliance data in September led to a repeated audit and profile raising exercise and is reported below in brackets.

		April	May	June	July	August	September
Q1.	**Has the falls assessment been completed within 6 hours of admission?**	100%	100%	95%	96%	96%	88% (98%)
Q2.	**If the patient is identified as high risk is a care plan in place?**	95%	95%	95%	92%	84%	74% (96%)

.

A reporting tool has recently been implemented to provide clarity of falls data reporting. This new tool will be evaluated for the benefits and outcomes in quarter three. A review of avoidable and unavoidable Falls is also being undertaken.

7. Ward Dashboard

The ward KPI's are currently being reviewed to ensure they reflect all the relevant care, quality and safety indicators, it is anticipated that an enhanced KPI tool will align to the new CQC assessment framework and be launched in quarter 4.

In September HDU has largely remained static. An overall red rating remains and whilst workforce and patient experience have moved to green, training, safety and outcomes are red for this month. The matron is supporting the ward manager with HR guidance.
Ward 12 is progressing well on KPI achievements.

The overall dashboard will be circulated at the Board meeting.

8. Compliments, Complaints and PALS

In September 298 compliments were received. Wards 1 (61), 2 (31) and Short stay (58) received the highest of our wards.
Number of Compliments by Directorate:

Directorate	Compliments Sept 2013
Clinical Support	13
Small Joint	4
Large Joint	126
Oncology	22
Paediatrics	30
Spinal	68
Theatres	10
Corporate	25

There has been an increase in the volume of complaints received this month from 7 (4 formal) to 22 (19 formal), a 214% increase. There was an expectation September would see an increase however this is a greater than anticipated based on the mean volume per month received in 2012/13 which was 13.3.

The results are directly comparable with the same period last year which also experienced a significant increase in complaints related to administrative processes. (Last year we saw a huge jump compared to the previous year). A significant number of complaints were dealt with

informally last year which is not the case for this year. September 2012, 10 of 27 were dealt with informally. September 2013, 3 of 22 were dealt with informally. This is due to the complainants wanting their complaint to be part of the formal process, regardless of the time taken to resolve their concerns.

The number of complaints responded to within an agreed timescale in September was100% (7/7), for which the KPI is 80%.

Formal complaints received in September are:

- Poor organisation and communications x 13
- Clinical outcome x 2
- Clinical care x 3
- Orthotics x 1

The reasons for this increase are being explored, with suggestions such as ROH annual leave is highest in summer months does this lead to inadequate communication and leadership of clinical services. It has also been suggested that our service users are more aware and therefore more demanding. Directorate teams continue to explore the causes of complaints and are requested to raise matters beyond their control with Executive leads.

PALS contacts rose in September from 73 to 91 (+25%) in comparison to last month. The areas of most concern are

- Transport/parking x 5
- Consultant appointment query x 3
- Private Patient enquiry x 2
- Clinical oncology queries x 4
- Interpreter requests x 3
- Physio referrals delay/going missing from OPD/Back Pain clinic to Physio x 7
- Spinal appointment/surgery date queries x 15

Number of PALS contacts received by Directorate

Clinical Support	31
Spinal	22
Large Joint	17
Corporate	11
Oncology	5
Paediatrics	3
Theatres	2
Small Joint	0

APPENDIX 1

New SIRIs September 2013 – 1

Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final report due
11539	07/9/13	10/09/13	Unexpected death	Catastrophic	Oncology	Investigation underway	05/11/13

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th October 2013 **ENCLOSURE NUMBER: 10**

SUMMARY OF REPORT TO Trust Board

NAME OF DIRECTOR:	**Graham Bragg, Acting Chief Executive**
SUBJECT:	**IT Programme Update**

SUMMARY

This paper is intended to update the members of the Trust Board on the changes that have taken place regarding the management of the Information Management & Technology (IM&T) Departments within the Trust and the actions being taken to continue the investment programme in IM&T to support the provision of patient care.

IMPLICATIONS

Leadership of the IM&T function is essential to ensure that staff engagement and users requirements are considered in the design of any IT infrastructure and software applications. The lack of leadership could lead to a lack of focus on value for money and implementation of a robust investment programme thereby hindering support to provide high quality care for patients.

RECOMMENDATIONS

The Trust Board are asked to note:

- The arrangements being made following the change in leadership of the IM&T function.
- The intention to proceed to tender in November/December for the provision of data storage and disaster recovery system and user facing hardware so that approval can be given at the February 2014 Trust Board for the purchase of the appropriate services/equipment.
- Progress in developing the IT Strategy.

Detail

Management and Governance Structure

The management of the IM&T Department and the development of the IT Investment Programme was in the hands of an external contractor until mid-September. The Acting Chief Executive decided that it was inappropriate to continue with this arrangement if he was to ensure value for money and staff engagement for the solutions being designed.

Since the middle of September the Acting Chief Executive has taken responsibility for the IT Department and the IT Investment Programme and the Director of Finance has taken responsibility for the Information Management function.

In order to ensure strong governance arrangements an IM&T Programme Board has been established which will report to the Executive Management Team. Underneath the IM&T Programme Board there will be project boards for each specific project going forward. The Acting Chief Executive is the chair of the IM&T Programme Board which includes the Director of Finance, Directorate Manager for Theatres, Anaesthetics & Critical Care as a senior business user and in attendance are the Programme Manager Support Officers, the IT Service Manager and the Informatics Service Manager. The group will include senior clinical user representation in the near future.

Review of IT Programme

There has been a full review of the IT programme to ensure that focus is placed on fewer schemes to ensure that they are completed on time. At the same time, consideration has been given to the amount of external resource that is required in order to deliver the projects.

The IM&T Programme Board have reviewed the schemes and agreed that the following should take place:-

- Infrastructure Project – business case to be completed and specification to be developed to go to the market in November/ December with the intention of awarding contracts by the end of February 2014 with phased implementation starting some 4 to 6 weeks after.
- Heel Pain (software system) – complete and operational by the 6th November 2013.
- Metal-on-Metal (software programme) – functional specification to be completed by the Directorate as soon as possible and business case to be submitted to the IM&T Programme Board for consideration of resource allocation to develop.
- Spinal Outcomes - This could consist of a software development in-house or purchase of bespoke software. Consideration is being given to a number of options by the Clinical Director. The Deputy Medical Director is developing a Trust Outcomes Strategy to ensure consistency of process, input and monitoring across all aspects of the Trust's activity.

- Electronic Data Transfer (Electronic Discharge Letters) – scheme to proceed as a matter of urgency.
- Approval to Recruit (HR recruitment and tracking software) – to be completed by the end of November.
- TIE (Trust Integration Engine) – to be postponed until infrastructure project is in implementation phase.
- E-Prescribing – development of a robust business case to commence in the near future. Bid for £500k toward the implementation costs has been made against a specific fund held by NHS England. Outcome will be known at the end of October.

In line with consideration of the above schemes it has been determined not necessary to continue with the contractor appointments for the business analysts and one of the programmers. Further consideration of the project management support will be carried out shortly.

IT Strategy

The IT Strategy has been drafted by the outgoing Chief Information Officer, however this needs a considerable amount of discussion and consultation with users before it will be brought to the Trust Board for approval. However it is clear that any strategy will require investment in the current infrastructure and therefore it is felt appropriate to continue with this significant project.

Next Steps

The Project Board has been established for the Infrastructure Project and will continue to meet in order to take the project forward within the timescales referred to above. The likely cost of this project is £1.1m capital and £270k recurring revenue.

Regarding the appointment of a Chief Information Officer the Remuneration Committee will be considering a recommendation to appoint a permanent individual in the near future.

Conclusion

The IM&T function and investment programme has experienced some disruption over the last few weeks and in an attempt to ensure greater value for money, staff engagement and a more appropriate outcome, strong governance arrangements have now been put in place.

The infrastructure project which will build the foundations for the future is continuing to its original timetable.

The appointment of a substantive Chief Information Officer will hopefully take place shortly.

The draft IT Strategy will be consulted on within the hospital; before it is brought to the Trust Board for consultation.

Thanks go to the officers who constitute the newly formed IM&T Programme Board who have taken on additional duties in order to maintain momentum of the programme and service provided to users.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th October 2013 **ENCLOSURE NUMBER: 11**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Bryan Jackson, Chairman**
AUTHOR:	**Joy Street** **Company Secretary**
SUBJECT:	**Board Assurance Framework Risks 2013/14**

SUMMARY

The attached report gives details of the one Board Assurance Framework Risk managed via Trust Board. It has recently been updated and transferred to the electronic risk register database ('Ulysses Risk Register').

IMPLICATIONS

Scrutiny and challenge of BAF risks is essential to ensure that any risks are identified and managed.

RECOMMENDATIONS

The Board is asked to:

- **Note** the attached risk paying particular attention to the current risk score for Executive Director Continuity and Corporate Memory, which is now lower than in the previous month following the successful appointment of a new CEO.
- **Identify** any additional risks for inclusion onto the BAF/ CRR

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Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Risk Number & Version			
Risk Number & Version:	11 Ver 1	**Risk Level:**	2. BAF Prinicpal Risk

Risk Details			
Opened:	09/09/2013		
Status:	Static	**Strategic Objective:**	2.3 Manage People To Enable To
Risk Type:	BAF Related	**Source Of Risk:**	
Team/Project:		**Risk Category:**	
Directorate:		**Risk Owner:**	Bryan Jackson
Monitoring Committee:	EMT	**Operational Lead:**	Joy Street

Details of the Risk	
Risk Description:	Executive Director Continuity and Corporate Memory
Causes:	Executive Director Continuity and Corporate Memory. Old ref: 155
Consequences:	3.0

Initial Risk Rating

Likelihood	***Consequence***				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	***Score : 16***	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	Score : 4	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Initial Risk Rating:	High (Red)
Initial Risk Score:	16

Current Controls & Assurances

Control Details:	Board turnover very high from November 2012 to October 2013. Regularly reviewed by Board and mitigated by prompt recruitment, appropriate and timely interim arrangements and effective handovers
Adequacy of Controls:	Adequate
Independent Assurance:	Regular review by remuneration committee of board Review of risk at each board meeting

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Current Risk Rating

Likelihood	*Consequence* 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	Score : 4	***Score : 6***	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Current Risk Rating:	Low (Yellow)
Current Risk Score:	6

Additional Controls & Assurances

Priority:			
Action Lead:	Joy Street		
Person Accountable:			
Action Details:			
Progress:			
Outcome:	Closed	**Completion Date:**	20/09/2013

Priority:		**Start Date:**	16/09/2013
Action Lead:	Bryan Jackson	**Target Date:**	25/09/2013
Person Accountable:	Joy Street	**Reminder Date:**	22/09/2013
Action Details:			
Appointment of new CEO september 2013 - start dat early 2014 Interim Director of Nursing appointed end September 13 NED continuity for two ends of term being recommended to governors			
Progress:			

Priority:		**Start Date:**	15/10/2013
Action Lead:		**Target Date:**	07/10/2013
Person Accountable:		**Reminder Date:**	04/10/2013
Action Details:			
Interim Director of Nursing in place for 6 months having had one week handover.			
Progress:			

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Target Risk Rating

Likelihood	*Consequence*				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	***Score : 4***	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Target Risk Rating:	Low (Yellow)
Target Risk Score:	4

Notifications

Date:	Notification Group:	Notified Staff Member:	Info Only:
16/09/2013	Additonal Notification	Joy Street	N

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th October 2013 **ENCLOSURE NUMBER: 12**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Graham Bragg, Acting Chief Executive**
AUTHOR(S)	**Graham Bragg**
TITLE	**Governance Declaration – Quarter 2 2013/14**

SUMMARY

To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 2 2013/14 to Monitor. This declaration is the last prepared in line with the requirements of the Compliance Framework issued by Monitor for 2013/14. Subsequent declarations will come under the new Risk Assessment Framework. .

RISK & IMPLICATIONS

The implications for the Trust relate to national policy/legislation and performance ratings, as well as compliance with our license.

RECOMMENDATIONS

It is recommended that the Board approve the following submissions to Monitor:

For Finance that:
The Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.

For Governance that:
The Board is unable to confirm its satisfaction that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application thresholds) as set out in Appendix 1; and a commitment to comply with all known targets going forwards. An exception report will be submitted to Monitor regarding the failure to achieve the 62 day cancer target.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report To	Trust Board
Report Of	Graham Bragg, Acting Chief Executive
Report Presented By	Graham Bragg, Acting Chief Executive
Purpose of the Report	To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 2 2013/14 to Monitor

1.00	**Background** The Trust is required to submit a quarterly declaration to Monitor concerning financial and governance performance. This covers achievement of national targets and core standards as outlined in Monitor's Compliance Framework. The Q2 submission is due on the 30th October 2013 and subsequent returns will be under the Risk Assessment Framework.
2.00	**Detail** The reporting requirements summarised above are addressed and evidenced as follows. 1. <u>Financial information</u> The evidence to assure the Board that the Trust has met its financial targets for the 3 months from the 1st July to 30th October 2013 is contained in the Trust Corporate Performance Report and the performance against the indicators of forward financial risk detailed in Appendix Two. 2. <u>Service Performance Targets – Governance and Patient Experience</u> The table of Monitor requirements and evidence is Appendix One of this report. The Trust has continued to achieve and sustain the delivery of the three waiting time targets that the Board were unable to confirm in the Quarter 4 report for 2012/13. This is evidenced in the Corporate Performance Report in July, August and September 2013. The numbers of tertiary referrals on a 62 day pathway for Quarter 2 were significantly lower than the comparable quarter last year (19 versus 14) although over the year referrals vary significantly. As an organisation we manage the following risks which impact upon cancer target performance: - Our referral numbers are relatively small and can be wide ranging from as high as 23 to as low as 9 patients on 62 day pathways - We are a specialist / tertiary centre and as such our patients have already had intervention from secondary centres prior to their referral. - Due to their complex nature, patients are often referred very late into

their pathway and occasionally they have already breached.

- We treat tumours from every part of the body and treat 200 different pathology types. Often patients require a custom made prosthesis or complex surgical reconstruction which requires irradiation and re-implantation of bone.

Despite this we have consistently achieved our cancer waiting time targets over recent years.

However the Trust has failed to achieve its 62 day cancer target in September 2013. One patient breached in July and two half breaches have been attributed to the hospital in September. In the first instance the patient was referred on 26th March 2013, the diagnosis was completed and was formally concluded on the 21st May 2013. The surgical plan was agreed but needed to be carried out in conjunction with another hospital, further complications occurred which delayed surgery and the patient was treated on the 14th July 2013.

The two shared breaches were due to referrals being received from other hospitals late in the pathway and a request by a patient to go on holiday before treatment together with delay by another hospital commencing radiotherapy.

After investigation the CCG's have agreed to see how they can ensure referrals are received as quickly as possible and with the correct information via the contractual process.

3. It is good practice for the Board to maintain an in-year review of its broader governance responsibilities although these are not required to be reported unless there are significant concerns about Board or Governor capability.

- The substantive Chief Executive has now been appointed and will take up post on December 2nd 2013. The current Acting Chief Executive will remain in at the Trust until the end of December 2013 to ensure a smooth handover.
- The Director of Nursing and Governance has been promoted to a position at Worcestershire Acute Hospitals NHS Trust. Her position has been filled on an interim basis for a six month period with effect from early October 2013. The appointment process for the substantive position will commence in November.
- Staff Governors' were elected as follows:-
  - Non Clinical – Sue Lococo
  - Clinical – Ronan Treacy (surgeon)

  There has been one governor resignation from Rest of the West Midlands, Ken Williams.
- The Company Secretary maintains a register of conflicts of interests for both the Board and Council of Governors which is updated on an annual basis and no material conflicts have arisen.
- An exercise on staff engagement across the Trust has been reported to the Board and been widely disseminated to staff on a face to face basis throughout the Trust. Recommendations have been validated by staff

who took part via an interactive feedback and voting session and these have been prioritised for the remainder of 2013/14.

- The Integrated Governance Committee has met twice during the quarter and reviewed the relevant assurances that risks to compliance are being managed.
    a. It has reviewed all risks on the Corporate Risk Register not contained within the Assurance Framework to ensure new risks are added, risks are escalated as necessary to the Assurance Framework and that action plans are in place to address any gaps in control or assurance.
    b. It has received assurance from reporting committees that these risks are being managed in a timely fashion.
    c. It has met the requirements laid out in the IGC annual work plan approved by the Audit Committee.
    d. It has received assurance that the Trust is delivering its mandatory services and partnership requirements.
    e. It has had assurance of compliance with the CQC central standards of safety and quality.
    f. It has reviewed and self assessed against the requirements set out in the Quality Governance Framework.
    g. It has been given assurances that recent PROMS data has been disseminated to clinical directorates and will be used to improve patient care.
    h. It has considered as part of the committee structure review those areas which it believes would be better monitored elsewhere and will be making recommendations to the Board.
    i. The IGC will, from October 2013, become the Clinical Governance Committee.
- The Audit Committee met once during the period in respect to this declaration and can offer the following assurance:
    a. The committee received updates on the work of the External Audit, Internal Audit and Local Counter Fraud Services. It was noted that two pieces of work planned for the end of Quarter One has been slipped into Quarter Two to enable systems that were being audited to be embedded. The Committee asked for assurance that this would not adversely affect the delivery of the overall work plan. Internal Audit confirmed that this was not a concern and that they would be in regular contact with the Director of Finance and the Chair of the Audit Committee to ensure that all work streams were on track.
    b. The Committee reviewed the losses and compensations and the Trust policies around single tender actions and procurement breaches and made constructive suggestions for improvement.
    c. The Committee approved the process for the production of the Trust's reference costs as per Monitor's new requirements, but requested that further assurance be sought through the year with support from audit.
    d. The Committee approved its annual report for circulation to the Trust Board.

	e. The Committee discussed the process for assuring themselves of the effectiveness of audit and counter fraud services. f. The Company Secretary presented proposals for a new Board sub-committee structure. g. The Committee reviewed the Board Assurance Framework and challenged where catastrophic risks to business continuity were recorded and managed. 4. The Trust Board received assurances from Integrated Governance and the Audit Committee that the management of risks is appropriate and key risks have been identified. 5. The Board received and approved the Audit Committee's Annual Report and formal work plan at its September meeting. 6. Board meetings have been held in public since July 2012.

Appendix One – Compliance Framework
Governance Declaration Criteria

CPR Area	**Indicator**	**Threshold (1)**	**Weighting**	**Evidence for Q2FY 2013/14**
Safety	Clostridium (C.) difficile – meeting the C. difficile objective	0	1.0	CPR – within target
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	0	1.0	CPR - within target
Quality	All cancers: 31-day wait for second or subsequent treatment, comprising: surgery	94%	1:0	CPR- 100%. Within target
Quality	All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	1:0	**CPR – 82%. Within target**
Patient Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	1.0	CPR – 90% Within target
Patient Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	1.0	CPR – 96% Within target
Patient Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	1.0	CPR – 92% Within target
Quality	All cancers: 31-day wait from diagnosis to first treatment	96%	0.5	CPR– 100%.Within target
Quality	Cancer: two week wait from referral to date first seen, comprising: all urgent referrals (cancer suspected)	93%	0.5	CPR– 100% Within target

Appendix Two – Finance Risk Indicators

	Finance Risk Indicators	Response
1	**Unplanned decrease in (quarterly) EBITDA margin in two consecutive quarters**	**FALSE**
2	**Trust is unable to certify that Board anticipates that the Quarterly FRR will be at least 3 over the next 12 months (from Governance Statement)**	**FALSE**
3	**Working capital facility (WCF) was used at any point in the quarter ending 30 Sep 2013**	**FALSE**
4	**Debtors > 90 days past due account for more than 5% of total debtor balances**	**TRUE**
5	**Creditors > 90 days past due account for more than 5% of total creditor balances**	**TRUE**
6	**Two or more changes in Finance Director in a twelve month period**	**FALSE**
7	**Interim Finance Director in place over more than one quarter end**	**FALSE**
8	**Quarter end cash balance <10 days of *(annualised)* operating expenses**	**FALSE**
9	**Capital expenditure < 85% of Latest Plan for the year to date**	**FALSE**
10	**Capital expenditure > 115% of Latest Plan for the year to date**	**FALSE**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th October 2013 **ENCLOSURE NUMBER: 13**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Joy Street**
SUBJECT:	**Board Committee Terms of Reference**

TITLE: Board Committee Terms of Reference

SUMMARY

The attached terms of reference have been prepared following discussion by each committee and are proposed for adoption.

IMPLICATIONS

There are no inherent risks in this proposal since its intention is to improve governance.

RECOMMENDATIONS

The board is asked to approve the terms of reference for:
Clinical Governance, Audit, Nominations and Remuneration, Investment and Charitable Funds committees. These will be reviewed by each committee on an annual basis for approval of any amendments prior to each financial year and this should be built into the committee's workplan between January and March on an annual basis.

REPORT ATTACHED:

Report Reference:

Royal Orthopaedic Hospital NHS Foundation Trust

Audit Committee

1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as Audit Committee. The Committee is a non-executive committee and as such has no delegated authority other than that specified in these Terms of Reference

2 Delegated Authority

The Committee has the following delegated authority:
2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
2.1.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,
2.1.3 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.
2.1.4 The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

To provide independent oversight and scrutiny of compliance and effectiveness across the whole organisation and all its functions. Internal and external auditors are a key means to providing that assurance.

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:

<u>6.1 Internal control and risk management</u>

6.1.1 To ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.
6.1.2 To maintain an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.
6.1.3 To review the adequacy of the policies and procedures in respect of all counter-fraud work.
6.1.4 To review the adequacy of the foundation trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.
6.1.5 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

6.1.6 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.
6.1.7 To provide assurance over the processes and information relied upon as part of the Trust's annual, quarterly and ad hoc declarations to Monitor.

6.2 Internal audit & counter fraud

6.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.
6.2.2 To oversee on an on-going basis the effective operation of internal audit in respect of:
• Adequate resourcing
• Its co-ordination with external audit
• Meeting mandatory Public Sector Internal Auditing Standards.
• Providing adequate independent assurances;
• Meeting the internal audit needs of the foundation trust.
• Delivering the agreed internal audit programme.
6.2.3 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.
6.2.4 To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
6.2.5 To conduct an annual review of the internal audit function and market test at least every 5 years.
6.2.6 To ensure that appropriate processes and resources are in place to support the detection and prevention of fraud.
6.2.7 To consider the major findings of counter fraud investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.3 External audit

6.3.1 To make recommendations to the Council of Governors in respect of external auditors covering:-
- Appointment
- Reappointment
- Removal

Consideration should be given auditors work and fees on an annual basis, involving a market testing exercise at least once every 5 years. To the extent that recommendations are not adopt by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendations were not adopted..
6.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.
6.3.3 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.
6.3.4 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

6.4 **Review of Annual Report & Accounts, incorporating the Quality Account**

6.4.1 To review the annual statutory accounts, before they are presented to the board of directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

• The meaning and significance of the figures, notes and significant changes
• Areas where judgment has been exercised
• Adherence to accounting policies and practices
• Explanation of estimates or provisions having material effect
• The schedule of losses and special payments
• Any unadjusted statements
• Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

6.4.2 To review the annual report and statement of internal control before they are submitted to the board of directors to determine completeness, objectivity, integrity and accuracy.

6.4.3 To receive the Annual report and associated annual opinion from the HOIA and to consider the AES is consistent with this opinion.

6.4.4 To review the annual quality account before it is submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

6.5 Standing orders, standing financial instructions and standards of business conduct

6.5.1 To review on behalf of the board of directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

6.5.3 To review the scheme of delegation.

6.6 Other

6.6.1 To review performance indicators relevant to the remit of the audit committee.

6.6.2 To examine any other matter referred to the audit committee by the board of directors and to initiate investigation as determined by the audit committee.

6.6.3 To annually review the accounting policies of the foundation trust and make appropriate recommendations to the board of directors.

6.6.4 To develop and use an effective assurance framework to guide the audit committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

6.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health (and social care) sector and professional bodies with responsibilities that relate to staff performance and functions.

6.6.6 To review the work of all other foundation trust committees in connection with the audit committee's assurance function.

6.6.7 To produce an annual report for Trust Board covering the activity and effectiveness of the Audit Committee.

7 Permanency

The Committee is permanent

8 Membership

Chair

A non-executive Director

Other members (voting)

At least two other NEDs

In attendance (non-voting)

Chief Executive
Director of Finance
Internal Auditors
External Auditors

9 Quorum

At least two NEDs and one from either CEO or DOF

Secretariat

PA to Director of Finance

Internal Executive Lead

Director of Finance

Frequency of meetings

Not less than 6 times per annum

Work programme

The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes

.

Review of terms of reference

This should be undertaken annually.

Date of adoption

Date of review

Royal Orthopaedic Hospital NHS Foundation Trust
Clinical Governance Committee

1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Clinical Governance Committee. The Committee is a non-executive committee and as such has no delegated authority other than that specified in these Terms of Reference

2 Delegated Authority

The Committee has the following delegated authority:
2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
2.1.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,
2.1.3 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

Oversight and scrutiny of all aspects of quality, patient safety, clinical outcomes, effectiveness and experience
To assure the board that robust systems and processes are in place to enable the Trust to:
5.1.1 Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,
5.1.2 Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:
6.1 Contract management and Commissioning
6.1.1 Ensure that commissioners are provided with evidence of trust performance in line with contractual requirements
6.2 Leadership for quality
6.2.1 Ensure that the clinical and non-clinical leadership of the Trust is focussed on quality and has the necessary skills to lead efforts across the organisation to drive continuous quality improvement.

6.2.2 The committee will review the trust's quality reports (from Quality Committee, Quality Governance Framework) and approve the annual Quality Account for inclusion in the Annual Report
6.3 Regulatory Assurance – Monitor and CQC (review of guidance, CQC outcome assurance report, quarterly governance declaration)
6.3.1 The committee will ensure compliance with standards set by the Care Quality Commission and, insofar as they relate to clinical matters, those set by Monitor
6.3.2The Committee will seek assurance that there are robust systems and processes in place for monitoring and assuring the quality of services and for driving continuous quality improvement.
6.4 Clinical Audit of outcomes and effectiveness (reports from Clinical Outcomes and effectiveness Committee)
6.4.1 The committee will oversee the annual programme of clinical audit – this will include surgical audit, anaesthetic audit, histopathology audit, radiology audit, participation in national audits and locally determined audits
6.5 Other
6.5.1 The committee will assure the Board that the Trust's research activity complies with necessary regulations and supports the Trust's strategy (reports from Research and Development Committee)
6.5.2 The committee will assure the board that the Trust's medical and clinical education meets the required standards.
6.6 Risk management
6.6.1 The committee will regularly review clinical risk - in particular, Board Assurance Framework clinical risks, Corporate Risk Register and those risks owned by executive committees providing assurance to the Clinical Governance Committee.
6.7 The committee will review reports from other committees as outlined below:
6.7.1. Committee reports at agreed intervals from -drugs and therapeutics, infection control, safeguarding children and adults
6.8 The committee will consider feedback from the Trust's patient groups and from peer reviews.
6.9 The committee will consider insurance cover for the Trust and will oversee NHSLA or any successor body's requirements for securing best value.

7 Permanency

The Committee is permanent

8 Membership

Chair
A non-executive Director with a clinical background
Other members (voting)
At least two other NEDs
Medical Director/Deputy Medical Director
Chief Executive
Director of Nursing, Strategy and Governance
Company Secretary
In attendance (non-voting)
Executive Committee chairs or members invited to attend.

9 Quorum

At least 2 NEDs and one from Medical Director or Director of Nursing

Secretariat
Executive Assistant to CEO

Internal Executive Lead
Director of Nursing, and Governance

Frequency of meetings
At least 8 meetings per annum

Work programme
The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes
.
Review of terms of reference
This should be undertaken annually.

Date of adoption October 30th 2013
Date of review January to March 2014 and annually thereafter

Royal Orthopaedic Hospital NHS Foundation Trust
Nominations and Remuneration Committee

1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee. The Committee is a non-executive committee and as such has no delegated authority other than that specified in these Terms of Reference

2 Delegated Authority

The Committee has the following delegated authority:
2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
2.1.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,
2.1.3 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

To assure the board that processes are in place for the recruitment and remuneration of CEO and Executive Directors and to assess risk with regard to overall organisational fitness for purpose.

6 Duties

The Committee will deliver its Objectives by seeking assurance across The following areas:

6.1 REMUNERATION

6.1.1 To decide and review the terms and conditions of office of the foundation trust's executive directors (and senior managers on locally-determined pay) in accordance with all relevant foundation trust policies, including:
• Salary, including any performance-related pay or bonus
• Provisions for other benefits, including pensions and cars
• Allowances.
6.1.2 To monitor and evaluate the board performance of individual directors.
6.1.3 To adhere to all relevant laws, regulations and trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors whilst remaining cost effective.
6.1.4 To advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments.

(No executive Director may take part in discussions affecting their own remuneration and terms of office)

6.2 ORGANISATIONAL CAPABILITY

6.2.1 Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board or Council of Governors where appropriate with regard to any changes.
6.2.2 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors taking into account the challenges and opportunities facing the foundation trust and the skills and expertise needed, in particular on the board in future.
6.2.3 Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
6.2.4 Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.
6.2.5 Consider any matter relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the foundation trust.
6.2.6 To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

7 Permanency

The Committee is permanent

8 Membership

Chair

A non-executive Director – the Chairman or Senior Independent Director

Other members (voting)

All Non-Executive Directors

In attendance, by invitation (non-voting)

CEO
Director of Finance
Director of Workforce and organisation Development

9 Quorum

At least 3 NEDs must be present including the Committee Chairman.

Secretariat

Company Secretary.

Internal Executive Lead

CEO

Frequency of meetings

Not less than 3 times per annum

Work programme

The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document, which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes.

.

Review of terms of reference

This should be undertaken annually.

Date of adoption **October 30th 2013**

Date of review **January to March 2014 and annually thereafter**

Royal Orthopaedic Hospital NHS Foundation Trust
Investment Committee

1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Investment Committee. The Committee is a non-executive committee and as such has no delegated authority other than that specified in these Terms of Reference

2 Delegated Authority

The Committee has the following delegated authority:
2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
2.1.2 The authority to give advice on projects and business propositions at an early stage on behalf of The Trust Board on matters relevant to the objective of the Committee; and,
2.1.3 The authority to establish Task and finish groups. The Committee shall determine the membership and terms of reference of those groups.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

To assure the board that new service developments which present a material financial or reputational risk have been assessed for potential impact prior to presentation to the Board for approval.

6 Duties

The Committee will deliver its Objective by seeking assurance that all factors influencing the financial impact have been considered, that potential risks have been identified and will be managed appropriately and that the proposals are in line with the strategic direction of the business across the following areas:

- New business proposals which require pump-priming investment in excess of a value to be determined from time to time by the Trust Board
- New business proposals which present potential reputational risk
- New projects which require any form of significant partnership or joint working with an external organisation within the NHS or outside the NHS
- Material proposals relating to the exploitation of intellectual property rights

7 Permanency

The Committee is permanent

8 Membership

Chair
A non-executive Director

Other members (voting)
At least two other NEDs
Chief Executive
Director of Finance
Company Secretary

In attendance (non-voting)
At the discretion of the committee

9 Quorum

At least 2 NEDs and either CEO or DOF

Secretariat
PA to Director of Finance

Internal Executive Lead
Director of Finance

Frequency of meetings
The committee will meet at least four times a year

Work programme
The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document, which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes
.

Review of terms of reference

This should be undertaken annually.

Date of adoption **October 30th 2013**

Date of review **January to March 2014 and annually thereafter**

Royal Orthopaedic Hospital NHS Foundation Trust
Charitable Funds Committee

Constitution
The Board hereby resolves to establish a Committee of the Board to be known as The Charitable Funds Committee.

1.1 The Trust Board is the corporate trustee and as such cannot delegate responsibility for the charity's overall priorities, strategy, budget and reporting responsibilities.
1.2 The Committee is a non-executive committee and as such has no delegated authority other than that specified in these Terms of Reference.

2.Delegated Authority
2.1 The Authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee.
2.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,
2.3 The Committee may act with such authority delegated to it by the Trust Board from time to time and in accordance with the legislation pertaining to the role of Trustees of Charitable Funds.

3. Accountability
3.1 The Trust Board

4. Reporting Line
4.1 The Trust Board

5. Objective
5.1 On behalf of all voting members of the Trust Board (being the Corporate Trustee In law under the Terms of the Charities Acts) oversee the day to day activities of the Charitable Funds in accordance with the Committee Terms of Reference.

6. Duties
6.1 On behalf of all Members of the Trust Board (being the corporate Trustee in law under the terms of the Charities Acts) the Committee will:
6.1.1 Develop and recommend for approval to the Trust Board (as the corporate Trustees) on an annual basis a business plan that sets out the strategy for the charity, its priorities for expenditure and how these priorities link with the business plan for the current year.
6.1.2 Develop an annual work plan for the committee to be approved by the Board
6.1.3 Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.
6.1.4 Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds.
6.1.5 Develop and recommend to the Trust Board a fundraising policy for the Charitable Funds.
6.1.6 Develop and recommend to the Trust Board an investment strategy for charitable funds.

6.1.7 Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds.
6.1.8 Receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds and to review the regular investment reports supplied by the Trust's investment brokers if appointed.
6.1.9 Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds
6.1.10 Receive regular budgetary information in respect of each fund. Consider and approve the Annual Charitable Funds accounts and the Annual Report to the Charities Commission.
6.1.11 Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance.
6.1.12 Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds.
6.1.13 To approve all individual items of expenditure within limits delegated by the Trust Board in accordance with the Charitable Funds Standing Financial Instructions.
6.1.14 To consider all business cases involving the use of Charitable Funds.

7. Permanency
7.1 The Committee is Permanent

8. Membership
8.1 The Chairman of the Committee will be a non-executive director.
8.2 Other members:
A governor representative
A patient representative
A patient facing staff member
All voting members of the Trust Board

8.3 At any meeting of the Committee, the Chairman if present shall preside. If the Chairman is absent from the meeting then another Non-Executive Director

9. Quorum
9.1 Four members of which one must be a Non-Executive Director and either Chief Executive Officer or Director of Finance

Secretariat
Head of Financial Accounting

Internal Executive Lead
Director of Finance

Minutes
The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.
Minutes of the meetings will record conflicts of interest and what steps were taken to manage them.

Reporting
A report of the proceedings will be given by the Chair at the next Trust Board.

Review
The Terms of Reference of the Committee will be reviewed by the Trust Board every 3 years.

Frequency of meetings
Meetings will be held four times a year.

Work programme
The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document, which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes.

Review of terms of reference
This should be undertaken annually.

Date of adoption	**October 30th 2013**
Date of review	**January to march 2014 and annually thereafter**

Royal Orthopaedic Hospital NHS
Foundation Trust

Charitable Funds Committee

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as The Charitable Funds Committee.

1.1 The Trust Board is the corporate trustee and as such cannot delegate responsibility for the charity's overall priorities, strategy, budget and reporting responsibilities.

1.2 The Committee is a non-executive committee and as such has no delegated authority other than that specified in these Terms of Reference.

2. Delegate Authority

2.1 The Authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee.

2.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,

2.3 The Committee may act with such authority delegated to it by the Trust Board from time to time and in accordance with the legislation pertaining to the role of Trustees of Charitable Funds.

3. Accountability

3.1 The Trust Board

4. Reporting Line

4.1 The Trust Board

5. Objective

5.1 On behalf of all writing members of the Trust Board (being the Corporate Trustee In law under the Terms of the Charities Acts) oversee the day to day activities of the Charitable Funds in accordance with the Committee Terms of Reference.

6. Duties

6.1 On behalf of all Members of the Trust Board (being the corporate Trustee in law under the terms of the Charities Acts) the Committee will:-

- Develop and recommend for approval to the Trust Board (as the corporate Trustees) on an annual basis a business plan that sets out the strategy for the charity, its priorities for expenditure and how these priorities link with the business plan for the current year.

- Develop an annual work plan for the committee to be approved by the Board

- Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.

- Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds.

- Develop and recommend to the Trust Board a fundraising policy for the Charitable Funds.

- Develop and recommend to the Trust Board an investment strategy for charitable funds.

- Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds.

- Receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds and to review the regular investment reports supplied by the Trust's investment brokers if appointed.

- Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds

- Receive regular budgetary information in respect of each fund.

- Consider and approve the Annual Charitable Funds accounts and the Annual Report to the Charities Commission.

- Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance.

- Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds.

- To approve all individual items of expenditure within limits delegated by the Trust Board in accordance with the Charitable Funds Standing Financial Instructions.

- To consider all business cases involving the use of Charitable Funds.

7. Permanency

7.1 The Committee is Permanent

8. Membership

8.1 The Chairman of the Committee will be a non-executive director.

8.2 Other members (voting)

- A governor representative
- A patient representative
- A patient facing staff member
- All voting members of the Trust Board

8.3 At any meeting of the Committee, the Chairman if present shall preside. If the Chairman is absent from the meeting then another Non-Executive Director

9. Quorum

9.1 Four members of which one must be a Non-Executive Director and either Chief Executive Officer or Director of Finance

Secretariat

PA to Director of Finance

The Company Secretary will service the Committee.

Internal Executive Lead

Director of Finance

Frequency of Meetings

Meetings will be held four times a year.

Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

Minutes of the meetings will record conflicts of interest and what steps were taken to manage them.

Reporting

A report of the proceedings will be given by the Chair at the next Trust Board.

Review

The Terms of Reference of the Committee will be reviewed by the Trust Board every 3 years.

31 July 2013

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC JOINT COUNCIL OF GOVERNORS'/TRUST BOARD MEETING

Notice of the Public Joint Council of Governors'/Trust Board meeting to be held on Wednesday 30th October 2013 at 8.30 am in the Board Room

AGENDA

Apologies for absence: Tim Pile, Elizabeth Mountford, Tauny Southwood, Frances Kirkham, Dia Martin, Richard Burden MP			To note	Time
Introductions & welcome			To note	08.30
Declarations of Interest	Register available on request from Company Secretary			
Minutes of the Trust Board meeting held on Wednesday 25 September 2013		Enc. 1	**For Board approval**	
Action Points		Enc. 2	To note	
Chairman's & Chief Executive's Update	Bryan Jackson & Graham Bragg	Verbal	To note	08.45
Medical Director's Report	Andrew Pearson	Enc. 3	To note	
Medical Staff Committee Report	Graham Bragg	Enc. 4	To note	
Ward Manager's Report	Helen Shoker	Enc. 5	To note	
Strategy and Organisation Development				09.15
External Auditor Contract 2013/14 & 2014/15	Paul Athey	Enc. 6	**For Board Approval**	
Performance Management/ Assurance Reports				09.30
Corporate Performance Report & Programme Board Update	Paul Athey	Enc. 7	For discussion	
Quarter 2 Workforce Report	Anne Cholmondeley	Enc. 8	For discussion	10.15

Director of Nursing & Governance Patient Safety Report	Helen Shoker	Enc. 9	For discussion	
Financial Implications of Capital Investment	Paul Athey	Presentation	To note	
Staff Engagement	Graham Bragg	Presentation	For discussion	11.00
IM&T Update Report	Graham Bragg	Enc. 10	To note	
Radiology & Scanning Update	Amanda Markall	Verbal	To note	
Integrated Governance Committee Report (no meeting held)	Tauny Southwood			
Audit Committee Report – (no meeting held)	Andrew Meehan			
Trust Board Risks	Bryan Jackson	Enc. 11	For discussion	
Quarter 2 Governance Quarterly Declaration Report	Graham Bragg	Enc. 12	**For Board approval**	
Board Committees & ad-hoc Groups not covered elsewhere				
Board Committee's & Terms of Reference	Joy Street	Enc. 13	**For Board Approval**	12.15
Remuneration Committee – no meeting held				
Charitable Funds Committee – no meeting held				
Items for Executive Question Time/ CEO Briefing				
Any Other Business				
Date and Time of Next Meeting Wednesday 27th November 2013 at 8.30 am in the Board Room (to be confirmed)				
Exclusion of the Press and Public The Board is asked to resolve 'that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.'	Chairman			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Trust Board Meeting
held in public on Wednesday 27th November 2013 in the Boardroom

Present:
Trust Board
Dr Bryan Jackson, Chairman (Chair)
Mr Graham Bragg, Acting Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Interim Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Mr Andrew Meehan, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mr Tim Pile, Non-Executive Director
Ms Elizabeth Mountford, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director

In attendance:
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Roger Tillman, Interim Deputy Medical Director
Mrs Jo Chambers, CEO Designate

ACTION

11/13/1511 **Apologies and welcomes**
None

11/13/1512 **Introductions & Welcome**
None

11/13/1513 **Declarations of Interest**
No other Declarations of Interest than those registered previously.

11/13/1514 **Minutes of the Trust Board meeting held on 30th October 2013**
The minutes of the meeting held on the 30th October 2013 were approved as a true and accurate reflection of the meeting.

Postscript to Medical Director's report – AP reported that the Trust's NJR reporting was behind and that as a result the ROH had not met the percentage requirement threshold which acts as a gateway to receipt of best practice tariff. The Medical Director assured the Board that by February 2014 the Trust would

achieve 100% completion rate by surgeon (from current base of 73%). This will be monitored at the Clinical Outcomes & Effectiveness Committee under the Chairmanship of RT. The WHO checklist will be amended to include a completion check of NJR return.

11/13/1515 Action Points

The action notes were deferred for updated review at the December meeting.

11/13/1516 Chairman's & Chief Executive's Update

Agenda item deferred for update at the December meeting.

Performance Management/Assurance Reports

11/13/1517 Corporate Performance Report & Programme Board Update

AM gave a presentation on activity:

- Day case activity was above plan putting pressure on ADCU as volume is higher than expected
- Inpatient activity was below plan and below the level of the previous year
- Outpatient appointments had increased by 10%
- Backlog over 18 weeks had grown in the summer due to the impact of surgeon and patient leave
- AP advised that orthopaedic treatment levels were declining nationally in part due to procedures of limited clinical value having been introduced and as a result of new triage arrangements.

AMe commented that the high percentage of fixed costs meant that a re-balancing of day case versus inpatients disproportionately impacts on finance and BJ suggested looking at increasing the proportion of variable costs if possible.

TS advised that it was likely that this pattern of activity would continue and that the Trust may need to make a fundamental change to the way it structures its clinical service. EM felt that the situation demanded real focus on robust workforce planning.

AMe asked if the impact of the Trust Business and Learning Day (TBALD) on activity had been accounted for and members debated the balance of benefit on service quality versus impact on financial outturn.

BJ felt that visual control and raising awareness was necessary but that in the year to date, had the Trust avoided just 50% of the 600 cancellations it would have remained on track. TP suggested positive targeting of patients who were available for procedures at short notice and was advised that, as far as possible this was done in order to fill lists when cancellations were made at short notice but that pre-op assessment, surgeon

availability and other factors made it quite complex to deliver in any numbers.

TS suggested that pre-op could be made available on an outreach basis to support patients having quick access to surgery. It was confirmed by AP that POAC assesses patients who already have a date for surgery and that there was scope for short notice assessments.

HS commented that from her visits to wards some staff seemed to feel that they were being asked to do extra work rather than having an understanding that this work should have been undertaken as part of planned activity earlier in the year.

EM felt that communications should encourage staff to feel that the Trust was trying to offer the best inpatient care and support them in this as the reason they do their jobs.

BJ asked for assurance on patient safety while this hike in activity took place and HS confirmed that core staffing levels would be agreed as well as optimum. This would give baseline safety as well as gold standard.

FK asked if there was evidence of action plans having had any impact yet and AM advised that these would be in place and monitored from the following week.

BJ thanked all members of staff on behalf of the Board for their work in developing the rectification plan which reflected a significant amount of work. He felt it was important to involve as many staff as possible in order to spread and embed the learning.

GB suggested, and it was agreed, that a workshop session be held to detail the patient pathway and encourage further sharing of ideas.

AP reported that many staff had suggested that TBALD be cancelled for the remainder of the financial year. **TS/FK suggested that different ways of delivery might be considered and agreed to meet outside the Board with AP and others**. EM felt it was a key tool for engagement and should not be cancelled. It was agreed that the cancelation of the next TBALD (in February) be held in abeyance for consideration in mid-January, as a possible means of mitigation, dependent upon progress.

TS/FK/AP

PA presented an update on the Trust's CIP position which showed areas of under-achievement. It was nonetheless expected that the Trust would deliver its overall financial position

by the end of the year.

The Board noted both the CPR report and the Programme Board update report.

11/13/1518 Patient Safety Report

HS introduced the Patient Safety Report and invited questions on patient safety and circulated the Ward Dashboard.

BJ asked that in future, where staff attitude was noted as an issue in PALs or complaints, more detail would be useful where possible.

The Board noted the Patient Safety Report

11/13/1519 Business Planning Timetable

This was noted and it was agreed to allocate at least 2 hours at the February Trust Board meeting. It was further agreed that a timetable and framework be presented at the December Board. **PA/JS**

11/13/1520 Any Other Business

EM asked that the site be made entirely non-smoking. After a brief discussion it was agreed to consider this at a future meeting.

11/13/1521 Date and Time of Next Trust Board Meeting

Trust Board meeting to be held on Wednesday 18th December 2013 at 8.30 am in the Board Room

The Board resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 30TH OCTOBER 2013

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
07/13/1443	Board Committees Committee's to review ToR and make amendments ready for formal adoption in October.	ADM/TS/ JS/PA	October 2013	√	
04/13/13 97	Q4 Workforce Report Appraisal forms to be refreshed.	AG	Nov 2013		Part of implementation of new national pay deal in 2013/14.
07/13/1446	Spinal Deformity Presentation GB to review the situation with outcomes data.	GB	September 2013		Meeting arranged 30/9. The CD for Spinal Surgery had been asked to consider options for a system to record outcomes.
05/13/1415	Medical Staff Committee Update Report Executive Directors to consider radiological staffing and to report back to the Board in July. Report to be completed by October.	Execs	October 2013		The Board were updated that a wider project is now being undertaken with input from the Intensive Support Team to understand better both additional workforce and additional equipment (in particular MRI) requirements. It was agreed that a report would be completed by October 2013.
05/13/1425	Equality Duty Report Data to be tracked over time in order to ensure that the Trust improved in meeting its diversity obligations.	AC	Feb 2014		Progress to be included in next annual Equality Duty Report

07/13/1444	Council of Governors' Constitution Comments on the constitution to be sent to JS by 15 August. JS to contact lawyers and feedback with their views and a timetable at the September Board meeting.	ALL JS	15 August 2013 September 2013		JS had met with Trust legal advisors and been advised that most of what was being proposed would be deliverable. The company had now been asked to provide an indication of cost and timescale for the preparation of a revised constitution. Among the key recommendations from the lawyers was to include annual elections which would avoid the costs of going out to election on an as and when basis and also the inclusion of conditions for becoming a member of the Council of Governors such that appropriate calibre could be maintained. This would be agreed by the Board and Governors and then could be enacted (at risk) prior to seeking a vote by those present at the next AGM.
07/13/1447	Proposal for Option Appraisal Commercial Tissue Requests Process to be fully explained to theatre staff.	ED	Sep 2013		
09/13/1469	Capital Programme & Site Development A full plan detailing planned capital spend to be presented in November under a business as usual arrangement, this could then be overlain with income projections.	PA	November 2013		
09/13/1473	CPR A presentation on CIP schemes to be provided to the Board's at its November meeting.	PA/AM	November 2013		

10/13/1494 11/13/1517	Information on activity progress to be brought back to the November Board meeting. A workshop session to be held to detail the patient pathway and encourage further sharing of ideas. TS/FK to meet outside the Board with AP and others to discuss and consider different ways of delivery for TBALD.	AM TS/FK/AP	November 2013 January 2014		
10/13/1489	<u>CEO & Chair's Update</u> Marketing plan to be circulated. Governors to be informed and invited to 6 day working sessions being held.	JS GB/AM/JS	Nov 2013 Nov 2013		
11/13/1519	<u>Business Planning Timetable</u> At least 2 hours at the February Trust Board meeting to be allocated to Business Planning Timetable.	PA/JS	February 2014		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Medical Directors Report to Board
Nov-Dec 2013

During the months of November & December, in addition to my role as medical director, I have performed the following activities.

Meetings

A. External

CQC Methodology for Specialist Hospitals
Meeting with Cheryl Cavanagh from the office of the Chief Inspector of Hospitals around the issue of inspections for specialist hospitals.

B. Internal

Junior Doctors Committee - Chaired
Discussions around junior doctor rotas and practical solutions to reducing the Trusts reliance on locum doctors.

Information Governance Group
Attended in my role as Caldicott Guardian.

Clinical Excellence Awards Panel Member

Older Patient Francis Task & Finish Group
Completed

Enhanced Recovery Project Group

One to One Meetings

CD for Out Patients and Support Services
Chief Executive
Director for Nursing & Clinical Governance

Issues to Note

Case Manager - Investigation of Staff Grade Anaesthetist

Andrew Pearson
13th December 2013

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ENCLOSURE NUMBER: 5

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Helen Shoker, Interim Director of Nursing and Governance**
SUBJECT:	**Nursing Report**

SUMMARY

The Nursing Report is designed to provide a summary of the actions undertaken by the nursing workforce, highlight areas of achievement and provide assurance that concerns are noted and addressed.
This report covers the month of November 2013.

Of note-
Nurse Leaders Forum launched
Senior Sisters title replaced Ward Managers for our Band 7 nurses
Senior Nurses meeting aims, agenda and outcomes re-engineered
Operational Management Team meeting established with the Director of Operations
Review of ward KPI commenced, Theatre department KPI review planned for January 2014
Senior Nurse Team Leadership away day planned
Compassion In Practice re launched
6C team challenge commenced
Celebration events planned, Pressure Ulcer free days
Patient Harm Review meetings commenced
Patient Acuity tool launched across all inpatient wards
CQC - preparation for new assessment framework

IMPLICATIONS eg. financial, operational, risk, etc

None identified at this time

RECOMMENDATIONS

Trust Board are asked to:-
note the new style of Nursing Report,
accept the contents,
provide recommendations for further development and additions

Trust Board Nursing Report December 2013

Nurse Leaders Forum

To support developing nurse leadership a review of all nursing meetings and committees was undertaken in October, involving many stakeholders. The Nurse Leaders Forum replaces the previous ward managers and matrons meeting which was poorly attended, not representational of all areas, lacked direction and impact. It was important to move forward from a meeting which was failing to provide the organisation with a functioning, unified nursing team with a clear remit founded on providing excellence in patient care.

The forum provides all clinical teams with the opportunity to come together to debate and agree, by consensus, how subjects such as Compassion In Practice can be used to strengthen patient care and the profession. The agenda is formatted with headings of Best Care, Best People, Best Hospital and standing agenda items are 6C's, Our Profession, Patient Story, KPI's.

A minimum attendance has been agreed by the forum members to foster commitment and discipline to working together. All clinical teams and services attended the first meeting.

Senior Sisters title replaces Ward Managers

This is an intuitive change of title with no implications to contract, role or pay scale. It aligns the organisation to the regional approach to nursing titles.

Site Visit to Heart of England Trust

A small number of senior sisters undertook this visit to explore how supervisory practice has been implemented within HEFT and what evidence of benefits have been noted for patient care, the nursing workforce and organisation. They are to feedback at the January Nurse Leaders Forum in support of the development of supervisory practice within the ROH.

Senior Nurses Meeting

The aims, agenda and measurement of outcomes of the collective Band 8A+ team have been re-engineered in line with developing unified, effective nurse leadership.

Operational Management Team

An approach to enhance collaborative working across the DM and Senior Nurse teams, exploring joint operational matters and role modelled by the Director of Operations and Director of Nursing & Governance.

Ward Key Performance Indicators

A review of ward KPI's has commenced with the Theatre department KPI review planned for January 2014. The current indicators have been in place sometime, are outdated in places or do not reflect patient outcomes. For example the measure for nutrition and hydration relates to link nurses rather than meeting patient's needs.

The use of indicators will move to a proactive process with peer review from January 2014 with the new tool being phased in during the last quarter of the financial year. It is planned to support good performance through shared learning at the Nurse Leaders Forum and to establish a responsive, preventative approach during the coming twelve months.

Ward One action plan has commenced with weekly progress review by the Directorate team and Interim Director of Nursing.

Senior Nurse Team Leadership Away Day

A facilitated team leadership event is planned for early December, Insights Discovery. This includes an online psychometric assessment linking all the aspects of team dynamics. It is envisaged that greater understanding of the team's strengths, weaknesses and communication will support effective team leadership and therefore patient care.

Compassion In Practice Strategy- Care, Compassion, Commitment, Courage, Competence, Communication

This national nursing strategy has been launched and the 6C team challenge commenced. All clinical areas have been issued with a set of core tools and suggestions to engage the team and their patients. Each month sees the celebration of two of the 'C' subjects. Many areas have embraced this opportunity and the challenge element will be judged in March by the Chairman and Chief Executive Officer after a walk around the site.

Celebration of Good Practice

December brings the first celebration of great care. Ward Three have achieved eight months of avoidable pressure ulcer free care which is to be recognised with a presentation by the Chief Executive and Interim Director of Nursing of a certificate which is to be displayed on the ward public notice board. The celebration will be shared on the intranet and internet.

Celebration events are designed to recognise and share good practice whilst building pride amongst teams.

Patient Harm Reviews

The patient harm meetings are now being followed up with ward based patient harm reviews to support teams translate learning into their ward practice.

Patient Acuity Measurement

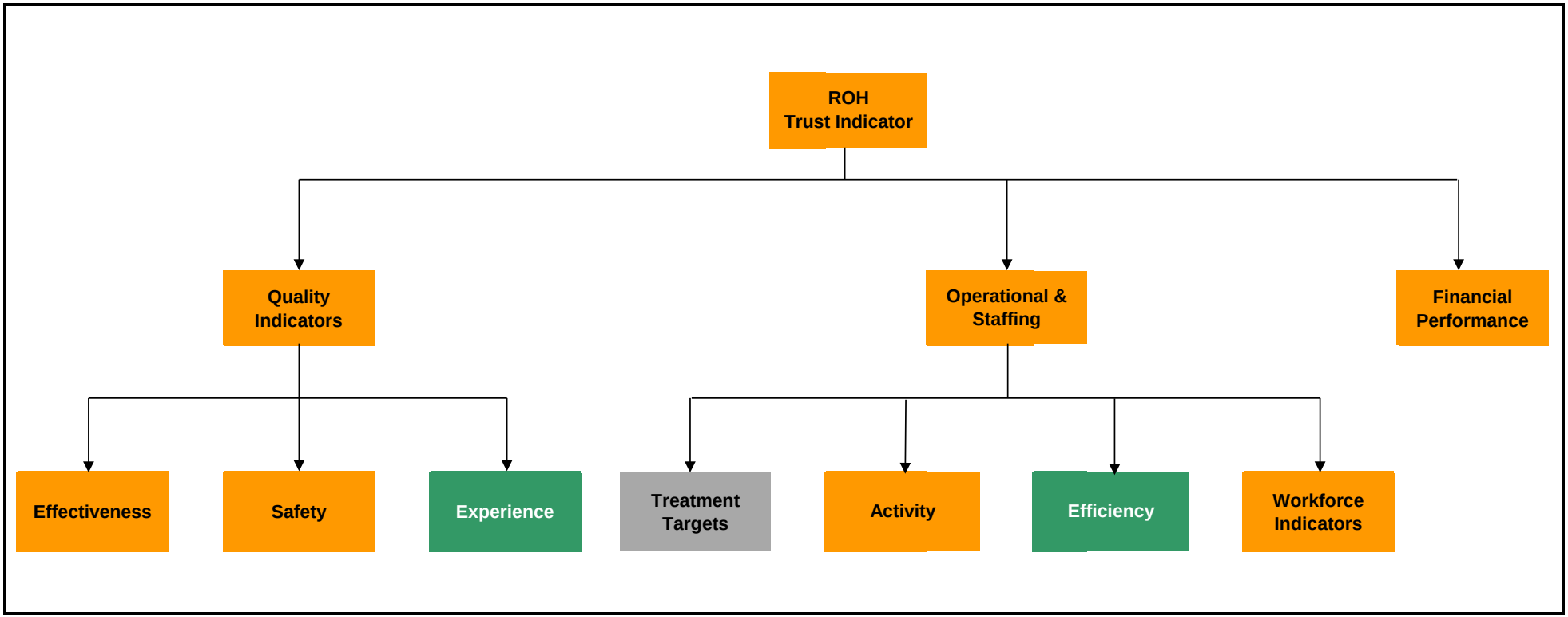
To effectively care for patients the correct skill mix and number of staff on duty is required in any clinical setting. Measuring the acuity and number of patients on a ward is the foundation of setting the appropriate staffing levels for patient safety therefore the nursing teams across the inpatient wards have commenced daily measurement using a nationally recognised tool. This will provide essential data to support the options paper and subsequent business case for the skill mix review to be presented to the Board in the new calendar year.

A review of the ADCU nursing workforce has commenced with Directorate team.

CQC - 5 Domain Preparation

To support the organisation's preparation for the new CQC assessment framework an approach has been drafted and shared with stakeholders. This will be actioned in January 2014.

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending November 2013



Quarterly Detailed Report
Executive Summary as at November 2013

Headlines

- Quality remains amber rated due to 8 inpatient falls, 4 SIRIs and 2 Grade 3/4 pressure ulcers in the month
- Activity in November was higher than in any other month in the previous 12 months
- The Trust has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. The in month position was however in balance

Monitor Compliance Framework Targets	November 2013 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	Not Currently Available		0	6
Referral to treatment time - Admitted %	90%	Not Currently Available		0	6
Referral to treatment time - Incomplete Pathways %	92%	Not Currently Available		0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	85.7%*	93.8%*	0	6
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%*	100%*	0	6
Cancer 31 day wait from diagnosis to first treatment	96%	100%*	100%*	0	6
Cancer 2 week (all cancers)	93%	100%*	100%*	0	6
Clostridium Difficile cases	2 (Full Year)	0	0	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating	One minor CQC compliance action outstanding regarding Outcome 4, Regulation 9 – Care and Welfare of People who use services.				

* The current month's cancer outturns are provisional position only. The cancer position for the quarter is based on provisional in-month and confirmed previous months data.

Indicative Monitor Governance Risk Rating	
Indicative Monitor Continuity of Service Rating	4

Key Trust Targets		November 2013 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	4		3
	Complaints	<=12	8		4
	CQUINS	100%	90%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<420	Not Currently Available		6
	Incomplete 14 - 18 Week Waiters	<500	Not Currently Available		6
	Total Elective Activity vs Plan	100%	95.1%		7
	Unused Theatre Sessions	<44	30		8
	Sickness	4.1%	4.4%		9
Financial	Surplus	£2,161k	£1,508k		10
	CIP	£2,207k	£1,787k		12
	Agency Expenditure	£91k	£133k		11
	Locum Doctor Expenditure	£46k	£60k		11

Trust Summary

The Trust is Amber rated for November based upon the assumption that treatment targets were achieved for the month (due to early Trust Board the position is not currently available). The amber rating is consistent with that reported in October.

The overall rating for quality remains amber due to 8 inpatient falls, 4 SIRIs and 2 Grade 3/4 pressure ulcers in the month. On a positive note the VTE target was achieved, the level of complaints reduced again and there were no hospital deaths or reportable infections. Additional detail is provided in the Safety Report.

Following a long period of being Red rated workforce has improved to Amber due to improvements in both sickness rates and mandatory training levels. In addition agency costs as a percentage of the total paybill is the lowest since January 2013. Staff turnover, appraisals and safeguarding training remain of concern. The number of staff in post at the Trust remains consistent with last month meaning total vacancies of c39wte or 5% of the funded establishment.

For the month of November the Trust made a surplus of £203,000 against a planned surplus of £220,000. The Trust therefore now has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. It is forecast that the Trust has a Monitor Continuity of Service Rating of 4, which is in line with our planned position (note that 4 is the highest rating available).

Activity in November was higher than in any other month in the previous 12 months however the Trust continued to underperform against elective cases and over perform against day cases. The increase in activity did however ensure a near planned in month surplus for the first month since August.

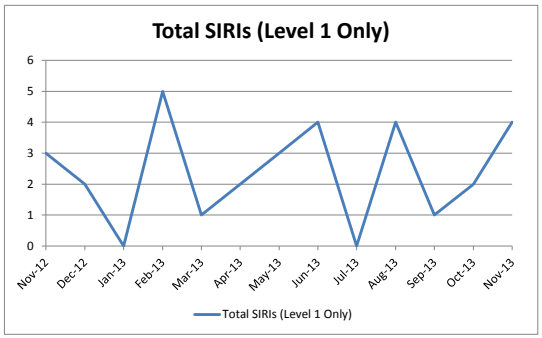
Due to early Trust Board the finalised position against treatment targets is not currently available. It is expected that all 3 RTT will be achieved however. Cancer targets have been achieved for November and it is now likely that the quarterly target will be achieved. 1 patient breached 52 weeks November but has been treated in early December.

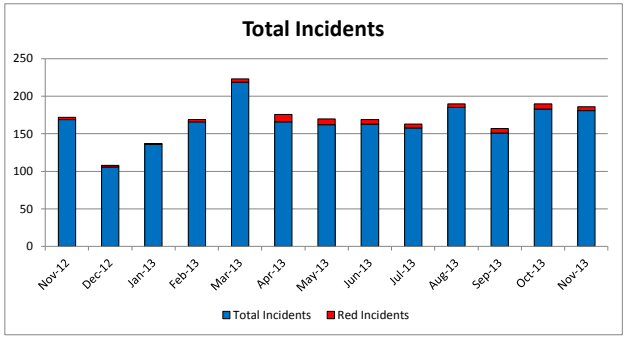
Quarterly Detailed Report
Safety Indicators as at November 2013

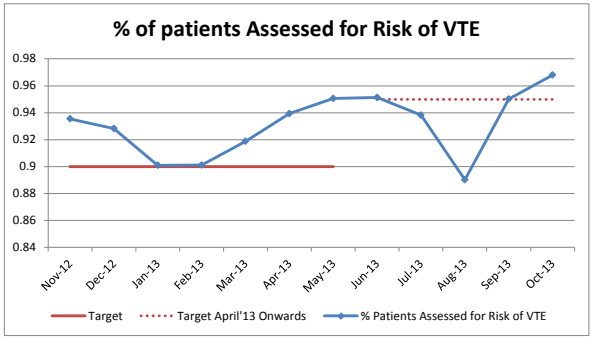
Headlines

- The VTE target for October was achieved for the second successive month
- There were 4 SIRIs in November
- There were 8 inpatients falls in November which is double the previous month

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	3	2	0	5	1	2	3	4	0	4	1	2	4	20
			4,16	SIRI per 1000 bed days	0.98	0.84	0.00	1.36	0.34	0.62	1.12	1.32	0.00	1.27	0.36	0.62	1.39	0.81
			4,16	Total Incidents	169	106	136	166	219	166	162	163	158	185	151	183	181	1349
			4,16	Incidents per 1000 bed days	55.08	44.41	46.31	56.23	74.19	51.83	60.23	53.95	47.07	58.96	54.12	56.82	62.70	54.46
			4,16	Red Incidents	3	2	1	3	4	10	8	6	5	5	6	7	5	52
			9,16	Total Drug Errors	26	15	17	19	66	31	21	15	15	23	18	21	16	160
			9,16	Drug Errors per 1000 bed days	8.47	6.28	5.79	6.44	22.36	9.68	7.81	4.96	4.47	7.33	6.45	6.52	5.54	6.46
		N	1	Mixed Sex Occurrences	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			9	% Patients Assessed for Risk of VTE	93.55%	92.83%	90.10%	90.11%	91.88%	93.94%	95.06%	95.13%	93.82%	89.02%	95.02%	96.80%	*	94.15%
			9	Incidence of Hospital Related VTE	1	0	0	1	1	0	0	1	1	0	1	1	0	4
			4	Patient Falls - Inpatients	5	8	0	6	7	4	7	6	4	9	2	4	8	44
			4	Patient Falls per 1000 bed days	1.63	3.35	0.00	2.03	2.37	1.25	2.60	1.99	1.19	2.87	0.72	1.24	2.77	1.78
			4,16	% Harm Free Care	98.85%	92.86%	97.22%	93.26%	93.26%	97.89%	96.19%	97.94%	98.90%	97.85%	98.70%	97.00%	98.90%	97.85%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

The trust has achieved the CQUIN target for October in relation to VTE with 96.6% compliance against the agreed target of 95%.

Fourteen incident forms received for the month of November (categorised as (adult) falls, slips or trips) and 8 of the 14 were identified as reportable falls.

There have been 4 SIRIs reported in November; compared to 2 reported during the previous month

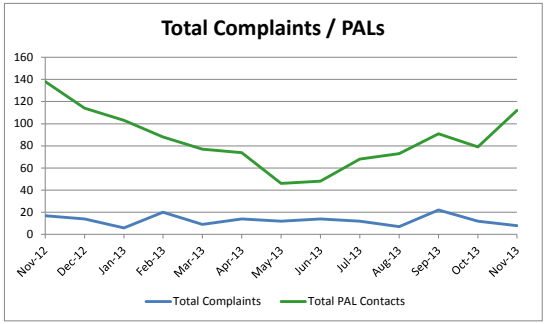
Additional detail is provided in the Safety Report

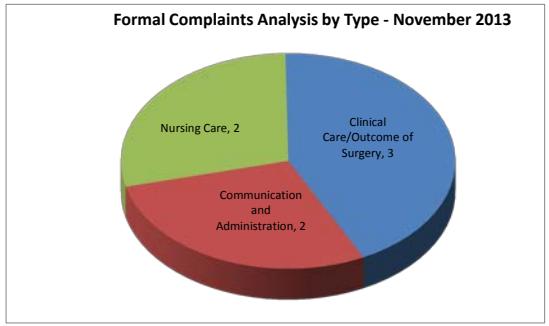
Quarterly Detailed Report
Experience Indicators as at November 2013

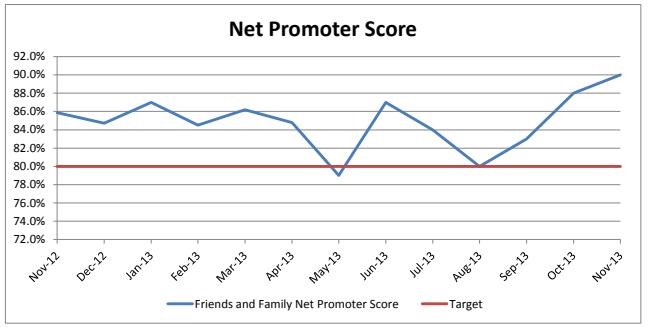
Headlines

- The number of complaints has again fallen in the month to the second lowest level this financial year
- PALs contacts increased in the month by 33 (42%) from October
- The Friends and Family Net Promoter score has increased for the 3rd successive month

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Experience			17	Complaints to Complements Ratio	1:13	1:33	1:63	1:20	1:46	1:25	1:25	1:29	1:32	1:46	1:14	1:34	1:16	1:26
			17	Total Complaints	17	14	6	20	9	14	12	14	12	7	22	12	8	101
			17	Complaints reverted to informal <48 hrs	3	0	0	1	0	1	0	1	1	3	3	0	1	10
			17	Formal	14	14	6	19	9	13	12	13	11	4	19	12	7	91
			17	Complaints per 1000 bed days	5.54	5.87	2.04	6.78	3.05	4.37	4.46	4.63	3.57	2.23	7.89	3.73	2.77	4.08
			17	Total PAL Contacts	138	114	103	88	77	74	46	48	68	73	91	79	112	591
			17	PALS Contacts per 1000 bed days	44.98	47.76	35.07	29.81	26.08	23.11	17.10	15.89	20.26	23.27	32.62	24.53	38.80	23.86
			17	Total Compliments	223	456	380	404	414	347	295	404	386	320	298	409	124	2583
			17	Compliments per 1000 bed days	72.69	191.03	129.38	136.86	140.24	108.35	109.69	133.72	114.99	101.99	106.81	127.00	42.96	104.27
				Food - Real Time Patient Survey	72.19%	66.07%	75.00%	69.75%	77.54%	77.50%	85.43%	86.67%	90.48%	92.40%	90.00%	90.60%	92.00%	85.02%
			17	Friends and Family Net Promoter Score	85.86%	84.73%	87.00%	84.50%	86.18%	84.8%	79.00%	87.0%	84.0%	80.0%	83.0%	88.0%	90.0%	83.7







Experience Commentary

COMPLAINTS

8 complaints (7 formal) received in the month down on last month's number of 12 which represents a reduction of 42% on last month. Number of complaints responded to in agreed timescale in November is 9/10 or 90% which is above the KPI of 80%. The 1 complaint that is overdue was as a result of a delay in the public and patient service team due to unexpected absence and increased volume of PALS.

Areas for formal complaints received this month are broken down as follows:
Clinical care and/or outcome of surgery x 3
Communication and administration x 2
Nursing care x 2

PALS:

PALS contacts up this month from 79 to 112 (an increase of 26%) In addition to new service users, a large number of patients known to the service have returned to us for help and support with needs around long standing problems, new treatment plans, need help coordinating admissions etc. which has taken a large amount of time.

Highest areas of concern:
Delays in spinal admin – patients unsure of plans for care and treatment
Metal on Metal queries
Orthotics – waiting times to get appointment for treatment
Appointment queries: repeated changes, cancelled and not informed and cannot get through
Work experience requests
Parking problems
Having an injection – lack of information on what to bring, waiting for date to be scheduled

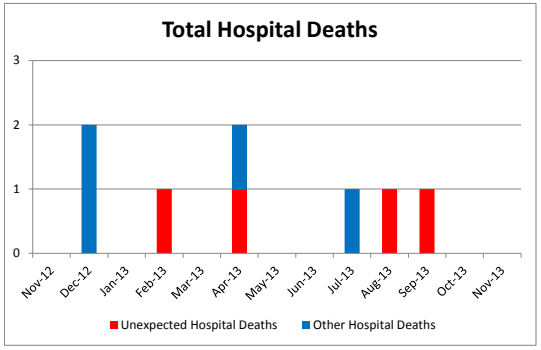
Real Time Patient Food Survey achieved 92% in November and has now been >90% for 5 consecutive months.

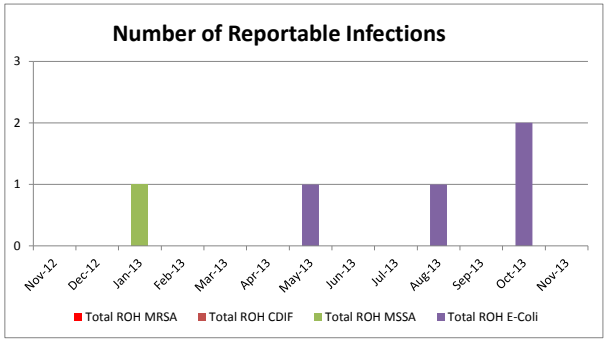
Quarterly Detailed Report
Effectiveness Indicators as at November 2013

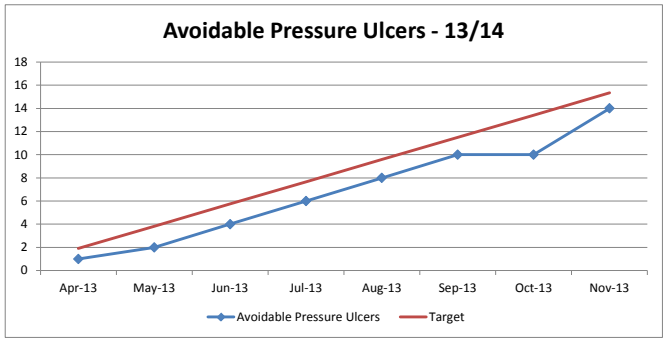
Headlines

- There were no deaths in November
- There were no reportable infections in the month
- There were 2 avoidable Grade 3/4 Pressure Ulcers

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	2	0	1	0	2	0	0	1	1	1	0	0	5
			4,18	Hospital Deaths per 1000 bed days	0.00	0.84	0.00	0.34	0.00	0.62	0.00	0.00	0.30	0.32	0.36	0.00	0.00	0.20
			4,18	Unexpected Hospital Deaths	0	0	0	1	0	1	0	0	0	1	1	0	0	3
				Other Hospital Deaths	0	2	0	0	0	1	0	0	1	0	0	0	0	
			8	MRSA % Screened	165.3%	149.7%	138.7%	135.5%	114.3%	129.56%	129.13%	140.59%	145.53%	127.51%	146.00%	132.00%	114.30%	133.09%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	M	N	8	Total ROH CDIF	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH MSSA	0	0	1	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	0	0	0	0	1	0	0	1	0	2	0	4
			8	HCAIs not attributable to ROH	1	2	0	1	0	0	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	0	0	0	0	1	1	0	2	4
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	3	3	5	5	5	1	1	2	2	1	1	0	2	10
			4	Avoidable Pressure Ulcers per 1000 bed days	0.98	1.26	1.70	1.69	1.60	0.31	0.37	0.66	0.60	0.64	2.51	0.00	1.39%	0.61







Effectiveness Commentary

There were no deaths or reportable infections in November

In November a total of six grade 2 pressure ulcers were reported, with two confirmed as unavoidable and the remaining four currently being investigated. Two avoidable grade 3 pressure ulcers were reported and investigated. The wards will participate in a future Patient Harm meeting.

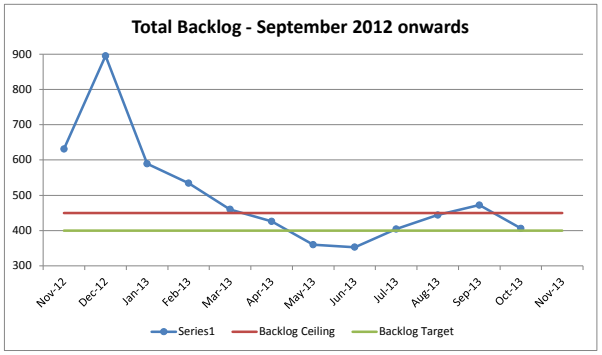
Quarterly Detailed Report
Treatment Targets as at November 2013

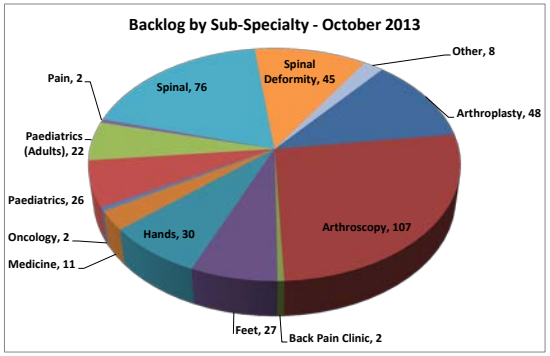
Headlines

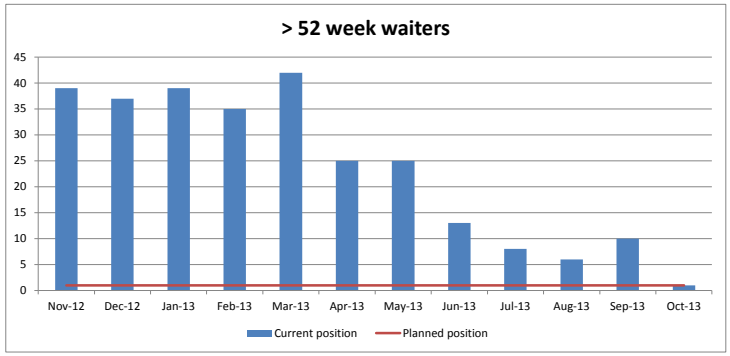
There was a 0.5 breach against the 62 day cancer wait target in November. However the target was still achieved

Due to the timing of the Board other treatment target information is not available at this stage

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	39	37	39	35	42	25	25	13	8	6	10	1	*	*
	M	N	4	Referral to treatment time - Non Admitted %	95.28%	95.09%	95.03%	95.07%	95.18%	95.24%	95.08%	95.35%	95.29%	95.78%	95.42%	95.24%	*	95.34%
	M	N	4	Referral to treatment time - Admitted %	90.38%	90.59%	90.42%	90.37%	90.00%	90.22%	90.39%	91.37%	92.05%	90.33%	90.19%	90.09%	*	90.68%
	M	N	4	Referral to treatment time - Incomplete Pathways %	90.56%	90.52%	90.68%	91.09%	92.01%	92.77%	94.36%	94.77%	94.18%	93.71%	93.34%	94.01%	*	93.89%
			4	Non admitted Backlog - Pathways waiting >18 wks	208	438	221	199	187	155	121	110	131	159	163	160	*	*
			4	Admitted Backlog - Pathways waiting >18 wks	423	457	368	335	273	271	239	243	273	285	309	246	*	*
			4	Total Backlog - 18 week pathways waiting >18 wks	631	895	589	534	460	426	360	353	404	444	472	406	*	*
			4	Incomplete 14 -18 Week Waiters	698	717	610	629	535	388	411	504	477	630	654	565	*	*
	M	N	4	Cancer 2 week (all cancers)	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100%*
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.0%	100.0%	100.0%	100.0%	100.0%	93.33%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	98.33%*
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%*
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.0%	100.0%	100.0%	100.0%	100.0%	90.00%	100.00%	66.67%	80.00%	100%*	83.30%	100.00%	85.70%	87.50%*
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	100.00%	100.00%	99.98%	100.00%	100.00%	99.24%	100.00%	99.52%	99.20%	99.09%	99.70%	99.13%	*	99.49%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			1,21	Data Quality on Ethnic Group - Inpatients	100.00%	95.12%	95.20%	95.11%	91.99%	97.64%	95.29%	96.44%	94.86%	95.30%	98.35%	95.65%	95.45%	96.17%







Treatment Targets Commentary

Due to early Trust Board, position is not currently available. A verbal update will be given at Trust Board, it is expected that all 3 RTT will be achieved however.

Cancer targets have been achieved for November and it is now likely that the quarterly target will be achieved.

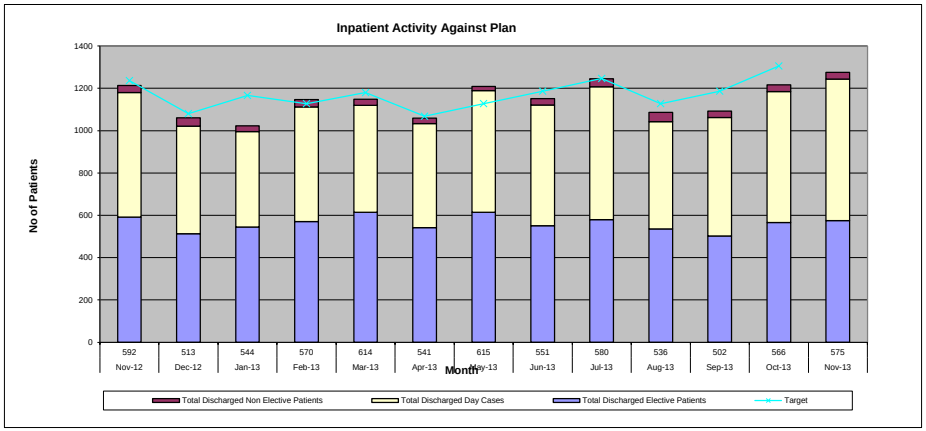
1 patient breached 52 weeks November but has been treated in early December. This was a complex case with input required from vascular surgeon from another centre, due to whose unavailability the case was cancelled in month.

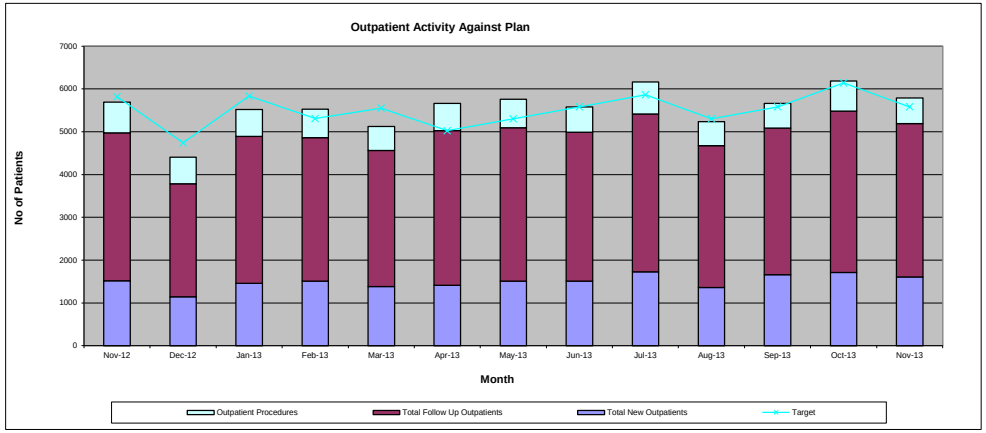
Quarterly Detailed Report
Activity Targets as at November 2013

Headlines

- Elective inpatients underperformed by 30 cases or 5% in November
- Day case activity was extremely high for the month with an over performance of 23% or 125 cases
- New outpatients continue to significantly overperform (14% in November)

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Activity			4	Total Discharged Elective Patients	592	513	544	570	614	541	615	551	580	536	502	566	575	4466
			4	Total Discharged Non Elective Patients	34	39	27	35	29	25	20	30	38	44	30	33	32	252
			4	Total Discharged Day Cases	588	508	451	542	506	493	574	570	627	506	560	618	669	4617
			4	Total New Outpatients	1517	1146	1455	1510	1381	1416	1513	1508	1728	1359	1661	1713	1609	12507
			4	Total Follow Up Outpatients	3458	2641	3435	3356	3179	3611	3583	3481	3691	3314	3428	3774	3581	28463
			4	Outpatient Procedures	716	622	631	662	562	635	662	594	743	560	575	697	604	5070
			4	Elective as % Against Plan	95.2%	94.4%	92.8%	100.5%	108.3%	99.43%	107.1%	91.1%	91.4%	93.3%	83.0%	85.1%	95.1%	92.92%
			4	Non Elective as % Against Plan	81.0%	106.3%	68.2%	91.4%	75.8%	72.4%	54.8%	78.1%	94.3%	120.6%	78.1%	78.1%	83.4%	82.57%
			4	Day Cases as % Against Plan	102.7%	101.5%	83.5%	103.8%	96.9%	100.7%	111.1%	104.8%	109.8%	97.9%	103.0%	103.3%	123.0%	106.78%
			4	% New Outpatients Against Plan	101.7%	94.3%	97.3%	111.0%	101.5%	111.1%	112.5%	106.5%	116.2%	101.0%	117.3%	110.0%	113.6%	111.11%
			4	% Follow Up Outpatients Against Plan	97.1%	91.0%	96.2%	103.3%	97.8%	114.2%	107.4%	99.1%	100.1%	99.3%	97.6%	97.7%	101.9%	101.93%
			4	% Outpatient Procedures Against Plan	93.6%	99.8%	82.3%	94.9%	80.6%	107.6%	106.3%	90.6%	108.0%	89.9%	87.7%	96.7%	92.2%	97.30%





Activity Commentary

Activity in November was higher than in any other month in the previous 12 months however the Trust continued to underperform against elective cases and over perform against day cases. Whilst this can be explained in part due to changes in practice from switch to DC from 1 night stay, further analysis of case mix is required.

Rectification plans for 4 directorates are in place and activity is being monitored on a daily basis.

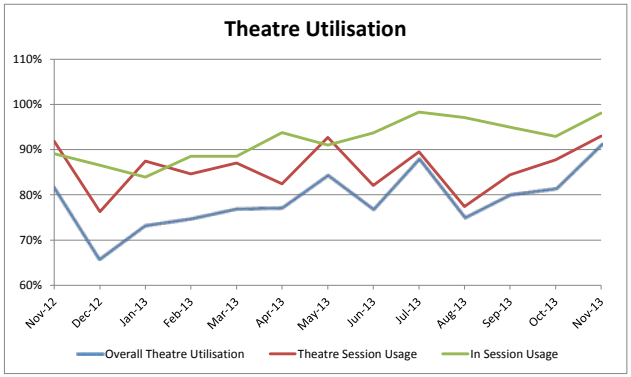
New OP continue to over perform against plan (by 11% YTD) which indicates a strong order book.

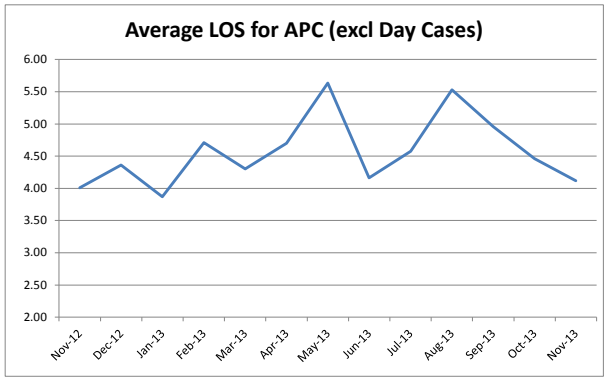
Quarterly Detailed Report
Efficiency Indicators as at November 2013

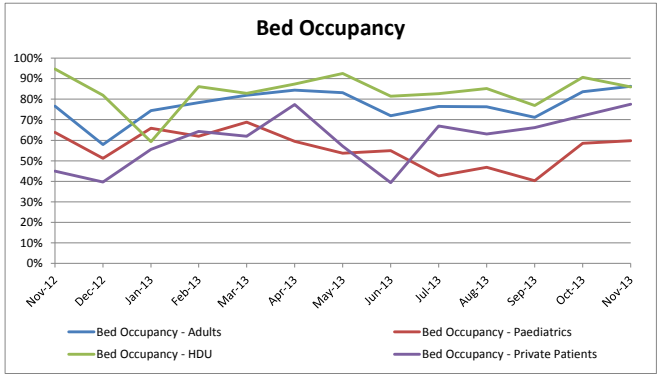
Headlines

- Theatre utilisation indicators are green for November
- Bed utilisation remains at a higher than average level for the year
- The number of cancelled operations has increased significantly in November

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Efficiency			4	Overall Theatre Utilisation	81.8%	66.0%	73.4%	74.9%	77.0%	77.30%	84.41%	76.95%	87.98%	75.15%	80.19%	81.51%	91.23%	80.80%
			4	Theatre Session Usage	91.85%	76.30%	87.50%	84.60%	87.07%	82.45%	92.72%	82.09%	89.50%	77.38%	84.42%	87.73%	93.02%	84.86%
			4	In Session Usage	89.1%	86.5%	83.9%	88.5%	88.5%	93.76%	91.04%	93.73%	98.31%	97.11%	94.99%	92.92%	98.07%	95.21%
			4	Unused Theatre Sessions	37	92	57	63	53	76	30	77	50	102	67	61	30	233
			4	Number of Cases per Theatre Session	2.79	3.45	2.46	3.13	3.11	2.82	3.01	3.08	2.79	2.95	2.90	2.67	2.95	2.89
			4	Total Cancelled Operations (On Day or Day Before)	91	95	108	78	52	91	72	63	88	58	62	82	120	314
			4	Total Cancelled Operations (On Day or Day Before) - Avoidable														
			4	Total Cancelled Operations (On Day or Day Before) - Unavoidable														
			4	Total Cancelled Operations by Hospital (On Day)	6	6	5	4	2	4	5	5	11	14	4	2	11	56
			4	% Cancelled Operations by Hospital	0.52%	0.59%	0.51%	0.37%	0.18%	0.40%	0.43%	0.46%	0.93%	1.36%	0.38%	0.17%	0.76%	0.61%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.49	2.51	2.63	2.30	2.59	2.76	2.44	2.53	2.24	2.53	2.36	2.32	2.35	2.48
			4	Pain Review-To-New Ratio	3.99	3.83	3.65	3.70	2.99	3.53	4.65	2.90	4.02	4.24	1.89	3.59	2.70	3.69
			4	Outpatient DNAs	8.91%	9.37%	10.51%	9.05%	10.52%	7.70%	8.79%	9.23%	8.70%	9.33%	8.49%	8.46%	8.34%	8.63%
			4	Bed Occupancy - Adults	76.67%	57.92%	74.44%	78.34%	81.96%	84.37%	83.16%	71.91%	76.53%	76.26%	71.19%	83.58%	86.36%	79.12%
			4	Bed Occupancy - Paediatrics	63.89%	51.18%	65.86%	61.90%	68.89%	59.44%	53.76%	55.00%	42.71%	46.77%	40.28%	58.60%	59.72%	51.97%
			4	Bed Occupancy - HDU	94.68%	81.99%	59.35%	86.06%	82.89%	87.36%	92.53%	81.44%	82.76%	85.15%	77.01%	90.67%	85.92%	87.34%
			4	Bed Occupancy - Private Patients	44.90%	39.63%	55.64%	64.29%	61.91%	77.47%	57.14%	39.29%	66.96%	63.13%	66.19%	71.89%	77.62%	65.73%
			4	Admissions on the Day of Surgery	429	357	384	400	457	381	433	403	417	372	370	417	392	1634
			4	AVLOS for APC (excl day cases)	4.01	4.36	3.87	4.71	4.30	4.70	5.63	4.16	4.58	5.53	4.96	4.46	4.12	4.75







Efficiency Commentary

Theatre utilisation was the highest recorded in previous 12 months with average LOS dropping to its lowest since January 13.

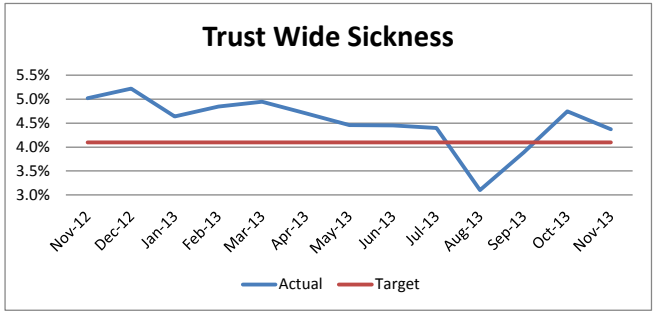
Cancelled operations on the day or day before surgery however increased to the highest level in the last 12 months, this is thought to be due to improved data collection. There are now 3 work streams in place to address the key issues related to cancellations: oncology pre-op pathway, spinal emergency pathway and pre-admission pathway. All work is being reported back through the Clinical Programme Board which meets monthly and is Chaired by the Director of Operations.

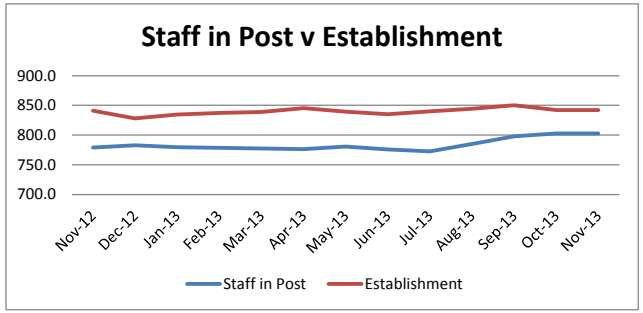
Monthly Report
Workforce Indicators as at November 13

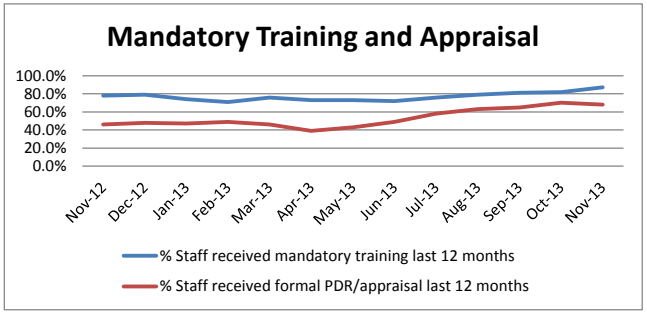
Headlines

- The number of staff employed by the Trust is consistent with the previous month
- Sickness has reduced to 4.4% in November
- Mandatory training levels continue to increase but there has been a slight reduction in appraisal and safeguarding training levels

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Workforce			13	Total WTE Employed	779.0	782.6	779.6	778.6	777.5	776.5	780.5	775.8	772.5	784.9	797.7	802.6	802.9	789.4
			13	Total WTE Employed as % of Establishment	92.6%	94.5%	93.4%	93.0%	92.7%	91.8%	93.0%	92.9%	92.0%	92.9%	93.8%	95.3%	95.4%	93.7%
			13	Staff Turnover (%)	10.4%	10.4%	11.1%	12.6%	12.7%	11.6%	12.0%	12.6%	12.5%	12.5%	12.7%	12.8%	12.9%	12.6%
			13	% of Sickness - Trust wide	5.0%	5.2%	4.6%	4.9%	5.0%	4.7%	4.5%	4.5%	4.4%	3.1%	3.9%	4.8%	4.4%	4.2%
			13	Agency % of Staff Cost	4.2%	4.2%	5.6%	6.4%	8.7%	6.1%	8.0%	8.4%	6.1%	6.5%	6.4%	6.2%	5.6%	6.5%
			13	Temporary staffing hours as a % of establishment														
			13	% Staff received mandatory training last 12 months	78%	79%	74%	71%	76%	73%	73%	72%	76%	79%	81%	82%	87%	80%
			13	% Staff received formal PDR/appraisal last 12 months	46%	48%	47%	49%	46%	39%	43%	49%	58%	63%	65%	70%	68%	62%
			13	% of required staff receiving safeguarding training						33%	30%	21%	51%	51%	54%	60%	58%	49%
			13	Qualified Nurse / Bed ratio														
			13	Staff Net Promoter score						3.84								







Workforce Commentary

Sickness has reduced in the majority of directorates/departments, with Facilities, Estates and Medical Secretaries being areas of concern.

Mandatory and statutory training has increased in month due to continued high levels of attendance at programmes.

Levels of appraisal have reduced in month and each Directorate/Department have been asked to produce an updated plan to ensure performance improves to 90%+ by the end of March. This will be reviewed monthly by the Director of Workforce and Director of Operations.

The cause of the reduction in levels of safeguarding training is being explored and a verbal update will be provided at the Board.

Quarterly Detailed Report
Financial Performance as at November 2013

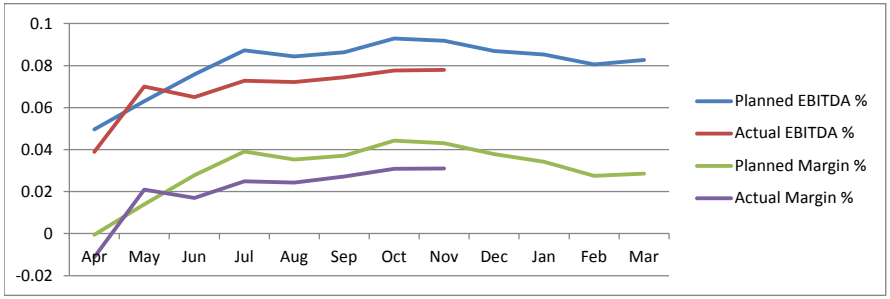
Headlines

- The Trust has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000.
- In the month of November the financial position was in line with plan which was driven by increased activity levels
- CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after Month 8.

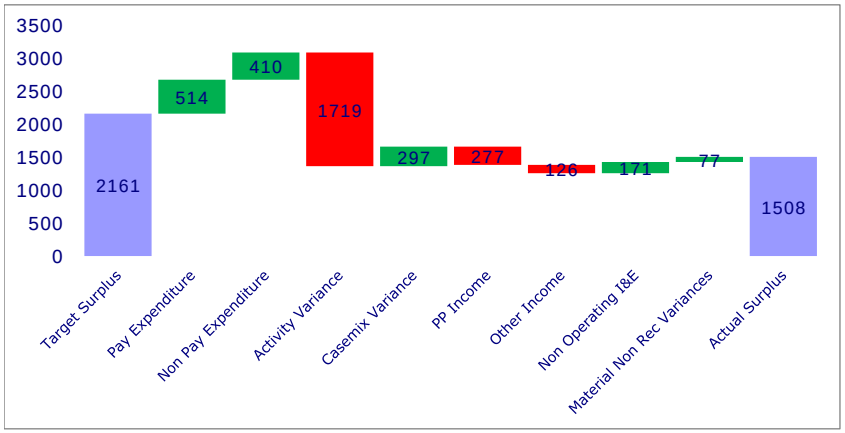
Trust Financial Metrics

	Year to Date		
	Actual	Plan	Risk Rating
Capital Servicing Capacity	4.2	5.2	4
Liquidity Ratio	86.0	76.4	4
Overall Continuity of Services Rating			4

Planned v Actual EBITDA & Margin Graph



Trust Performance Bridge Graph



Executive Financial Summary

Overall Performance

For the month of November the Trust made a surplus of £203,000 against a planned surplus of £220,000. The Trust therefore now has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. The normalised surplus having excluded material non recurrent income and expenditure is £1,431,000.

It is forecast that the Trust has a Monitor Continuity of Service Risk Rating of 4 (compared to a plan of 4 – note 4 is the highest rating available).

Income

November was an improved month for activity and associated income. Although inpatient activity continued to underperform this reduced to 6% or 36 cases in November which is the highest percentage compared to plan since May 2013. Day cases increased dramatically and overperformed by 115 cases or 23%. Rectification plans have been developed by underperforming Directorates to move to contracted levels by the end of the financial year.

Private patients remain a concern and are now under recovering by £277,000 or 39%. Bed occupancy levels have however increased mainly with long stay bone infection patients.

Pay

The paybill has increased slightly again in November and is £76,000 or 2% higher than 12 month average. The substantive paybill has increased for the past 2 months which is consistent with the reduction in vacancies we have seen in the Trust in recent months. It is encouraging to see a reduction in both bank and agency spend in the month but this needs to continue to offset the increase in substantive staff costs.

Compared to the Monitor plan we are spending less on pay than predicated. When the Monitor plan was set we were anticipating activity over performance to meet the £1.1m income CIP target. This and the associated costs are yet to materialise which shows as a negative activity variance and a positive pay variance on the Performance Bridge Graph.

Non Pay

Non pay spend was relatively high for the month (£83,000 or 3% more than the average for the first 7 months) which is consistent with the higher than average levels of activity for the month. As with pay we are now showing a positive variance which is driven by the general underperformance plus not achieving planned activity growth.

CIP

CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after month 8.

Balance Sheet & Cash Flow

The Statement of Position is broadly in line with plan as month end. Cash balances remain healthily but is £1.9m behind plan which is consistent with the previous month.

Quarterly Detailed Report

CQUIN & Financial Efficiency Indicators as at November 13

Headlines

- The paybill is above the monthly average for this financial year and it is at its highest since July this year.
- Agency costs were the lowest this financial year
- Both the Trust surplus and CIP performance remain below planned levels

		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Cost of Staffing	Total Paybill	£3,071,000	£3,069,000	£3,168,095	£3,247,000	£3,388,000	£3,217,000	£3,313,000	£3,259,000	£3,324,000	£3,252,000	£3,234,000	£3,279,000	£3,311,000
	Substantive Pay	£2,723,000	£2,713,000	£2,800,783	£2,813,000	£2,841,000	£2,810,000	£2,852,000	£2,822,000	£2,864,000	£2,806,000	£2,805,000	£2,861,500	£2,919,000
	Bank Pay	£214,000	£222,000	£183,483	£226,000	£246,000	£203,000	£187,000	£197,000	£252,000	£230,000	£214,000	£208,000	£195,000
	Overtime Pay	£4,000	£5,000	£5,665	£4,000	£5,000	£10,000	£4,000	£4,000	£4,000	£5,000	£8,000	£5,500	£4,000
	Agency Pay (excluding Medical Locums)	£66,000	£75,000	£140,543	£123,000	£234,000	£140,000	£241,000	£191,000	£150,000	£144,000	£138,000	£177,000	£133,000
	Medical Locum Pay	£64,000	£54,000	£37,621	£80,000	£62,000	£54,000	£28,000	£81,000	£54,000	£67,000	£68,000	£52,000	£60,000
	ADH Payments - Surgical	£20,000	£25,000	£28,000	£45,000	£40,000	£26,000	£38,000	£20,000	£17,000	£26,000	£23,000	£22,000	£31,000
	ADH Payments - Clinics	£10,000	£7,000	£14,000	£20,000	£17,000	£11,000	£14,000	£7,000	£17,000	£9,000	£13,000	£15,000	£19,000
	ADH Payments - Anaesthetics	£25,000	£27,000	£35,000	£48,000	£84,000	£46,000	£47,000	£48,000	£63,000	£46,000	£53,000	£48,000	£53,000
	ADH Payments - Spot Work & Strategy	£1,000	£1,000	£1,000	£1,000	£0	£0	£0	£0	£0	£0	£0	£0	£0
Income & Efficiency	Trust Surplus	£2,485,000	£2,350,000	£2,033,000	£2,074,000	£2,203,000	-£66,000	£250,000	£305,000	£602,000	£729,000	£978,000	£1,305,000	£1,509,000
	Normalised Surplus	£1,740,000	£1,605,000	£1,397,000	£1,409,000	£1,853,000	-£66,000	£250,000	£443,000	£891,000	£912,000	£977,000	£1,228,000	£1,431,000
	Total Income	£6,032,000	£5,815,000	£5,395,000	£5,727,000	£6,409,000	£5,910,000	£6,135,000	£5,914,000	£6,575,000	£5,515,000	£5,884,000	£6,429,000	£6,202,000
	CIP	£3,531,000	£3,579,326	£3,630,122	£3,679,000	£3,820,000	-	£339,000	£561,000	£869,000	£1,125,000	£1,260,000	£1,537,000	£1,787,000

Summary

The paybill is above the monthly average for this financial year.

Agency expenditure is higher than plan but it has is at its lowest level this financial year.

The Trust has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. The normalised position having excluded material non recurrent income and expenditure is £1,431,000

CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after Month 8.

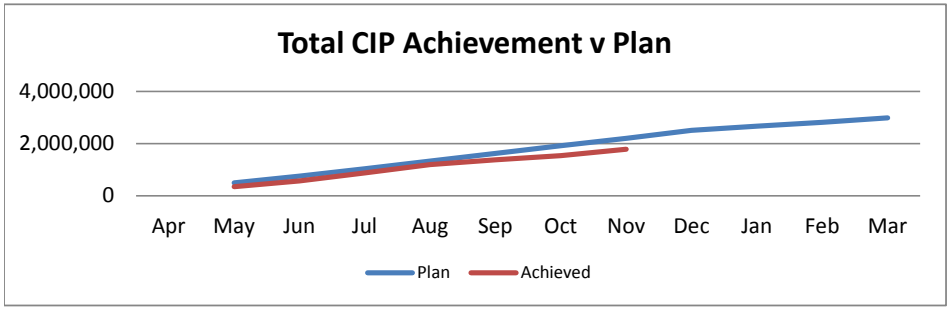
Monthly Report

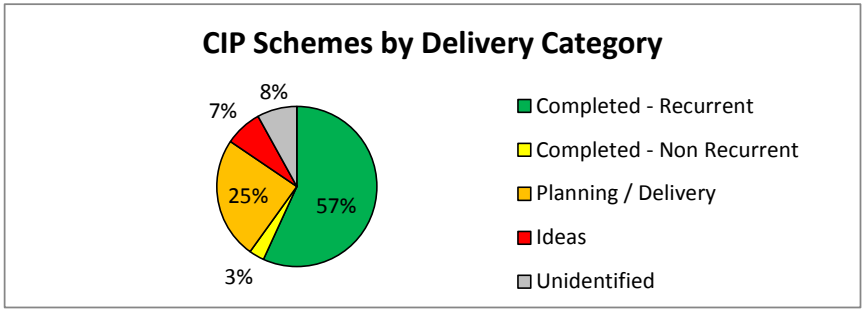
Cost Improvement Programme Indicators as at November 13

Headlines

- CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after Month 8.
- To date 60% of the required CIP value is completed and implemented. 15% is not identified or ideas at this stage
- No medium of high risk quality issues have been raised or identified

Cost Improvement Programme	Annual Performance					YTD Performance		
	Target £'000	Completed £'000	Planning / Delivery £'000	Ideas £'000	Unidentified £'000	Target £'000	Completed %	Shortfall £'000
Clinical Directorates	1,108	663	33	213	200	907	73%	244
Corporate Areas	774	624	99	10	40	627	100%	3
Income	1,100	500	600	0	0	673	74%	173
Total	**2,982**	**1,787**	**732**	**223**	**240**	**2,207**	**81%**	**420**



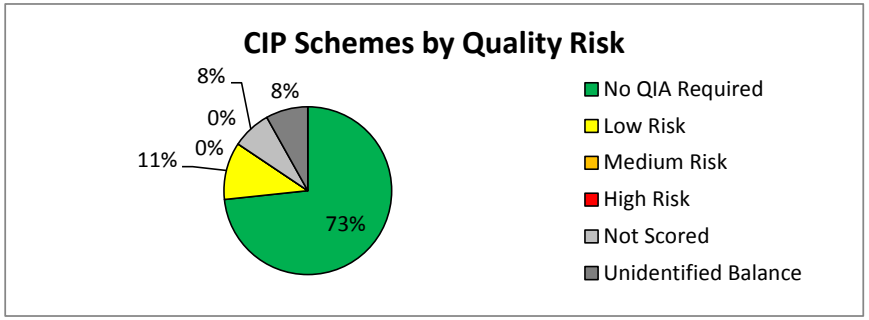


Significant Exceptions

Theatres & Anaesthetics. To date only 19% of the £473k target has been implemented. 32% requires further significant reduction in agency spend and 42% is unidentified at this stage.

Income. To date only 45% of the £1.1m plan has been implemented. The remaining requires the Trust to deliver activity levels over and above baseline contract which we are failing to achieve.

Management. To date 28% is yet to be identified and this is under discussion at Senior Management Team



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 18th December 2013 **ENCLOSURE NUMBER: 8**

SUMMARY OF REPORT TO TRUST BOARD

Director Lead:	Helen Shoker, Interim Director of Nursing & Governance
Authors:	Lisa Pim, Interim Deputy Director of Nursing & Governance Alison Braham, Governance Manager
SUBJECT:	**Patient Quality, Safety and Experience Report**

SUMMARY

This paper will provide Trust Board with an update on patient quality, safety and experience activity during November 2013. The format of this paper will be developed from next month with the aims of providing the Trust Board with a succinct and collaborative safety report.

RISKS

Patient quality, safety and experience must remain a high priority for the organisation and it is anticipated this report will assist the Trust Board in bringing together several key quality issues.

RECOMMENDATIONS

The Board is asked to:

- **discuss** the Patient Quality Safety and Experience report
- **identify** areas of risk requiring further assurance
- **identify** any other patient safety and experience issues for inclusion in future reports
- **note** the proposed report changes for next month

1. Serious Incidents requiring investigation (SIRI)

There have been 5 SIRIs reported in November; compared to 2 reported during the previous month (see appendix 1).

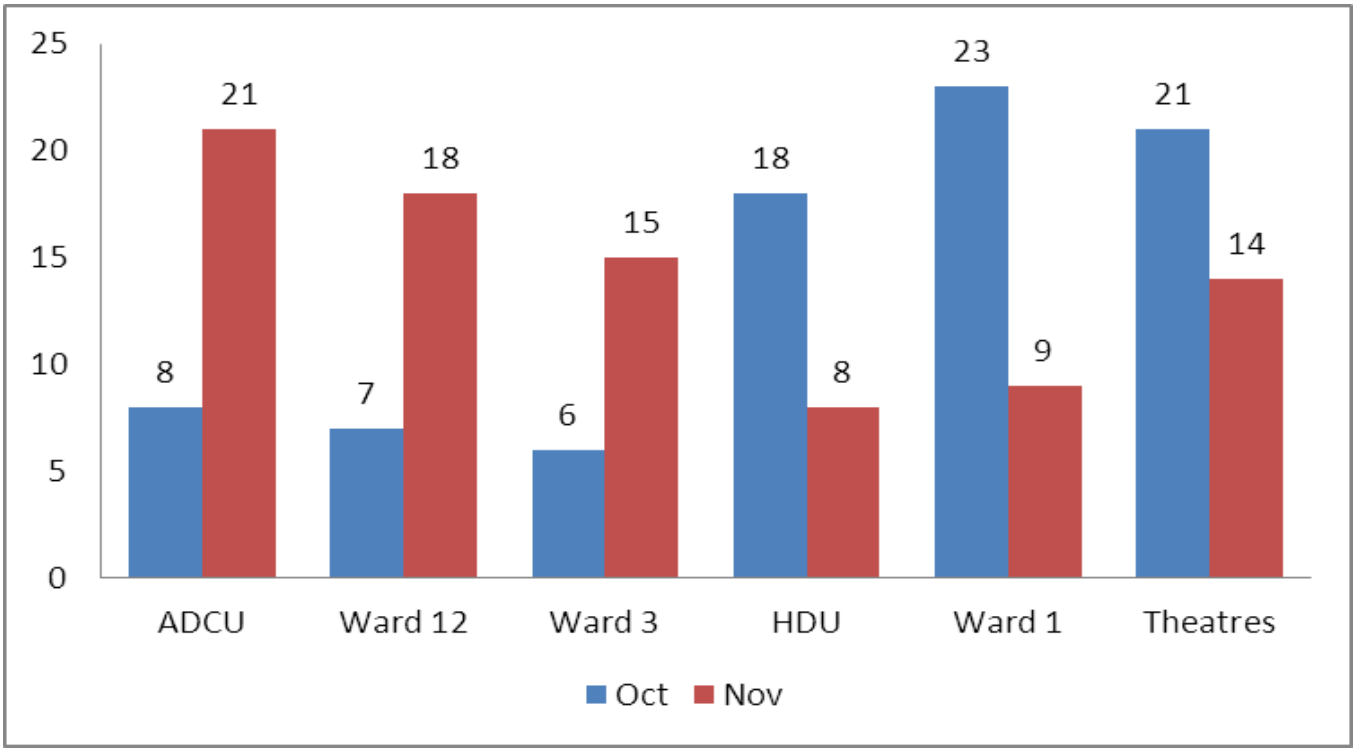
2. Deaths

There have been no deaths during November.

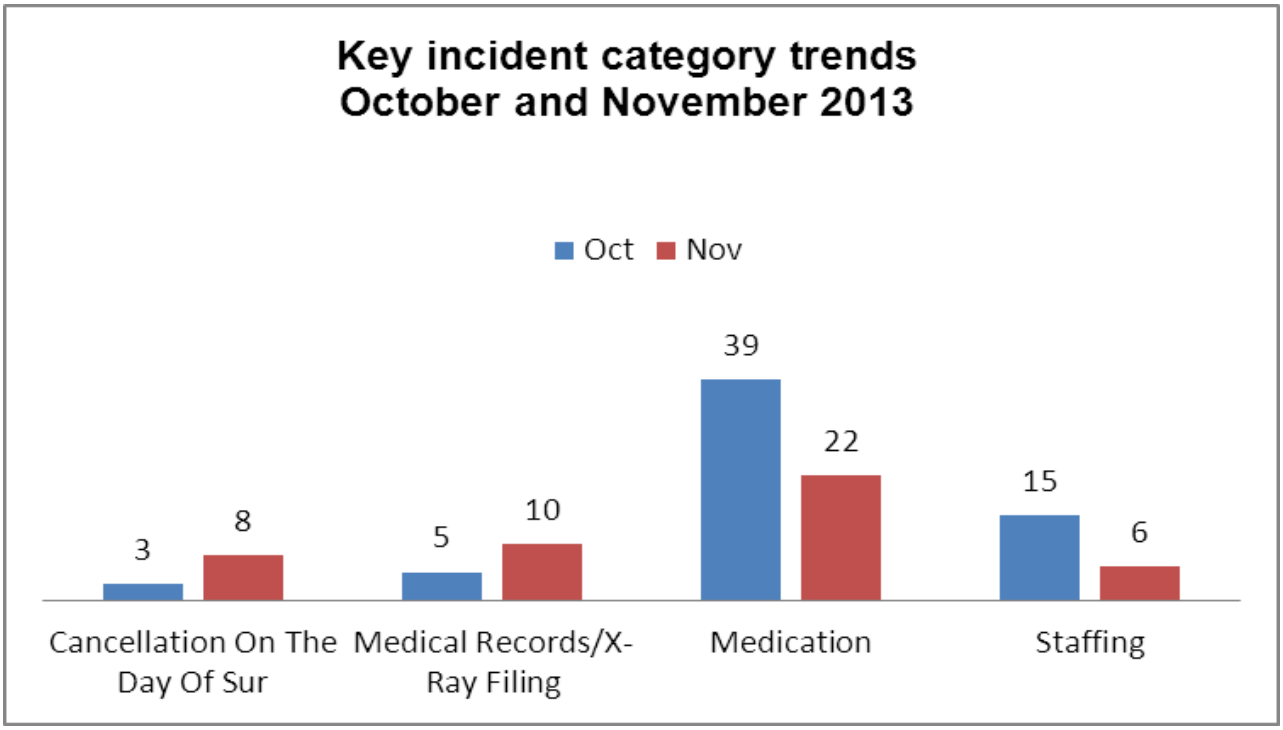
3. Incident trends

A total of 181 incidents were reported during November, compared to 183 incidents reported during October. Although there has been no substantial increase in incidents reported (when compared to the previous month) specific areas have seen significant increases and decreases, details are outlined in the graph below.

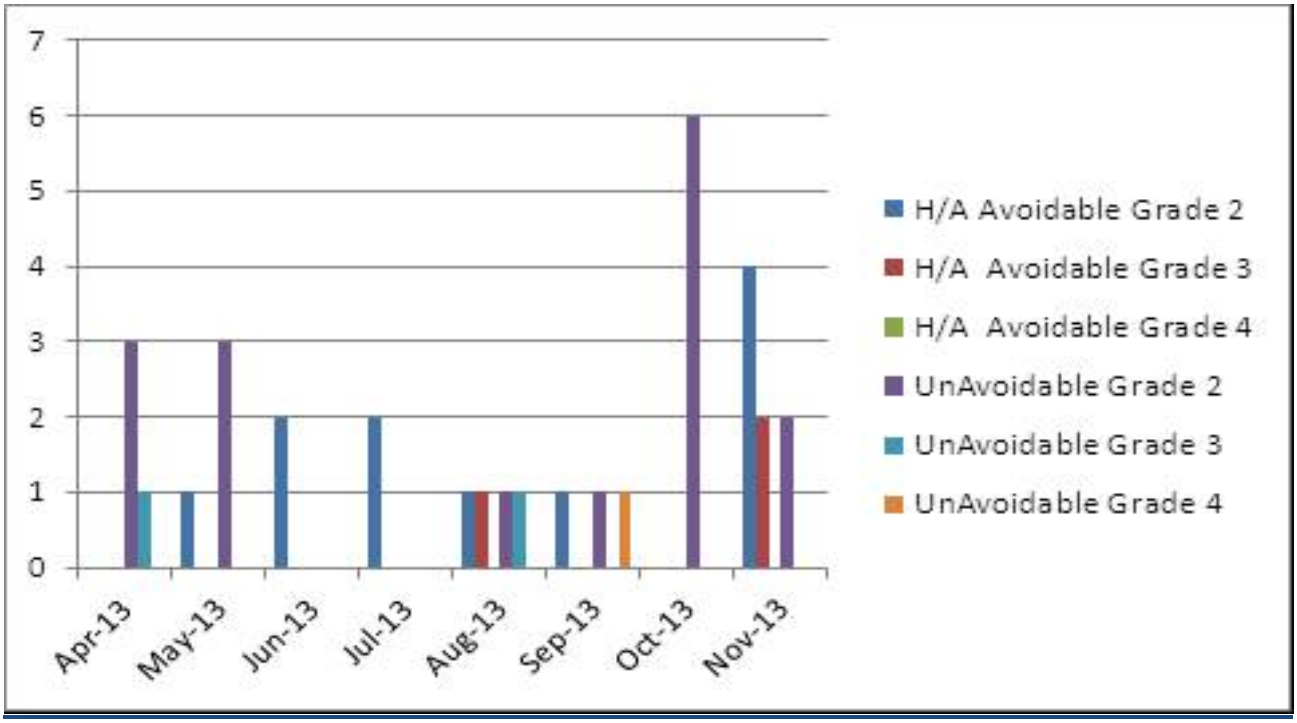
Key incident trends (by department)
October and November 2014



In terms of incident categories medical records incidents and cancellations on day of surgery have seen a rise when compared to October, whilst medication and incidents have reduced, see below:



4. Pressure Ulcers



In November a total of six grade 2 pressure ulcers were reported, with two confirmed as unavoidable and the remaining four currently being investigated. Two avoidable grade 3 pressure ulcers were reported and investigated. The wards will participate in a future Patient Harm meeting.

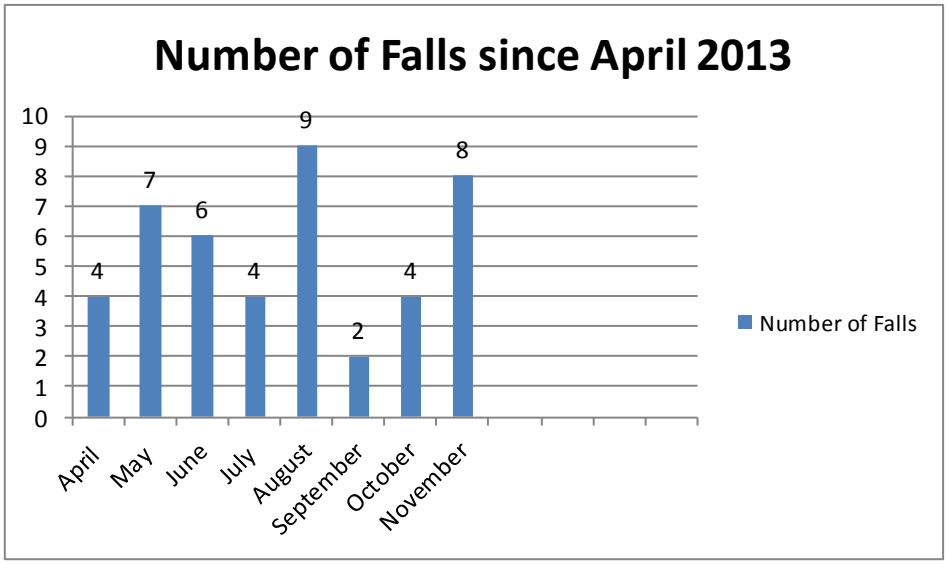
5. VTE risk assessment

The trust has achieved the CQUIN target for October in relation to VTE with 96.6% compliance against the agreed target of 95%.

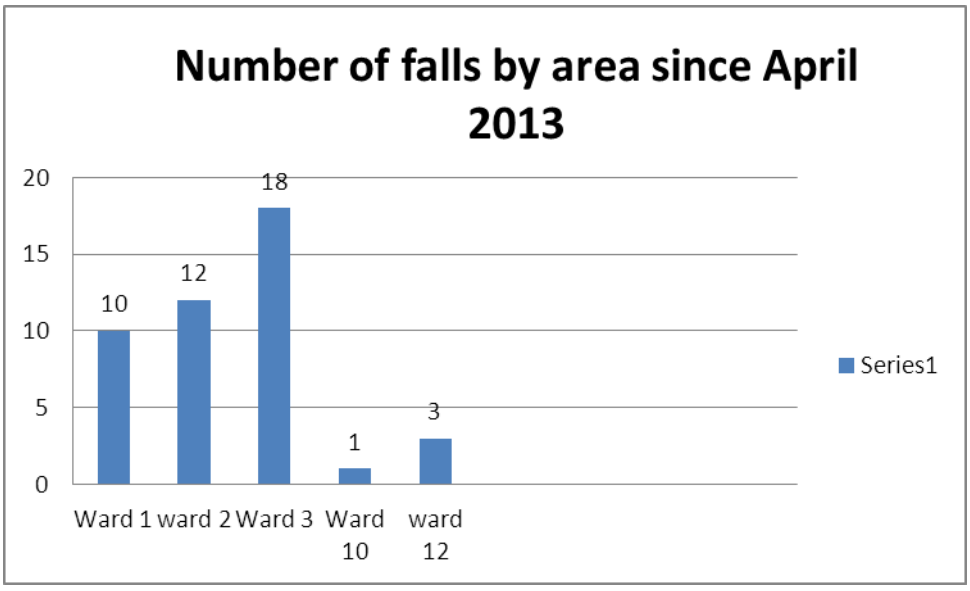
6. Falls

Fourteen incident forms received for the month of November (categorised as (adult) falls, slips or trips) and **8 of the 14** were identified as **reportable falls**. Rationale for the removal of the **6** remaining falls from the report is shown at the end.

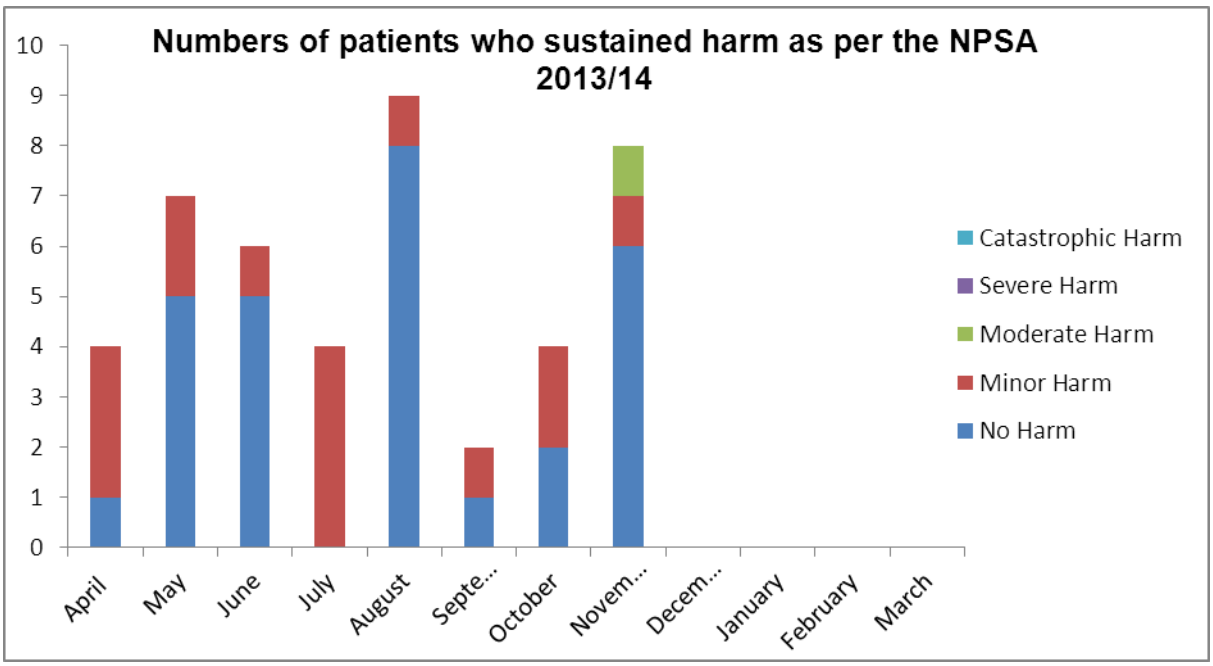
Number of Inpatient Adult falls since April 2013



Falls by Area since April 2013



The number of patients who have sustained harm as a result of a fall

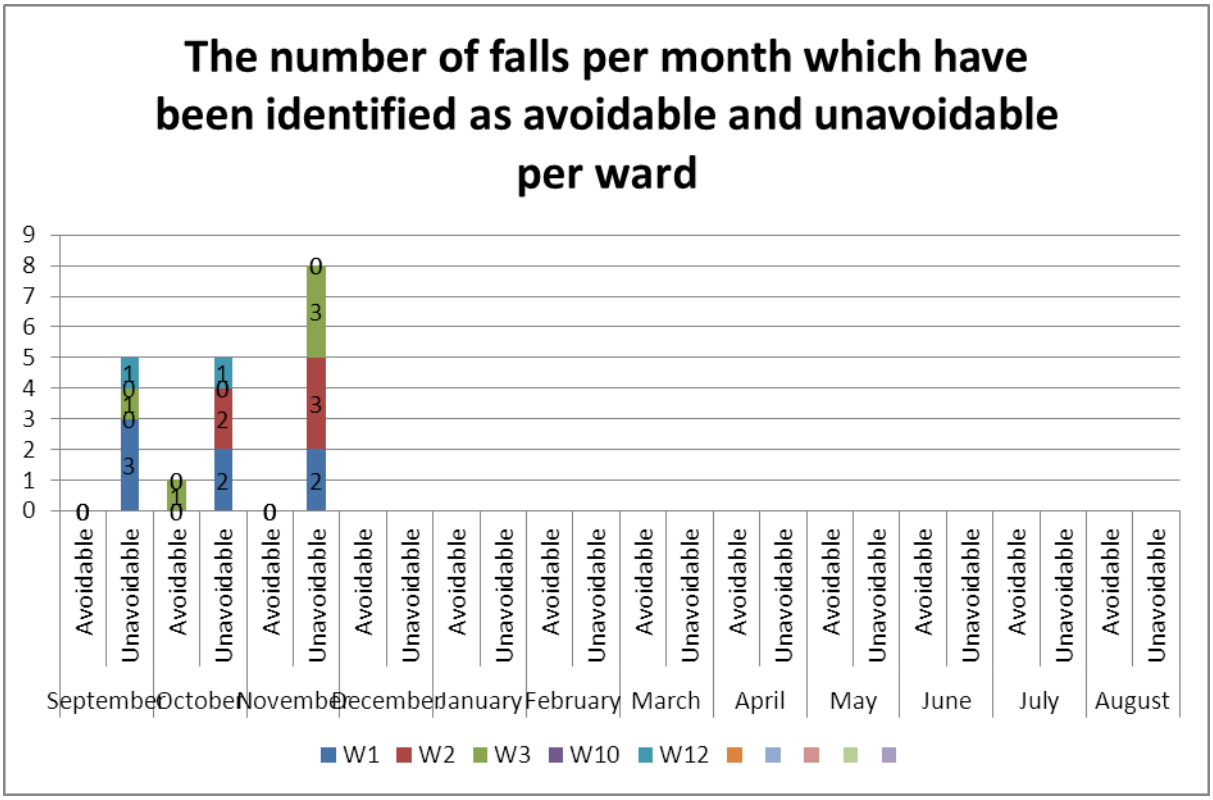


Number of falls, slips or trips reported in each area during November

Location of Falls	Number of falls per area
Ward 1	4
Ward 2	3
Ward 3	5
Ward 10	0
Ward 12	1
Physio Gym	1

Out of the 14 reported falls only 8 were reportable as inpatient adult falls. Details of the excluded incidents below:

Area	Incident Number	Detail
Ward 3	**11841**	Faint not fall
Ward 1	**11842**	Slip not fall
Ward 12	**11870**	Fit not fall
Ward 3	**11884**	Controlled sit to the floor
Ward 1	**11967**	Slip not fall
Physio Gym	**11982**	Faint not fall (visitor not patient)



Quality indicator requirements

Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	**91%** compliance required each month by ward
If the patient is identified as high risk is a care plan in place? Yes/ N/A	**91%** compliance required each month by ward

Documentation audit results taken from Wards 1, 2, 3, 10 and 12 (Adult in- patient wards). The wards have audited their own documentation.

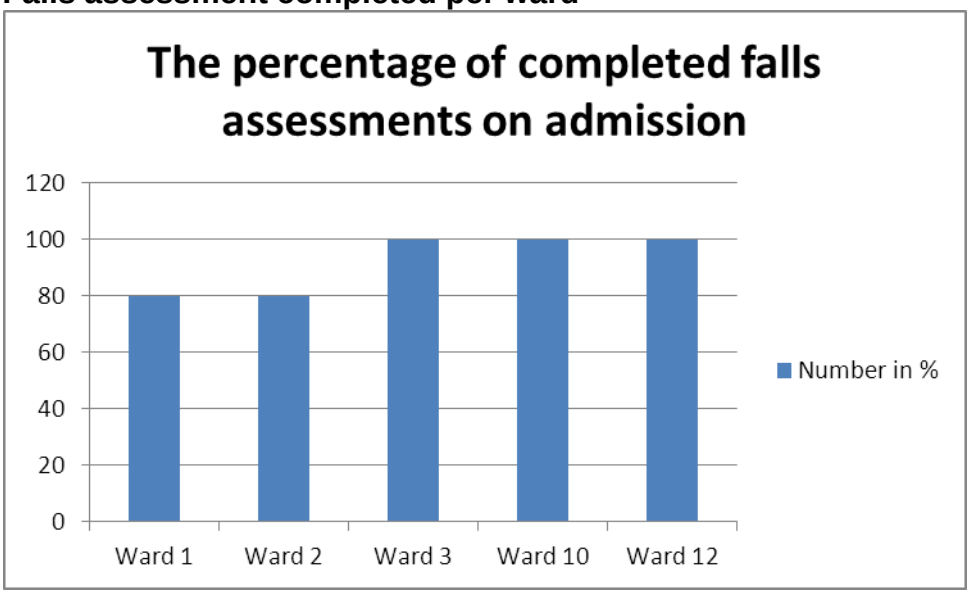
Audit results are from data obtained in the month of **November 2013.**

Overall Results

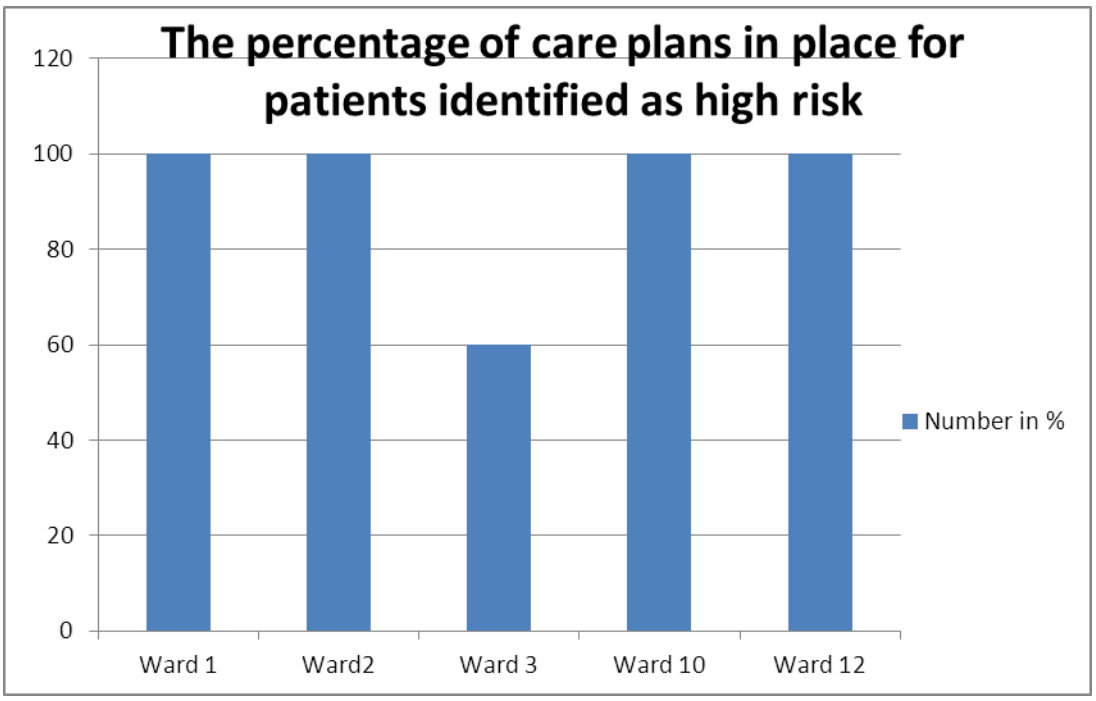
		April	May	June	July	Aug	Sept	Oct	Nov	Dec
Q1.	**Has the falls assessment been completed within 6 hours of admission?**	100 %	100 %	95%	96%	96%	88% 98%*	92%	92%	
Q2.	**If the patient is identified as high risk is a care plan in place?**	95%	95%	95%	92%	84%	74% 96%*	81%	92%	
Q3.	**Has the falls assessment been reviewed as per risk assessment**						96%	88%	88%	

*** Repeat audit**

Falls assessment completed per ward



The percentage of care plans in place for patients identified as high risk.



7. Compliments, Complaints and PALS

COMPLIMENTS

There have been 124 recorded compliments this month. Several areas have not submitted the data and have been reminded of the importance of this positive measure of our patients experience

The majority of compliments this month have been for care given

Directorate	Compliments November 2013
Clinical Support	16
Small Joint	8
Large Joint	61
Oncology	5
Paediatrics	20
Spinal	1
Corporate	5
Theatres	8

COMPLAINTS
There have been 8 complaints (7 formal) received in the month, which is a reduction of 42% on last month (12).
Ninety percent (9/10) of complaints were responded to within the agreed timescale in November, this is above the KPI of 80%. The 1 complaint that is overdue was as a result of a process delay in the public and patient service team as a result of unexpected absence and an increased volume of PALS.

Areas for formal complaints received this month are broken down as follows:

- Clinical care and/or outcome of surgery x 3
- Communication and administration x 2
- Nursing care x 2

PALS:
PALS contacts up this month from 79 to 112 (an increase of 26%)
In addition to new service users of this service a large number of patients known to the service have returned to us for help and support. The needs expressed include long standing problems, new treatment plans, need help coordinating admissions etc. all of which has taken a large amount of time to support.

- Numbers of PALS received by Directorate:

Corporate	14
Small Joint	5
Large Joint	18
Oncology	9
Clinical Support	26
Paediatrics	3
Spinal	32
Theatres	5
Total	**112**

Highest areas of concern:

- Delays in spinal admin – patients unsure of plans for care and treatment
- Metal on Metal queries
- Orthotics – waiting times to get appointment for treatment
- Appointment queries: repeated changes, cancelled and not informed and cannot get through
- Work experience requests
- Parking problems
- Having an injection – lack of information on what to bring, waiting for date to be scheduled

Please note the Ward and Theatre KPI are not available at this time, the report mechanism for the KPI process closes at ward level on the 10th of the month. It will be circulated on email at a later date.

APPENDIX 1

New SIRIs November 2013

Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final report due
11829	30/10/2013	5/11/2013	Patient received x 2 radiation doses (x-rayed twice)	Minor	OPD & Spinal	Investigation underway	10/01/2014
11847	2/11/2013	4/11/2013	Medical device unavailable	Minor	Paediatric	Downgrade request submitted to commissioners	N/A
11958	05/11/2013	21/11/2013	Grade 3 pressure ulcer	Minor	Large Joints	Investigation underway	03/02/2014
11936	18/11/2013	27/11/2014	Grade 3 Pressure Ulcer	Minor	Large Joints	Investigation underway	03/02/2014
11994	25/11/2014	27/11/2014	Grade 3 Pressure Ulcer	No harm	Theatre & Anaesthetics	Investigation underway	05/02/2014

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to Trust Board

Date: 18.12.13 **Enclosure 9**

Report Title: Emergency Planning Resilience and Response Organisational Assurance to the Local Area Team
Report By: Suzanne Nicholl **Directorate Manager and Emergency planning Lead**
Report Presented by: Suzanne Nicholl
Purpose of the Report: **To inform the Board of the Trust's self-assessment against the EPRR Core Standards. For the Board to endorse the assessment and improvement actions**
Recommendation: **To endorse the self-assessment and improvement plan**

1.0	**Summary / Background** The Trust has been asked by NHS England – Birmingham, Solihull & Black Country Area Team to complete a self-assessment and improvement plan against the EPRR Core Standards launched in April 2013 (app 1). This assessment needs to be approved by the Accountable Emergency Officer and endorsed by the Trust Board by the end of December 2013
2.0	**Detail** This is the first time since the introduction of the revised EPRR Core Standards that Trusts have been asked to assess their arrangements and in doing so has provided the opportunity to robustly benchmark our emergency planning service against national standards. The self-assessment in appendix 1 is rated as follows: Green – Arrangements currently in place Amber - Arrangements scheduled to be completed by December 2013 Red - Arrangements not in place by December 2013 Timescales for improvement plans are to be determined and agreed by individual Trusts. Annual reassessment is likely and will occur May/June 2014 There are 2 standards that are currently requiring action. Where this is the case the improvement plans indicate the actions to be taken and the timescale for completion.

	8.2 Detailed Evacuation plans 8.3 Plans for managing patients a relative for a period of time Improvement Plan Currently the Trust has detailed departmental evacuation plans in the event of fire. However the Trust does not have a total hospital evacuation plan which would detail the management and shelter of patients and relatives. This will be completed & ratified by April 2014 Completion of these actions will provide full compliance by reassessment. Progress will be monitored through the Emergency Planning Group and reported to EMT. The Local Area Team (LAT) is establishing peer review of EPRR arrangements for 2014, however the ROH EP lead has agreed an informal peer review with the EP officer for South Birmingham Community Trust in Feb 2014. The Emergency planning lead has offered assurance to the LAT that the Trust will be fully compliant with the core standards by April 2014.
8.0	**Conclusion and Recommendations** The EPRR self-assessment identifies areas for improvement required by the Trust. The Board is asked to endorse the assessment and improvement plan.

Report attachments – Appendix 1 Core Standards Self-Assessment

Signed: Date: **12.12.13**

Insert Organisation name The Royal Orthopaedic NHS Foundation Trust
Insert Organisation type(s) Specialist Orthopaedic Hospital
Insert name of completing officer Suzanne Nicholl
Insert name of authorising officer Amanda Markell
Insert submission date 18.10.13 revised 2.12.13 & 5.12.13

Select your organisation type using Autofilter dropdown arrow(s)

		Cat 1				Cat 2	Incategoris	
	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	**Acute trusts**	**Ambulance trusts**	**NHS England area teams**	**NHS England regional &**	**CCGs**	**Community providers**	**Mental health**
1	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	X	X	X	X	X	X	X
2	**All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency.**	X	X	X	X	X	X	X
3	**All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	X	X	X	-	X	X	X
3 . 1	director-level representation at the LHRP; and	X	X	X	-	X	X	X
3 . 2	representation at the LRF.	-	X	X	-	-	-	-
4	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	X	X	X	X	X	X	X
4 . 1	Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme must link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X
5	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	X	X	X	X	x	x	x
5 . 1	be based on risk-assessed worst-case scenarios;	X	X	X	X	X	X	X
5 . 2	make sure that all arrangements are trialled and validated through testing or exercises;	X	X	X	X	X	X	X
5 . 3	make sure that the funding and resources are available to cover the EPRR arrangements;	X	X	X	X	X	X	X
5 . 4	plan for the potential effects of a significant incident or emergency or for providing healthcare services to prisons, the military and iconic sites; and	X	X	-	X	-	X	X
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X	X	-	X	-	X	X
	Incident response plans must be in line with published guidance, threat-specific plans and the plans of other responding partners. They must:	X	X	X	X	X	X	X
5 . 6	refer to all relevant national guidance, other supporting and threat-specific plans (eg pandemic flu, CBRN, mass casualties, burns, fuel shortages, industrial action, evacuation, lockdown, severe weather etc) and policies, and all other supporting documents that enhance the organisation's incident response plan;	X	X	X	X	X	X	X
5 . 7	refer to all other associated plans identified by local, regional and national risk registers;	X	X	X	X	X	X	X
5 . 8	have been written in collaboration with all relevant partner organisations;	X	X	X	X	X	X	X
5 . 9	refer to incident response plans used by partners, including LRF plans;	X	X	X	X	X	-	-
5 . 10	have been written in collaboration with PHE;	X	X	X	X	X	-	X
5 . 11	have been written in collaboration with all burns, trauma and critical care networks; and	X	X	X	X	X	X	-

GREEN - arrangements in place now,		GREEN - Assured
AMBER - draft or scheduled on action		AMBER - Partially assured, seeking clarification/ draft
RED - arrangements not in place or		RED - Not assured; insufficient evidence provided
N/A - Not applicable to organisation		N/A - Not applicable to organisation
N/R - Not rated by reviewing team		N/R - Not rated by reviewing team

	Commentary/ References to Evidence Supplied	**Self Assessment**	**Improvement plan**	**Review Team Comment**	**Review Team Assessment**
1	Emergency Planning lead - Suzanne Nicholl - Directorate manager				
2	Mutual aid is referred to in the major incident plan. MOU exist with other local Trusts; Attendance and agreement with the LAT expectations of mutual aid.				
3					
3 . 1	Emergency Accountable officer will have regular attendance at the LHRP				
3 . 2					
4	Comms exercises: October 2012 x2 & April 2013 Exercises: 30.12.12 - live ward fire. Debrief: Jan 2013				
4 . 1	Work plan contains the recommended information				
4 . 2	Pertinent risks are on Trust CRR				
5					
5 . 1	Detailed in MI Plan				
5 . 2	Comms exercises: October 2012 x2 & April 2013 Exercises: 30.12.12 - live ward fire. Debrief: Jan 2013				
5 . 3	Provided as required				
5 . 4	Outlined in the Major incident plan				
5 . 5	Estates & Facilities are integral part of the EPRR group; Business continuity plans are held for all core services & departments				
5 . 6	Major Incident plan				
5 . 7	Major Incident plan				
5 . 8	Major Incident plan				
5 . 9	Major Incident plan				
5 . 10	N/A				
5 . 11	N/A				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
5 . 12	define how the organisation will meet the Prevent strategy's objectives for health (1. prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and 2. work with sectors and institutions where there are risks of radicalisation which we need to address, and the wider CONTEST strategy).	X	X	X	-	X	X	X		N/R			N/R
	Incident response plans must follow NHS governance arrangements. They must:	X	X	X	X	X	X	X					
5 . 13	be approved by the relevant board;	X	X	X	X	X	X	X	Major Incident plan				
5 . 14	be signed off by the appropriate Senior Responsible Officer;	X	X	X	X	X	X	X	Major Incident plan				
5 . 15	set out how legal advice can be obtained in relation to the CCA;	X	X	X	X	X	-	X	Details not currently included in plan, however in practice this is available via Trust solicitors				
5 . 16	identify who is responsible for making sure the plan is updated, distributed and regularly tested;	X	X	X	X	X	X	X	Major Incident plan				
5 . 17	explain how internal and external consultation will be carried out to validate the plan;	X	X	X	X	X	X	X	Major Incident plan				
5 . 18	include version controls to be sure the user has the latest version;	X	X	X	X	X	X	X	Major Incident plan				
5 . 19	set out how the plan will be published – for example, on a website;	X	X	X	X	X	X	X	The plan is available on the Trust website , On-call pack, Bleep holders file and p drive				
5 . 20	include an audit trail to record changes and updates;	X	X	X	X	X	X	X	Major Incident plan				
5 . 21	explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	X	X	X	X	X	X	X	This facility is available in practice and has been enacted twice in the last 4 years without difficulty				
5 . 22	demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.	X	X	X	X	X	X	X	The EPG reviews and escalates related risks to the CRR/BAF: Flu; Heat wave management & Industrial action . In additions all core services have risk assessments relating to their Business continuity plans				
	Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.	X	X	X	X	X	X	X					
5 . 23	Key staff must know where to find the plan on the intranet or shared drive.	X	X	X	X	X	X	X	Training records				
5 . 24	There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.	X	X	X	X	X	X	X	Debrief from exercises; feedback from training				
5 . 25	Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rotas must meet NHS published competencies.	X	X	X	X	X	X	X	Training records				
5 . 26	It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).	X	X	X	X	X	X	X	Training records & feedback				
5 . 27	It must be clear how key staff can achieve and maintain suitable knowledge and skills.	X	X	X	X	X	X	X	Training is available to key individuals on an annual and bespoke basis				
	Set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols.	X	X	X	X	X	X	X					
5 . 28	Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X	X	X	X	X	X	X	major Incident plan				
5 . 29	Set out the procedures for escalating emergencies to NHS England area teams, regions, national office and DH	-	-	X	X	-	X	-					
5 . 30	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	X	X	X	X	-	X	-	Established and robust on-call rota in situ. Call out protocol included in MI plan				
5 . 31	Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X	X	X	X	X	X	X	Admin role assigned to system				
5 . 32	Set out the responsibilities of key staff and departments.	X	X	X	X	X	X	X	Major Incident plan				
5 . 33	Set out the responsibilities of the appropriate Senior Responsible Officer or nominated Executive Director.	X	X	X	X	X	X	X	Major Incident plan				
5 . 34	Explain how mutual aid arrangements will be activated and maintained.	X	X	X	X	X	X	X	Major Incident plan				
5 . 35	Identify where the incident or emergency will be managed from (the ICC).	X	X	X	X	X	X	X	Major Incident plan				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
5 . 36	Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.	X	X	X	X	X	X	X	Major Incident plan				
5 . 37	**Best Practice:** Use an electronic data-logging system to record the decisions made.	X	X	-	-	-	-	-	Not considered to be necessary to the safe and effective management of an incident within a specialist Trust with no A&E				
5 . 38	**Best Practice:** Use the National Resilience Extranet.	X	X	X	X	-	X	-					
5 . 39	Refer to specific action cards relating to using the incident response plan.	X	X	X	X	X	X	X	MIP & action cards				
5 . 40	Explain the process for completing, authorising and submitting NHS England standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X	X	X	X	X	X	X	In practice as an incident unfolds or preparations are made the operations team establish the reporting mechanism, as demonstrated during the Workforce strikes 30.10.11				
5 . 41	Explain how extended working hours will apply and how they can be sustained. Explain how handovers are completed.	X	X	X	-	X	X	X	This has been managed successfully during actual incidents in Dec 2012 and Sept 2009.				
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X	X	X	X	X	X	X	During incidents the Trust has posted messages on our web site to inform patients and visitors eg the fire in Dec 2012. The MI plan has an action card for our communications officer to ensure effective and timely communication with				
5 . 43	Have agreements in place with local 111 providers so they know how they can help with an incident	X	X	X	X	X	X	-	As a specialist Trust the role the ROH will play within a MI will be informed by the LAT requirements and mutual aid agreements				
5 . 44	Consider using helplines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	X	X	X	X	X	X	X	As a non receiving acute organisation the relevance of helplines is minimal. The Trust will respond as directed by the co-ordinating body				
5 . 45	Describe how stores and supplies will be maintained.	X	X	-	-	X	X	X	Contained within the BCP				
5 . 46	Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	X	X	-	-	-	X	X	Casualties will be transferred to local A&E as required				
5 . 47	Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.	X	X	-	X	-	-	X	Action cards				
5 . 48	Explain the process of recovery and returning to normal processes.	X	X	X	X	X	X	X	Action cards				
5 . 49	Explain the de-briefing process (hot, local and multi-agency)at the end of an incident.	X	X	X	X	X	X	X	Debriefing post incident is routine practice at ROH and informs the incident report and learning				
5 . 50	Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	X	X	X	X	X	X	X	The MI plan includes facility for a relative centre and support from chaplaincy in and after an incident. In house occupational health facility is also available				
	Set out how surges in demand will be managed.	X	X	X	X	X	X	X					
5 . 51	Explain who will be responsible for managing escalation and surges.	X	X	X	X	X	X	X	In additional to routine capacity management arrangements an escalation process can be activated which ensures minimal disruption to patient services				
5 . 52	Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X	X	X	X	X	X	X	N/A				
	Link the Incident Response Plan to threat-specific incidents	X	X	X		X	X	X					
5 . 53	CBRN incidents;	X	X	-	-	-	X	X	N/a				
5 . 54	mass casualty incidents;	X	X	-	-	-	X	X	N/A				
5 . 55	pandemic flu;	X	-	X	-	-	X	X	N/A				
5 . 56	patients with burns requiring critical care; and	X	-	-	-	-	X	X	N/A				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
5 . 57	severe weather.	X	X	X	-	X	X	X	N/A				
6	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This must include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	X	X	X	X	X	X	X	Primary and secondary Incident control rooms				
6 . 1	There must be a plan setting out how the ICC will operate.	X	X	X	X	X	X	X	ICR - set up document				
6 . 2	There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	X	X	X	X	X	X	X	ICR - set up document				
6 . 3	There must be a plan setting out how the Incident Coordination Team will be called in and managed over any length of time	X	X	X	X	X	X	X	ICR - set up document				
6 . 4	Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.	X	X	X	X	X	X	X	ICR - set up document; audit document				
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	X	X	X	X	X	X	X					
7 . 1	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	X	X	X	X	X	X	Not currently included				
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X	X	X	X	X	X	X	Not currently included				
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X	X	X	X	X	X	X	BCP & stand alone plans - IT & Estates				
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X	X	X	X	X	X	X	BCP				
	Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.	X	X	X	X	X	X	X	BCP				
7 . 5	Each organisation's BCMS must be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X	X	X	X	X	X	X	BCP				
7 . 6	Organisations must establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X	X	X	X	X	X	X	BCP				
7 . 7	Organisations must make clear how their plan will be published, for example on a website.	X	X	X	X	X	X	X	Not currently included				
7 . 8	The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the appropriate Senior Responsible Officer.	X	X	X	X	X	X	X	BCP				
7 . 9	There must be an audit trail to record changes and updates such as changes to policy and staffing.	X	X	X	X	X	X	X	BCP				
7 . 10	The planning process must take into account nationally available toolkits that are seen as good practice.	X	X	X	X	X	X	X	**BCP**				
	Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.	X	X	X	X	X	X	X					
7 . 11	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X	X	X	X	X	X	X	BCP & Dept. BCP				
7 . 12	Plans must be maintained based on risk-assessed worst-case scenarios.	X	X	X	X	X	X	X	BCP & Dept. BCP				
7 . 13	Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heat wave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	X	X	X	X	X	X	X	Dept. BCP				
7 . 14	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	X	X	X	X	X	X	BCP				
7 . 15	They must identify all critical activities using a business impact analysis. This must set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	X	X	X	X	X	X	X	BCP				
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	X	X	X	X	X	X	BCP				
	Business continuity plans must set out how the plans will be called into use, escalated and operated.	X	X	X	X	X	X	X					
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	X	X	X	X	X	X	X	Use of email address; shortwave radio and telephones				
7 . 18	Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X	X	X	X	X	X	X	Action card & plan				
7 . 19	the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	X	X	X	X	X	X	X	Action card				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
7 . 20	24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X	X	X	X	X	X	X	cascade doc; Comms doc; admin role				
7 . 21	the responsibilities of key staff and departments;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 22	the responsibilities of the appropriate Senior Responsible Officer or Executive Director;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 23	how mutual aid arrangements will be called into use and maintained;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 24	where the incident or emergency will be managed from (the ICC);	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 25	how the independent healthcare sector may help if required; and	X	X	X	X	X	X	X	MOU with private provider				
7 . 26	the insurance arrangement that are in place and how they may apply.	X	X	X	X	X	X	X	Action Cards				
	Business continuity plans must describe the effects of any disruption and how they can be managed. Plans must include:	X	X	X	X	X	X	X					
7 . 27	contact details for all key stakeholders;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 28	alternative locations for the business;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 29	a scalable plan setting out how incidents will be managed and by whom;	X	X	X	X	X	X	X	Action Cards				
7 . 30	recovery and restoration processes and how they will be set up following an incident;	X	X	X	X	X	X	X	Action Cards; reference to MIP				
7 . 31	how decisions and meetings will be recorded during and after an incident, and how the incident report will be compiled;	X	X	X	X	X	X	X	Post incident report; action cares				
7 . 32	how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	X	X	X	X	X	X	X	Action cards				
7 . 33	how staff will be accommodated overnight if necessary;	X	X	X	X	X	X	X	Not currently included				
7 . 34	how stores and supplies will be managed and maintained; and	X	X	-	-	X	X	X	BC plan and stand alone doc				
7 . 35	details of a surge plan to maintain critical services.	X	X	X	X	X	X	X	N/A				
	Business continuity plans must specify how they will be used, maintained and reviewed.	X	X	X	X	X	X	X					
7 . 36	Organisations must use, exercise and test their plans to show that they meet the needs of the organisation and of other interested parties. If possible, these exercises and tests should involve relevant interested parties. Lessons learnt must be acted on as part of continuous improvement.	X	X	X	X	X	X	X	Comms exercises: October 2012 x2 & April 2013 Exercises: 30.12.12 - live ward fire. Debrief: Jan 2013				
7 . 37	Plans must identify who is responsible for making sure the plan is updated, distributed and regularly tested.	X	X	X	X	X	X	X					
7 . 38	Organisations must monitor, measure, analyse and assess the effectiveness of their BCMS against their own requirements, those of relevant interested parties and any legal responsibilities.	X	X	X	X	X	X	X	Report to IGC				
7 . 39	Organisations must identify and take action to correct any irregularities identified through the BCMS and must take steps to prevent them from happening again. They must continually improve the suitability and effectiveness of their BCMS.	X	X	X	X	X	X	X	Report to IGC; Post incident reports				
	Business continuity plans must specify how they will be communicated to and accessed by staff. Plans must include:	X	X	X	X	X	X	X					
7 . 40	details of the training provided to staff and how the training record is maintained;	X	X	X	X	X	X	X	Incident controllers training events and records				
7 . 41	reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);	X	X	X	X	X	X	X	Incident controllers are trained to a best practice standard				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
7 . 42	details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and	X	X	X	X	X	X	X	BCP training has largely through exercises , actual incidents and support to dept. owners via local BCP review		BCP workshops are to be held in Jan 2014. Awareness training available via induction and mandatory training from April 2014. Bespoke training and advise available as required		
7 . 43	details of how suitable knowledge and skills will be achieved and maintained.	X	X	X	X	X	X	X	a/a		BCP workshops are to be held in Jan 2014. Awareness training available via induction and mandatory training from April 2014. Bespoke training and advise available as required		
8	**NHS Acute Trusts must also include:**	X	-	-	-	-	-	-					
8 . 1	detailed lockdown procedures;	X	-	-	-	-	-	-	Stand alone doc				
8 . 2	detailed evacuation procedures;	X	-	-	-	-	-	-	Currently the Trust has departmental evacuation plans in place, however a total evacuation plan has not been developed		This is for development in Q4		
8 . 3	details of how they will manage relatives for any length of time, how patients and relatives will be reunited and how patients will be transported home if necessary;	X	-	-	-	-	-	-	Currently the Trust has departmental evacuation plans in place, however a total evacuation plan has not been developed		This is for development in Q4		
8 . 4	details of how they will manage fatalities and the relatives of fatalities; and	X	-	-	-	-	-	-	N/A				
8 . 5	**Best Practice:** reference to the Clinical Guidelines for Major Incidents.	X	X	-	-	-	-	-	N/A				
9	**NHS Ambulance Trusts must also:**	-	X	-	-	-	-	-					
9 . 1	refer to the National Ambulance Service Command and Control Guidance 2012 and any other relevant ambulance specific guidance relating to major incidents;	-	X	-	-	-	-	-					
9 . 2	manage up to four incidents at a time in urban areas and two in rural areas;	-	X	-	-	-	-	-					
9 . 3	have flexible IT and staff arrangements so that they can operate more than one control centre and manage any events required;	-	X	-	-	-	-	-					
9 . 4	have formal arrangements for recalling staff to duty if necessary;	-	X	-	-	-	-	-					
9 . 5	be able to provide a forward control team if necessary;	-	X	-	-	-	-	-					
9 . 6	have an on-call and an on duty loggist drawn from a wide pool of staff;	-	X	-	-	-	-	-					
9 . 7	have arrangements to communicate with and control resources from other ambulance providers;	-	X	-	-	-	-	-					
9 . 8	have a 24-hour specialist adviser for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support gold and silver command in managing these events;	-	X	-	-	-	-	-					
9 . 9	have 24-hour radiation protection supervisor arrangements in line with local and national mutual aid arrangements;	-	X	-	-	-	-	-					
9 . 10	make sure all commanders maintain a continuous personal development portfolio;	-	X	-	-	-	-	-					
9 . 11	have a Hazardous Area Response Team (HART) in line with the current national service specification, including a vehicles and equipment replacement programme;	-	X	-	-	-	-	-					
9 . 12	be able to respond to firearms incidents in line with National Joint Operating Procedures;	-	X	-	-	-	-	-					
9 . 13	have a Mobile Emergency Response Incident Team (MERIT) to cover the area in line with Department of Health guidance;	-	X	-	-	-	-	-					
9 . 14	be able to manage a casualty clearing station with large numbers of patients for a long period of time in line with Department of Health guidance;	-	X	-	-	-	-	-					
9 . 15	be able to identify the location and availability of assets across the organisation and the country;	-	X	-	-	-	-	-					
9 . 16	be able to respond with assets across the organisation and the country and provide situation reports to the National Ambulance Co-ordination Centre;	-	X	-	-	-	-	-					
9 . 17	be able to dispatch and receive assets following an agreed trigger mechanism, supported by a robust audit process;	-	X	-	-	-	-	-					
9 . 18	have a trigger mechanism for requesting mutual aid and a nominated person to agree to these requests, supported by a clear profile of what is required, what can be provided and how the response will be managed in the field;	-	X	-	-	-	-	-					
9 . 19	have systems to manage the media at Emergency Operational Centres, fall-back locations and across the organisation;	-	X	-	-	-	-	-					
9 . 20	have arrangements in place for routine public events, for example, demonstrations and public gatherings;	-	X	-	-	-	-	-					
9 . 21	attend safety advisory groups to reduce organisational risk during planning and at the actual event;	-	X	-	-	-	-	-					
9 . 22	have arrangements in place to deal with public disorder incidents;	-	X	-	-	-	-	-					
9 . 23	have arrangements in place to provide radiation protection supervisors;												
9 . 24	have arrangements in place to train voluntary and community first responders	-	X	-	-	-	-	-					

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
9 . 25	have arrangements in place to provide training support to NHS partners in the use of personal protective equipment for chemical, biological, radiological, nuclear, hazardous material and casualty clearing.	-	X	-	-	-	-	-					
9 . 26	have processes and an audit trail which allow all staff to train with partner agencies;	-	X	-	-	-	-	-					
9 . 27	have arrangements in place to train with the voluntary sector;	-	X	-	-	-	-	-					
9 . 28	have arrangements in place to train with acute trusts;	-	X	-	-	-	-	-					
9 . 29	have arrangements in place to share the outcome of training and exercises with other ambulance trusts and government stakeholders across the country;	-	X	-	-	-	-	-					
9 . 30	have strong processes for profiling staff and managing facilities to accommodate EPRR and store assets in line with CCA requirements;	-	X	-	-	-	-	-		N/R			N/R
9 . 31	have arrangements in place for counselling and supporting staff, and advising on long-term clinical care following a traumatic or high-profile incident;	-	X	-	-	-	-	-					
9 . 32	have suitable IT arrangements in place to support a significant incident or any event that requires specialised IT;	-	X	-	-	-	-	-					
9 . 33	explain the systems for alerting, mobilising and co-ordinating all primary NHS resources necessary to deal with an incident on the scene (in coordination with NHS England area team gold command);	-	X	-	-	-	-	-					
9 . 34	list their key strategic, tactical and operational responsibilities as set out in the NHS Emergency Planning Guidance 2005 (or subsequent relevant guidance);	-	X	-	-	-	-	-					
9 . 35	explain how and when MERIT, HART and MIA (the Medical incident Adviser) will be used;	-	X	-	-	-	-	-					
9 . 36	identify how voluntary aid societies will be used;	-	X	-	-	-	-	-					
9 . 37	explain working arrangements with all emergency services;	-	X	-	-	-	-	-					
9 . 38	explain the arrangements for managing triage, treatment and transport for casualties;	-	X	-	-	-	-	-					
9 . 39	state who will represent the service at LHRP, LRF and similar groups;	-	X	-	-	-	-	-					
9 . 40	explain the roles of the Hospital Ambulance Liaison Officer (HALO) and Hospital Ambulance Liaison Control Officer (HALCO) in acute trusts;	-	X	-	-	-	-	-					
9 . 41	refer to other relevant plans such as REAP;	-	X	-	-	-	-	-					
9 . 42	explain how the Mobile Privileged Access Scheme (MTPAS) and Fixed Telecommunications Privileged Access Scheme (FTPAS) will be provided across the organisation; and	X	X	-	-	X	X	X					
9 . 43	describe how Airwave systems will be managed within the organisation and how talk groups will be used to communicate with the emergency services.	-	X	-	-	-	-	-					
10	**NHS England area teams must also:**	-	-	X	-	-	-	-					
10 . 1	make sure that the incident response plans for all providers in an LRF are co-ordinated and compatible;	-	-	X	-	-	-	-					
10 . 2	define when the NHS will take the leading role in a significant incident or emergency`;	-	-	X	-	-	-	-					
10 . 3	mobilise primary and secondary care resources to support acute and non-acute trusts;	-	-	X	-	X	-	-					
10 . 4	describe the arrangements for setting up a Science and Technical Advice Cell (STAC) in consultation with local Public Health England centres;	-	-	X	X	-	-	-					
10 . 5	identify who will attend the Strategic Co-ordination Group (SCG);	-	-	X	X	-	-	-					
10 . 6	provide a co-chair and secretariat for LHRPs;	-	-	X	-	-	-	-					
10 . 7	define the roles and responsibilities of LHRP; and	-	-	X	-	-	-	-					
10 . 8	develop plans which demonstrate the command and control of resources from all NHS organisations and providers of NHS funded care within an LRF area to respond to a significant incident or emergency; and	-	-	X	-	-	-	-					
10 . 9	outline how GP services will be delivered 24 hours a day – either directly or through out-of-hours services.	-	-	-	-	X	-	-					
11	**NHS England corporate and regional offices must also:**	-	-	-	X	-	-	-					

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
11 . 1	assign an NHS England area team to each LHRP or LRF;	-	-	-	X	-	-	-					
11 . 2	define how strategic EPRR advice and support will be given to these teams;	-	-	-	X	-	-	-					
11 . 3	make sure that area team incident response plans in a region are co-ordinated and compatible;	-	-	-	X	-	-	-					
11 . 4	outline the procedure for responding to incidents which affect two or more LHRPs or LRFs;	-	-	-	X	-	-	-					
11 . 5	outline the procedure for responding to incidents which affect two or more regions;	-	-	-	X	-	-	-					
11 . 6	define how links will be made between the NHS England, the Department of Health and PHE	-	-	X	X	-	-	-					
11 . 7	define how the NHS's ability to respond to emergencies will be measured and controlled;	-	-	-	X	-	-	-					
11 . 8	outline how the Department of Health will be supported in its emergency response role;	-	-	-	X	-	-	-					
11 . 9	outline how information relating to national emergencies will be co-ordinated and shared; and	-	-	X	X	-	-	-					
11 . 10	establish a link between the Regional Prevent Co-ordinator in the NHS England local area and those involved in Protect.	-	-	-	X	-	-	-		N/R			N/R
12	**CCGs will, in addition:**	-	-	-	-	X	-	-					
12 . 1	carry out their duties as category two responders under the CCA and provide details of how they will do this;	-	-	-	-	X	-	-					
12 . 2	**Core Standard 12.2 has been TRANSFERRED to 10.9 above.**												
12 . 3	make sure agreements with providers of NHS funded care include suitable EPRR provisions and categorise funds allocated to EPRR activities (for example, testing and exercising);	-	-	-	-	X	-	-					
12 . 4	**Core Standard 12.4 has been DELETED.**	-	-	-	-	X	-	-					
12 . 5	define a route for their commissioned providers to escalate issues 24 hours a day, supported by trained and competent people, in case they cannot maintain delivery of core services;	-	-	-	-	X	-	-					
12 . 6	outline how the CCG will carry out its supporting role during and after an incident;	-	-	-	-	X	-	-					
12 . 7	Demonstrate the annual plan for training and exercises as part of the duties of a category two responder; and	-	-	-	-	X	-	-					
12 . 8	those CCG's with ambulance Trust commissioning responsibilities must ensure, in relation to both planned and non-planned events, that specific EPRR-related services in response are itemised.	-	-	-	-	X	-	-					
13	**Community pharmacists must also:**	-	-	-	-	-	-	-					
13 . 1	explain how they will support essential care in the community during a significant incident or emergency;	-	-	-	-	-	-	-					
13 . 2	support hospitals, GPs and ambulance services during the treatment phase of an influenza pandemic or any other public health emergency;	-	-	-	-	-	-	-					
13 . 3	outline how they will give accurate and specific clinical advice;	-	-	-	-	-	-	-					
13 . 4	outline how they will share information with other relevant organisations; and	-	-	-	-	-	-	-					
13 . 5	describe how the police or other emergency services can get access to a key-holder list for any pharmacy.	-	-	-	-	-	-	-					
14	**NHS Logistics must also:**	-	-	-	-	-	-	-					
14 . 1	outline how healthcare products and supply chain services can be provided 24 hours a day in times of crisis; and	-	-	-	-	-	-	-					
14 . 2	explain how an efficient and effective procurement service can be maintained for NHS organisations.	-	-	-	-	-	-	-					
15	**NHS Protect must also:**	-	-	-	-	-	-	-					
15 . 1	refer to all relevant guidance that provides a safe and secure environment for NHS staff and resources	-	-	-	-	-	-	-					
15 . 2	define its aims for managing security issues across the NHS;	-	-	-	-	-	-	-					
15 . 3	outline how conflict resolution training can be used by all NHS organisations to prevent violence against staff and patients;	-	-	-	-	-	-	-					
15 . 4	outline how NHS organisations can manage risks relating to economic crime such as fraud, bribery and corruption;	-	-	-	-	-	-	-					
15 . 5	describe how their plans will be related to the national threat levels for counter terrorism security;	-	-	-	-	-	-	-					
15 . 6	explain how threat levels will be based on the broad nature of the threat but could include specific areas of business, geographic vulnerabilities, acceptable risk and specific events;	-	-	-	-	-	-	-					
15 . 7	describe how NHS sites can be locked down by managing site security and the security of staff, patients and visitors;	-	-	-	-	-	-	-					
15 . 8	outline how NHS organisations can access Project Artemis and Project Argus Health;	-	-	-	-	-	-	-					
15 . 9	outline how local security management specialists (LSMS) can advise on managing a security culture;	-	-	-	-	-	-	-					
15 . 10	outline how NHS organisations can manage specific security issues, for example, VIPs and bomb threats;	-	-	-	-	-	-	-					
15 . 11	explain how it will use effective communication strategies to work in partnership with EPRR stakeholders; and	-	-	-	-	-	-	-					
15 . 12	establish links with LSMS and Prevent leads in trusts.	-	-	-	-	-	-	-					

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
16	**NHS Direct / 111**	-	X	-	-	-	-	-					
16 . 1	must also outline how they will support NHS organisations affected by service disruption, including communications and response procedures for significant incidents and emergencies (for example, informing the public and GPs if local emergency departments are closed).	-	X	-	-	-	-	-					
17	**Community providers must also:**	-	-	-	-	-	X	-					
17 . 1	take into account how vulnerable adults and children can be managed to avoid admissions, with special focus on providing healthcare to displaced populations in rest centres;	-	-	-	-	-	X	-					
17 . 2	outline how they can assist acute trusts and ambulance services during and after an incident (with reference to specific roles that support discharge from hospital);	-	-	-	-	-	X	-					
17 . 3	where relevant, set out detailed plans for lockdown, evacuation and managing relatives.	-	-	-	-	-	X	-					
18	**Mental healthcare providers must also:**	-	-	-	-	-	-	X					
18 . 1	co-ordinate and provide mental health support to staff, patients and relatives in collaboration with Social Services;	-	-	-	-	-	-	X					
18 . 2	outline how, when required, Ministry of Justice approval will be gained for an evacuation;	-	-	-	-	-	-	X					
18 . 3	identify locations which patients can be transferred to if there is an incident;	-	-	-	-	-	-	X					
18 . 4	support local acute trusts by managing physically unwell inpatients if there is an infectious disease outbreak; and	-	-	-	-	-	-	X					
18 . 5	make sure the needs of mental health patients involved in a significant incident or emergency are met and that they are discharged home with suitable support.	-	-	-	-	-	-	X					
19	**Urgent care centres must also:**	X	-	-	-	-	X	X					
19 . 1	outline how they can support NHS organisations affected by service disruption, especially by treating minor injuries to reduce the pressure on emergency departments. They will need to develop procedures for this in partnership with local acute trusts and ambulance and patient care transport providers.	X	-	-	-	-	X	X					

Date of Trust Board: 18th December 2013 ENCLOSURE NUMBER: 11

REPORT TO TRUST BOARD – Summary cover sheet

NAME OF DIRECTOR PRESENTING	**Andrew Meehan**
AUTHOR(S)	**Paul Athey**

TITLE	**Trust Board Feedback from the Audit Committee Meeting held on 19th November 2013.**

SUMMARY

The committee held a meeting on 19th November and the following key items were covered:

- The external audit plan for 2013-14 was received and accepted
- Internal Audit progress was noted and assurance was gained that any audits behind schedule would be addressed prior to February's meeting
- Counter Fraud progress was noted. Feedback from the review of HR personnel files was received, and Counter Fraud were asked to undertake additional sample testing with regards to photo identification.
- Changes to the Trust's accounting policies were approved. These included the changes required as a result of the consolidation of charitable funds accounts and updates to the treatment of capital assets and their depreciation.
- The Terms of Reference for the Audit Committee were formally approved with one amendment relating to the frequency of meetings which should read "no less than 5 per annum", rather than "6 per annum". Audit colleagues agreed this was in line with usual practice at other NHS organisations.
- The process for the appointment of Internal Audit and Counter Fraud Services from 2014/15 onwards was noted.
- The committee received a draft report on the Board Assurance Framework, in line with discussions that had been held between Andy Meehan, Paul Athey, Lisa Pim and Alison Braham. The committee were happy that the new format of the report would make the understanding of the Trust's key risks far clearer. Further discussions were to be held with other stakeholders to ensure the proposed process worked across all key assurance committees.

RISK & IMPLICATIONS

There are no risks from this report.

RECOMMENDATIONS

The Board are asked to note this report.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 18th December 2013 **ENCLOSURE NUMBER: 12**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Bryan Jackson, Chairman**
AUTHOR:	**Joy Street** **Company Secretary**
SUBJECT:	**Board Assurance Framework Risks 2013/14**

SUMMARY

The attached report gives details of the one Board Assurance Framework Risk managed via Trust Board. It has recently been updated and transferred to the electronic risk register database ('Ulysses Risk Register').

IMPLICATIONS

Scrutiny and challenge of BAF risks is essential to ensure that any risks are identified and managed.

RECOMMENDATIONS

The Board is asked to:

- **Note** the attached risk paying particular attention to the current risk score for Executive Director Continuity and Corporate Memory, which is now lower than in the previous month following the successful appointment of a new CEO.
- **Identify** any additional risks for inclusion onto the BAF/ CRR

.

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Risk Number & Version			
Risk Number & Version:	11 Ver 1	**Risk Level:**	2. BAF Prinicpal Risk

Risk Details			
Opened:	09/09/2013		
Status:	Static	**Strategic Objective:**	2.3 Manage People To Enable To
Risk Type:	BAF Related	**Source Of Risk:**	
Team/Project:		**Risk Category:**	
Directorate:		**Risk Owner:**	Bryan Jackson
Monitoring Committee:	EMT	**Operational Lead:**	Joy Street

Details of the Risk	
Risk Description:	Executive Director Continuity and Corporate Memory
Causes:	Executive Director Continuity and Corporate Memory. Old ref: 155
Consequences:	3.0

Initial Risk Rating

Likelihood	***Consequence***				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	***Score : 16***	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	Score : 4	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Initial Risk Rating:	High (Red)
Initial Risk Score:	16

Current Controls & Assurances

Control Details:	Board turnover very high from November 2012 to October 2013. Regularly reviewed by Board and mitigated by prompt recruitment, appropriate and timely interim arrangements and effective handovers
Adequacy of Controls:	Adequate
Independent Assurance:	Regular review by remuneration committee of board Review of risk at each board meeting

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Current Risk Rating

Likelihood	*Consequence* 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	Score : 4	***Score : 6***	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Current Risk Rating:	Low (Yellow)
Current Risk Score:	6

Additional Controls & Assurances

Priority:			
Action Lead:	Joy Street		
Person Accountable:			
Action Details:			
Progress:			
Outcome:	Closed	**Completion Date:**	20/09/2013

Priority:		**Start Date:**	16/09/2013
Action Lead:	Bryan Jackson	**Target Date:**	25/09/2013
Person Accountable:	Joy Street	**Reminder Date:**	22/09/2013
Action Details:			
Appointment of new CEO september 2013 - start dat early 2014 Interim Director of Nursing appointed end September 13 NED continuity for two ends of term being recommended to governors			
Progress:			

Priority:		**Start Date:**	15/10/2013
Action Lead:		**Target Date:**	07/10/2013
Person Accountable:		**Reminder Date:**	04/10/2013
Action Details:			
Interim Director of Nursing in place for 6 months having had one week handover.			
Progress:			

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Target Risk Rating

Likelihood	*Consequence*				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	***Score : 4***	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Target Risk Rating:	Low (Yellow)
Target Risk Score:	4

Notifications

Date:	Notification Group:	Notified Staff Member:	Info Only:
16/09/2013	Additonal Notification	Joy Street	N

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Trust Board Meeting
held in public on Wednesday 27th November 2013 in the Boardroom

Present:
Trust Board
Dr Bryan Jackson, Chairman (Chair)
Mr Graham Bragg, Acting Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Interim Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Mr Andrew Meehan, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mr Tim Pile, Non-Executive Director
Ms Elizabeth Mountford, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director

In attendance:
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Roger Tillman, Interim Deputy Medical Director
Mrs Jo Chambers, CEO Designate

ACTION

11/13/1511 **Apologies and welcomes**
None

11/13/1512 **Introductions & Welcome**
None

11/13/1513 **Declarations of Interest**
No other Declarations of Interest than those registered previously.

11/13/1514 **Minutes of the Trust Board meeting held on 30th October 2013**
The minutes of the meeting held on the 30th October 2013 were approved as a true and accurate reflection of the meeting.

Postscript to Medical Director's report – AP reported that the Trust's NJR reporting was behind and that as a result the ROH had not met the percentage requirement threshold which acts as a gateway to receipt of best practice tariff. The Medical Director assured the Board that by February 2014 the Trust would

achieve 100% completion rate by surgeon (from current base of 73%). This will be monitored at the Clinical Outcomes & Effectiveness Committee under the Chairmanship of RT. The WHO checklist will be amended to include a completion check of NJR return.

11/13/1515 Action Points

The action notes were deferred for updated review at the December meeting.

11/13/1516 Chairman's & Chief Executive's Update

Agenda item deferred for update at the December meeting.

Performance Management/Assurance Reports

11/13/1517 Corporate Performance Report & Programme Board Update

AM gave a presentation on activity:

- Day case activity was above plan putting pressure on ADCU as volume is higher than expected
- Inpatient activity was below plan and below the level of the previous year
- Outpatient appointments had increased by 10%
- Backlog over 18 weeks had grown in the summer due to the impact of surgeon and patient leave
- AP advised that orthopaedic treatment levels were declining nationally in part due to procedures of limited clinical value having been introduced and as a result of new triage arrangements.

AMe commented that the high percentage of fixed costs meant that a re-balancing of day case versus inpatients disproportionately impacts on finance and BJ suggested looking at increasing the proportion of variable costs if possible.

TS advised that it was likely that this pattern of activity would continue and that the Trust may need to make a fundamental change to the way it structures its clinical service. EM felt that the situation demanded real focus on robust workforce planning.

AMe asked if the impact of the Trust Business and Learning Day (TBALD) on activity had been accounted for and members debated the balance of benefit on service quality versus impact on financial outturn.

BJ felt that visual control and raising awareness was necessary but that in the year to date, had the Trust avoided just 50% of the 600 cancellations it would have remained on track. TP suggested positive targeting of patients who were available for procedures at short notice and was advised that, as far as possible this was done in order to fill lists when cancellations were made at short notice but that pre-op assessment, surgeon

availability and other factors made it quite complex to deliver in any numbers.

TS suggested that pre-op could be made available on an outreach basis to support patients having quick access to surgery. It was confirmed by AP that POAC assesses patients who already have a date for surgery and that there was scope for short notice assessments.

HS commented that from her visits to wards some staff seemed to feel that they were being asked to do extra work rather than having an understanding that this work should have been undertaken as part of planned activity earlier in the year.

EM felt that communications should encourage staff to feel that the Trust was trying to offer the best inpatient care and support them in this as the reason they do their jobs.

BJ asked for assurance on patient safety while this hike in activity took place and HS confirmed that core staffing levels would be agreed as well as optimum. This would give baseline safety as well as gold standard.

FK asked if there was evidence of action plans having had any impact yet and AM advised that these would be in place and monitored from the following week.

BJ thanked all members of staff on behalf of the Board for their work in developing the rectification plan which reflected a significant amount of work. He felt it was important to involve as many staff as possible in order to spread and embed the learning.

GB suggested, and it was agreed, that a workshop session be held to detail the patient pathway and encourage further sharing of ideas.

AP reported that many staff had suggested that TBALD be cancelled for the remainder of the financial year. **TS/FK suggested that different ways of delivery might be considered and agreed to meet outside the Board with AP and others**. EM felt it was a key tool for engagement and should not be cancelled. It was agreed that the cancelation of the next TBALD (in February) be held in abeyance for consideration in mid-January, as a possible means of mitigation, dependent upon progress.

TS/FK/AP

PA presented an update on the Trust's CIP position which showed areas of under-achievement. It was nonetheless expected that the Trust would deliver its overall financial position

by the end of the year.

The Board noted both the CPR report and the Programme Board update report.

11/13/1518 Patient Safety Report

HS introduced the Patient Safety Report and invited questions on patient safety and circulated the Ward Dashboard.

BJ asked that in future, where staff attitude was noted as an issue in PALs or complaints, more detail would be useful where possible.

The Board noted the Patient Safety Report

11/13/1519 Business Planning Timetable

This was noted and it was agreed to allocate at least 2 hours at the February Trust Board meeting. It was further agreed that a timetable and framework be presented at the December Board. **PA/JS**

11/13/1520 Any Other Business

EM asked that the site be made entirely non-smoking. After a brief discussion it was agreed to consider this at a future meeting.

11/13/1521 Date and Time of Next Trust Board Meeting

Trust Board meeting to be held on Wednesday 18th December 2013 at 8.30 am in the Board Room

The Board resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 30TH OCTOBER 2013

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
07/13/1443	Board Committees Committee's to review ToR and make amendments ready for formal adoption in October.	ADM/TS/ JS/PA	October 2013	√	
04/13/13 97	Q4 Workforce Report Appraisal forms to be refreshed.	AG	Nov 2013		Part of implementation of new national pay deal in 2013/14.
07/13/1446	Spinal Deformity Presentation GB to review the situation with outcomes data.	GB	September 2013		Meeting arranged 30/9. The CD for Spinal Surgery had been asked to consider options for a system to record outcomes.
05/13/1415	Medical Staff Committee Update Report Executive Directors to consider radiological staffing and to report back to the Board in July. Report to be completed by October.	Execs	October 2013		The Board were updated that a wider project is now being undertaken with input from the Intensive Support Team to understand better both additional workforce and additional equipment (in particular MRI) requirements. It was agreed that a report would be completed by October 2013.
05/13/1425	Equality Duty Report Data to be tracked over time in order to ensure that the Trust improved in meeting its diversity obligations.	AC	Feb 2014		Progress to be included in next annual Equality Duty Report

07/13/1444	Council of Governors' Constitution Comments on the constitution to be sent to JS by 15 August. JS to contact lawyers and feedback with their views and a timetable at the September Board meeting.	ALL JS	15 August 2013 September 2013		JS had met with Trust legal advisors and been advised that most of what was being proposed would be deliverable. The company had now been asked to provide an indication of cost and timescale for the preparation of a revised constitution. Among the key recommendations from the lawyers was to include annual elections which would avoid the costs of going out to election on an as and when basis and also the inclusion of conditions for becoming a member of the Council of Governors such that appropriate calibre could be maintained. This would be agreed by the Board and Governors and then could be enacted (at risk) prior to seeking a vote by those present at the next AGM.
07/13/1447	Proposal for Option Appraisal Commercial Tissue Requests Process to be fully explained to theatre staff.	ED	Sep 2013		
09/13/1469	Capital Programme & Site Development A full plan detailing planned capital spend to be presented in November under a business as usual arrangement, this could then be overlain with income projections.	PA	November 2013		
09/13/1473	CPR A presentation on CIP schemes to be provided to the Board's at its November meeting.	PA/AM	November 2013		

10/13/1494 11/13/1517	Information on activity progress to be brought back to the November Board meeting. A workshop session to be held to detail the patient pathway and encourage further sharing of ideas. TS/FK to meet outside the Board with AP and others to discuss and consider different ways of delivery for TBALD.	AM TS/FK/AP	November 2013 January 2014		
10/13/1489	<u>CEO & Chair's Update</u> Marketing plan to be circulated. Governors to be informed and invited to 6 day working sessions being held.	JS GB/AM/JS	Nov 2013 Nov 2013		
11/13/1519	<u>Business Planning Timetable</u> At least 2 hours at the February Trust Board meeting to be allocated to Business Planning Timetable.	PA/JS	February 2014		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Medical Directors Report to Board
Nov-Dec 2013

During the months of November & December, in addition to my role as medical director, I have performed the following activities.

Meetings

A. External

CQC Methodology for Specialist Hospitals
Meeting with Cheryl Cavanagh from the office of the Chief Inspector of Hospitals around the issue of inspections for specialist hospitals.

B. Internal

Junior Doctors Committee - Chaired
Discussions around junior doctor rotas and practical solutions to reducing the Trusts reliance on locum doctors.

Information Governance Group
Attended in my role as Caldicott Guardian.

Clinical Excellence Awards Panel Member

Older Patient Francis Task & Finish Group
Completed

Enhanced Recovery Project Group

One to One Meetings

CD for Out Patients and Support Services
Chief Executive
Director for Nursing & Clinical Governance

Issues to Note

Case Manager - Investigation of Staff Grade Anaesthetist

Andrew Pearson
13th December 2013

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ENCLOSURE NUMBER: 5

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Helen Shoker, Interim Director of Nursing and Governance**
SUBJECT:	**Nursing Report**

SUMMARY

The Nursing Report is designed to provide a summary of the actions undertaken by the nursing workforce, highlight areas of achievement and provide assurance that concerns are noted and addressed.
This report covers the month of November 2013.

Of note-
Nurse Leaders Forum launched
Senior Sisters title replaced Ward Managers for our Band 7 nurses
Senior Nurses meeting aims, agenda and outcomes re-engineered
Operational Management Team meeting established with the Director of Operations
Review of ward KPI commenced, Theatre department KPI review planned for January 2014
Senior Nurse Team Leadership away day planned
Compassion In Practice re launched
6C team challenge commenced
Celebration events planned, Pressure Ulcer free days
Patient Harm Review meetings commenced
Patient Acuity tool launched across all inpatient wards
CQC - preparation for new assessment framework

IMPLICATIONS eg. financial, operational, risk, etc

None identified at this time

RECOMMENDATIONS

Trust Board are asked to:-
note the new style of Nursing Report,
accept the contents,
provide recommendations for further development and additions

Trust Board Nursing Report December 2013

Nurse Leaders Forum

To support developing nurse leadership a review of all nursing meetings and committees was undertaken in October, involving many stakeholders. The Nurse Leaders Forum replaces the previous ward managers and matrons meeting which was poorly attended, not representational of all areas, lacked direction and impact. It was important to move forward from a meeting which was failing to provide the organisation with a functioning, unified nursing team with a clear remit founded on providing excellence in patient care.

The forum provides all clinical teams with the opportunity to come together to debate and agree, by consensus, how subjects such as Compassion In Practice can be used to strengthen patient care and the profession. The agenda is formatted with headings of Best Care, Best People, Best Hospital and standing agenda items are 6C's, Our Profession, Patient Story, KPI's.

A minimum attendance has been agreed by the forum members to foster commitment and discipline to working together. All clinical teams and services attended the first meeting.

Senior Sisters title replaces Ward Managers

This is an intuitive change of title with no implications to contract, role or pay scale. It aligns the organisation to the regional approach to nursing titles.

Site Visit to Heart of England Trust

A small number of senior sisters undertook this visit to explore how supervisory practice has been implemented within HEFT and what evidence of benefits have been noted for patient care, the nursing workforce and organisation. They are to feedback at the January Nurse Leaders Forum in support of the development of supervisory practice within the ROH.

Senior Nurses Meeting

The aims, agenda and measurement of outcomes of the collective Band 8A+ team have been re-engineered in line with developing unified, effective nurse leadership.

Operational Management Team

An approach to enhance collaborative working across the DM and Senior Nurse teams, exploring joint operational matters and role modelled by the Director of Operations and Director of Nursing & Governance.

Ward Key Performance Indicators

A review of ward KPI's has commenced with the Theatre department KPI review planned for January 2014. The current indicators have been in place sometime, are outdated in places or do not reflect patient outcomes. For example the measure for nutrition and hydration relates to link nurses rather than meeting patient's needs.

The use of indicators will move to a proactive process with peer review from January 2014 with the new tool being phased in during the last quarter of the financial year. It is planned to support good performance through shared learning at the Nurse Leaders Forum and to establish a responsive, preventative approach during the coming twelve months.

Ward One action plan has commenced with weekly progress review by the Directorate team and Interim Director of Nursing.

Senior Nurse Team Leadership Away Day

A facilitated team leadership event is planned for early December, Insights Discovery. This includes an online psychometric assessment linking all the aspects of team dynamics. It is envisaged that greater understanding of the team's strengths, weaknesses and communication will support effective team leadership and therefore patient care.

Compassion In Practice Strategy- Care, Compassion, Commitment, Courage, Competence, Communication

This national nursing strategy has been launched and the 6C team challenge commenced. All clinical areas have been issued with a set of core tools and suggestions to engage the team and their patients. Each month sees the celebration of two of the 'C' subjects. Many areas have embraced this opportunity and the challenge element will be judged in March by the Chairman and Chief Executive Officer after a walk around the site.

Celebration of Good Practice

December brings the first celebration of great care. Ward Three have achieved eight months of avoidable pressure ulcer free care which is to be recognised with a presentation by the Chief Executive and Interim Director of Nursing of a certificate which is to be displayed on the ward public notice board. The celebration will be shared on the intranet and internet.

Celebration events are designed to recognise and share good practice whilst building pride amongst teams.

Patient Harm Reviews

The patient harm meetings are now being followed up with ward based patient harm reviews to support teams translate learning into their ward practice.

Patient Acuity Measurement

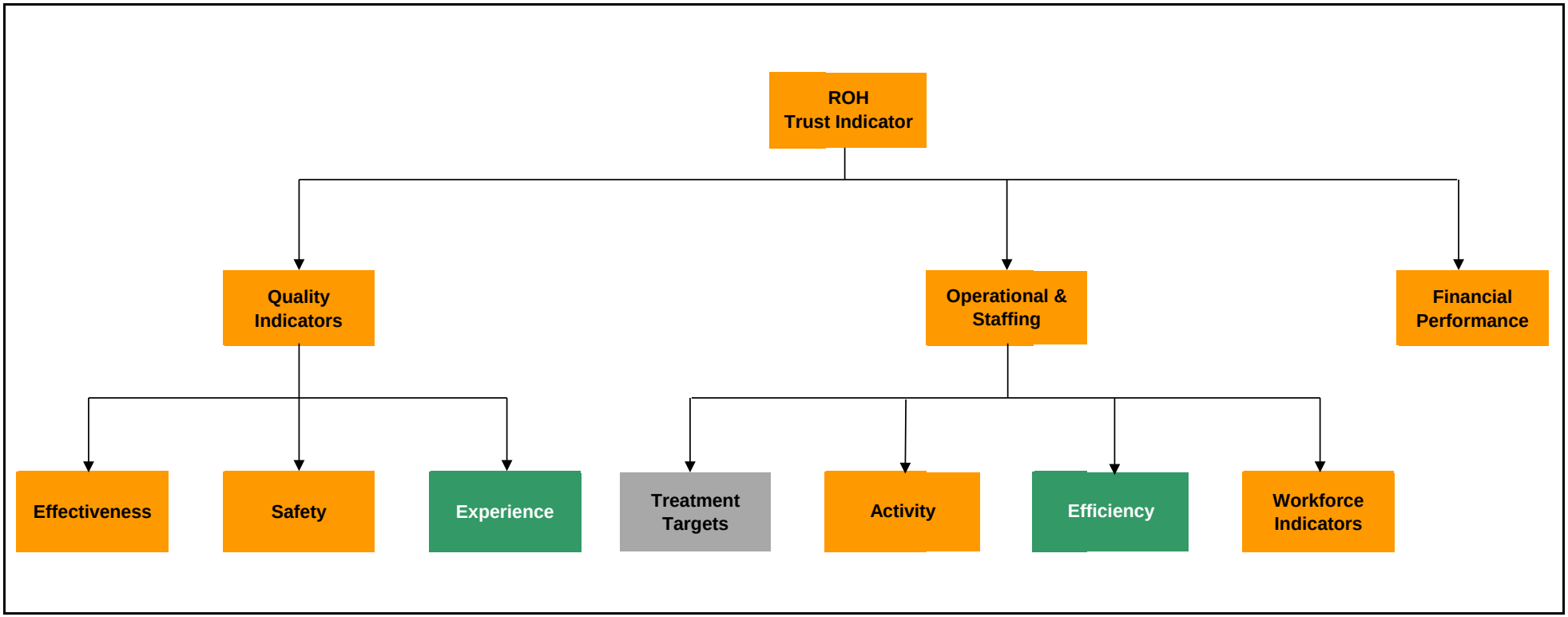
To effectively care for patients the correct skill mix and number of staff on duty is required in any clinical setting. Measuring the acuity and number of patients on a ward is the foundation of setting the appropriate staffing levels for patient safety therefore the nursing teams across the inpatient wards have commenced daily measurement using a nationally recognised tool. This will provide essential data to support the options paper and subsequent business case for the skill mix review to be presented to the Board in the new calendar year.

A review of the ADCU nursing workforce has commenced with Directorate team.

CQC - 5 Domain Preparation

To support the organisation's preparation for the new CQC assessment framework an approach has been drafted and shared with stakeholders. This will be actioned in January 2014.

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending November 2013



Quarterly Detailed Report
Executive Summary as at November 2013

Headlines

- Quality remains amber rated due to 8 inpatient falls, 4 SIRIs and 2 Grade 3/4 pressure ulcers in the month
- Activity in November was higher than in any other month in the previous 12 months
- The Trust has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. The in month position was however in balance

Monitor Compliance Framework Targets	November 2013 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	Not Currently Available		0	6
Referral to treatment time - Admitted %	90%	Not Currently Available		0	6
Referral to treatment time - Incomplete Pathways %	92%	Not Currently Available		0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	85.7%*	93.8%*	0	6
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%*	100%*	0	6
Cancer 31 day wait from diagnosis to first treatment	96%	100%*	100%*	0	6
Cancer 2 week (all cancers)	93%	100%*	100%*	0	6
Clostridium Difficile cases	2 (Full Year)	0	0	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating	One minor CQC compliance action outstanding regarding Outcome 4, Regulation 9 – Care and Welfare of People who use services.				

* The current month's cancer outturns are provisional position only. The cancer position for the quarter is based on provisional in-month and confirmed previous months data.

Indicative Monitor Governance Risk Rating	
Indicative Monitor Continuity of Service Rating	4

Key Trust Targets		November 2013 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	4		3
	Complaints	<=12	8		4
	CQUINS	100%	90%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<420	Not Currently Available		6
	Incomplete 14 - 18 Week Waiters	<500	Not Currently Available		6
	Total Elective Activity vs Plan	100%	95.1%		7
	Unused Theatre Sessions	<44	30		8
	Sickness	4.1%	4.4%		9
Financial	Surplus	£2,161k	£1,508k		10
	CIP	£2,207k	£1,787k		12
	Agency Expenditure	£91k	£133k		11
	Locum Doctor Expenditure	£46k	£60k		11

Trust Summary

The Trust is Amber rated for November based upon the assumption that treatment targets were achieved for the month (due to early Trust Board the position is not currently available). The amber rating is consistent with that reported in October.

The overall rating for quality remains amber due to 8 inpatient falls, 4 SIRIs and 2 Grade 3/4 pressure ulcers in the month. On a positive note the VTE target was achieved, the level of complaints reduced again and there were no hospital deaths or reportable infections. Additional detail is provided in the Safety Report.

Following a long period of being Red rated workforce has improved to Amber due to improvements in both sickness rates and mandatory training levels. In addition agency costs as a percentage of the total paybill is the lowest since January 2013. Staff turnover, appraisals and safeguarding training remain of concern. The number of staff in post at the Trust remains consistent with last month meaning total vacancies of c39wte or 5% of the funded establishment.

For the month of November the Trust made a surplus of £203,000 against a planned surplus of £220,000. The Trust therefore now has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. It is forecast that the Trust has a Monitor Continuity of Service Rating of 4, which is in line with our planned position (note that 4 is the highest rating available).

Activity in November was higher than in any other month in the previous 12 months however the Trust continued to underperform against elective cases and over perform against day cases. The increase in activity did however ensure a near planned in month surplus for the first month since August.

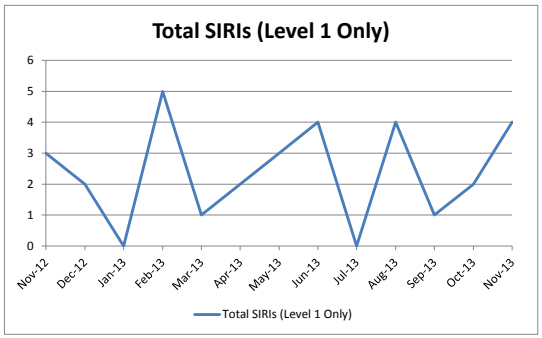
Due to early Trust Board the finalised position against treatment targets is not currently available. It is expected that all 3 RTT will be achieved however. Cancer targets have been achieved for November and it is now likely that the quarterly target will be achieved. 1 patient breached 52 weeks November but has been treated in early December.

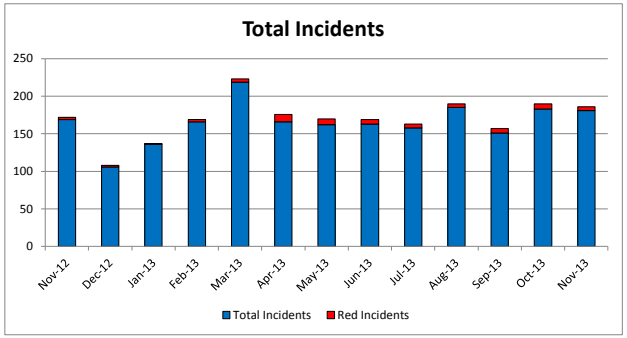
Quarterly Detailed Report
Safety Indicators as at November 2013

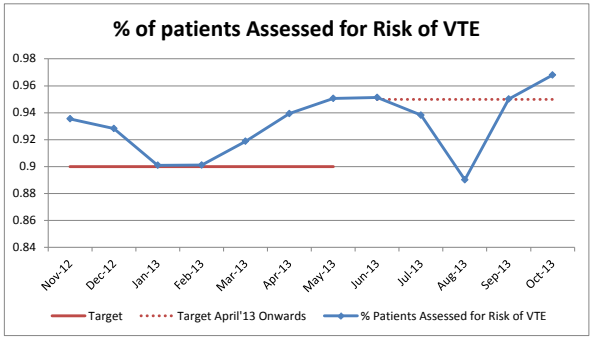
Headlines

- The VTE target for October was achieved for the second successive month
- There were 4 SIRIs in November
- There were 8 inpatients falls in November which is double the previous month

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	3	2	0	5	1	2	3	4	0	4	1	2	4	20
			4,16	SIRI per 1000 bed days	0.98	0.84	0.00	1.36	0.34	0.62	1.12	1.32	0.00	1.27	0.36	0.62	1.39	0.81
			4,16	Total Incidents	169	106	136	166	219	166	162	163	158	185	151	183	181	1349
			4,16	Incidents per 1000 bed days	55.08	44.41	46.31	56.23	74.19	51.83	60.23	53.95	47.07	58.96	54.12	56.82	62.70	54.46
			4,16	Red Incidents	3	2	1	3	4	10	8	6	5	5	6	7	5	52
			9,16	Total Drug Errors	26	15	17	19	66	31	21	15	15	23	18	21	16	160
			9,16	Drug Errors per 1000 bed days	8.47	6.28	5.79	6.44	22.36	9.68	7.81	4.96	4.47	7.33	6.45	6.52	5.54	6.46
		N	1	Mixed Sex Occurrences	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			9	% Patients Assessed for Risk of VTE	93.55%	92.83%	90.10%	90.11%	91.88%	93.94%	95.06%	95.13%	93.82%	89.02%	95.02%	96.80%	*	94.15%
			9	Incidence of Hospital Related VTE	1	0	0	1	1	0	0	1	1	0	1	1	0	4
			4	Patient Falls - Inpatients	5	8	0	6	7	4	7	6	4	9	2	4	8	44
			4	Patient Falls per 1000 bed days	1.63	3.35	0.00	2.03	2.37	1.25	2.60	1.99	1.19	2.87	0.72	1.24	2.77	1.78
			4,16	% Harm Free Care	98.85%	92.86%	97.22%	93.26%	93.26%	97.89%	96.19%	97.94%	98.90%	97.85%	98.70%	97.00%	98.90%	97.85%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

The trust has achieved the CQUIN target for October in relation to VTE with 96.6% compliance against the agreed target of 95%.

Fourteen incident forms received for the month of November (categorised as (adult) falls, slips or trips) and 8 of the 14 were identified as reportable falls.

There have been 4 SIRIs reported in November; compared to 2 reported during the previous month

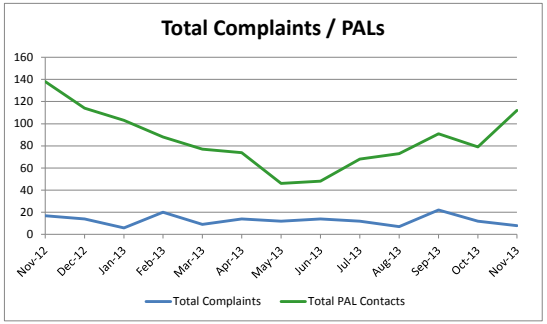
Additional detail is provided in the Safety Report

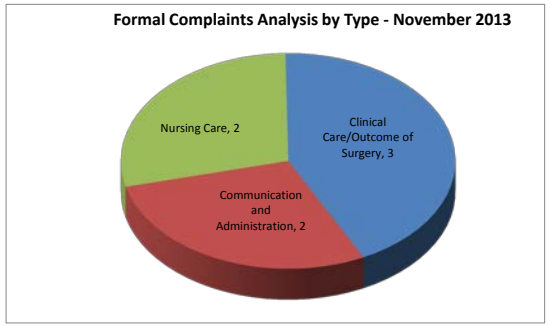
Quarterly Detailed Report
Experience Indicators as at November 2013

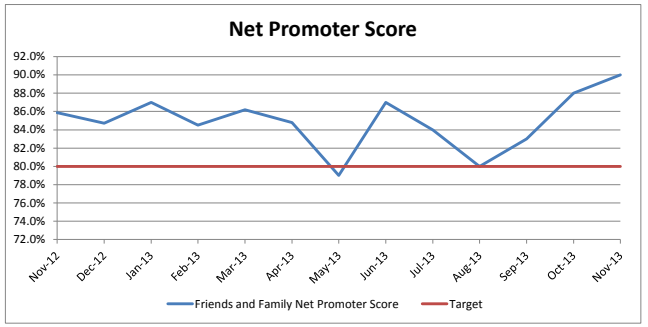
Headlines

- The number of complaints has again fallen in the month to the second lowest level this financial year
- PALs contacts increased in the month by 33 (42%) from October
- The Friends and Family Net Promoter score has increased for the 3rd successive month

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Experience			17	Complaints to Complements Ratio	1:13	1:33	1:63	1:20	1:46	1:25	1:25	1:29	1:32	1:46	1:14	1:34	1:16	1:26
			17	Total Complaints	17	14	6	20	9	14	12	14	12	7	22	12	8	101
			17	Complaints reverted to informal <48 hrs	3	0	0	1	0	1	0	1	1	3	3	0	1	10
			17	Formal	14	14	6	19	9	13	12	13	11	4	19	12	7	91
			17	Complaints per 1000 bed days	5.54	5.87	2.04	6.78	3.05	4.37	4.46	4.63	3.57	2.23	7.89	3.73	2.77	4.08
			17	Total PAL Contacts	138	114	103	88	77	74	46	48	68	73	91	79	112	591
			17	PALS Contacts per 1000 bed days	44.98	47.76	35.07	29.81	26.08	23.11	17.10	15.89	20.26	23.27	32.62	24.53	38.80	23.86
			17	Total Compliments	223	456	380	404	414	347	295	404	386	320	298	409	124	2583
			17	Compliments per 1000 bed days	72.69	191.03	129.38	136.86	140.24	108.35	109.69	133.72	114.99	101.99	106.81	127.00	42.96	104.27
				Food - Real Time Patient Survey	72.19%	66.07%	75.00%	69.75%	77.54%	77.50%	85.43%	86.67%	90.48%	92.40%	90.00%	90.60%	92.00%	85.02%
			17	Friends and Family Net Promoter Score	85.86%	84.73%	87.00%	84.50%	86.18%	84.8%	79.00%	87.0%	84.0%	80.0%	83.0%	88.0%	90.0%	83.7







Experience Commentary

COMPLAINTS

8 complaints (7 formal) received in the month down on last month's number of 12 which represents a reduction of 42% on last month. Number of complaints responded to in agreed timescale in November is 9/10 or 90% which is above the KPI of 80%. The 1 complaint that is overdue was as a result of a delay in the public and patient service team due to unexpected absence and increased volume of PALS.

Areas for formal complaints received this month are broken down as follows:
Clinical care and/or outcome of surgery x 3
Communication and administration x 2
Nursing care x 2

PALS:

PALS contacts up this month from 79 to 112 (an increase of 26%) In addition to new service users, a large number of patients known to the service have returned to us for help and support with needs around long standing problems, new treatment plans, need help coordinating admissions etc. which has taken a large amount of time.

Highest areas of concern:
Delays in spinal admin – patients unsure of plans for care and treatment
Metal on Metal queries
Orthotics – waiting times to get appointment for treatment
Appointment queries: repeated changes, cancelled and not informed and cannot get through
Work experience requests
Parking problems
Having an injection – lack of information on what to bring, waiting for date to be scheduled

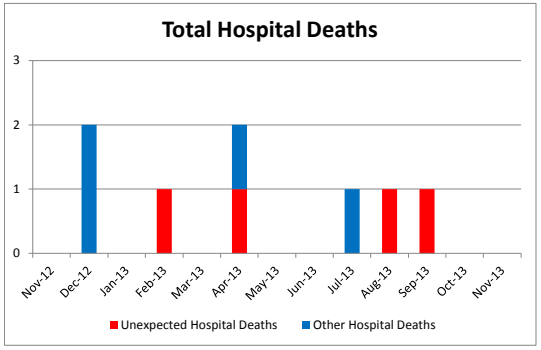
Real Time Patient Food Survey achieved 92% in November and has now been >90% for 5 consecutive months.

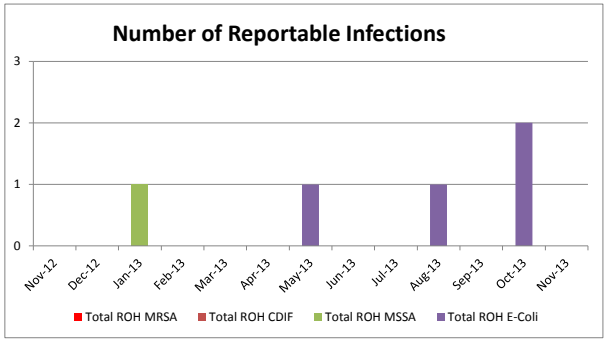
Quarterly Detailed Report
Effectiveness Indicators as at November 2013

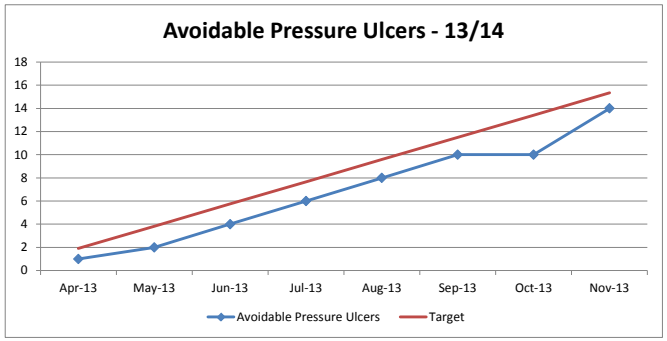
Headlines

- There were no deaths in November
- There were no reportable infections in the month
- There were 2 avoidable Grade 3/4 Pressure Ulcers

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	2	0	1	0	2	0	0	1	1	1	0	0	5
			4,18	Hospital Deaths per 1000 bed days	0.00	0.84	0.00	0.34	0.00	0.62	0.00	0.00	0.30	0.32	0.36	0.00	0.00	0.20
			4,18	Unexpected Hospital Deaths	0	0	0	1	0	1	0	0	0	1	1	0	0	3
				Other Hospital Deaths	0	2	0	0	0	1	0	0	1	0	0	0	0	
			8	MRSA % Screened	165.3%	149.7%	138.7%	135.5%	114.3%	129.56%	129.13%	140.59%	145.53%	127.51%	146.00%	132.00%	114.30%	133.09%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	M	N	8	Total ROH CDIF	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH MSSA	0	0	1	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	0	0	0	0	1	0	0	1	0	2	0	4
			8	HCAIs not attributable to ROH	1	2	0	1	0	0	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	0	0	0	0	1	1	0	2	4
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	3	3	5	5	5	1	1	2	2	1	1	0	2	10
			4	Avoidable Pressure Ulcers per 1000 bed days	0.98	1.26	1.70	1.69	1.60	0.31	0.37	0.66	0.60	0.64	2.51	0.00	1.39%	0.61







Effectiveness Commentary

There were no deaths or reportable infections in November

In November a total of six grade 2 pressure ulcers were reported, with two confirmed as unavoidable and the remaining four currently being investigated. Two avoidable grade 3 pressure ulcers were reported and investigated. The wards will participate in a future Patient Harm meeting.

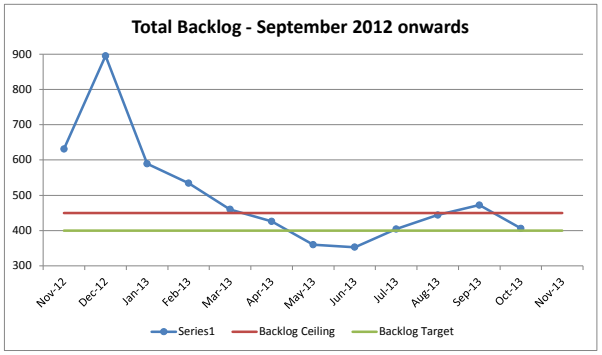
Quarterly Detailed Report
Treatment Targets as at November 2013

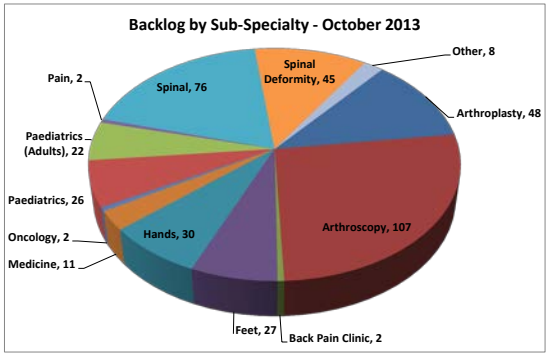
Headlines

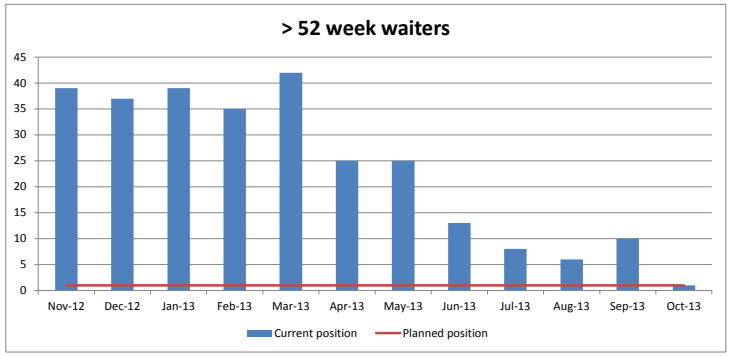
There was a 0.5 breach against the 62 day cancer wait target in November. However the target was still achieved

Due to the timing of the Board other treatment target information is not available at this stage

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	39	37	39	35	42	25	25	13	8	6	10	1	*	*
	M	N	4	Referral to treatment time - Non Admitted %	95.28%	95.09%	95.03%	95.07%	95.18%	95.24%	95.08%	95.35%	95.29%	95.78%	95.42%	95.24%	*	95.34%
	M	N	4	Referral to treatment time - Admitted %	90.38%	90.59%	90.42%	90.37%	90.00%	90.22%	90.39%	91.37%	92.05%	90.33%	90.19%	90.09%	*	90.68%
	M	N	4	Referral to treatment time - Incomplete Pathways %	90.56%	90.52%	90.68%	91.09%	92.01%	92.77%	94.36%	94.77%	94.18%	93.71%	93.34%	94.01%	*	93.89%
			4	Non admitted Backlog - Pathways waiting >18 wks	208	438	221	199	187	155	121	110	131	159	163	160	*	*
			4	Admitted Backlog - Pathways waiting >18 wks	423	457	368	335	273	271	239	243	273	285	309	246	*	*
			4	Total Backlog - 18 week pathways waiting >18 wks	631	895	589	534	460	426	360	353	404	444	472	406	*	*
			4	Incomplete 14 -18 Week Waiters	698	717	610	629	535	388	411	504	477	630	654	565	*	*
	M	N	4	Cancer 2 week (all cancers)	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100%*
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.0%	100.0%	100.0%	100.0%	100.0%	93.33%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	98.33%*
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%*
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.0%	100.0%	100.0%	100.0%	100.0%	90.00%	100.00%	66.67%	80.00%	100%*	83.30%	100.00%	85.70%	87.50%*
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	100.00%	100.00%	99.98%	100.00%	100.00%	99.24%	100.00%	99.52%	99.20%	99.09%	99.70%	99.13%	*	99.49%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			1,21	Data Quality on Ethnic Group - Inpatients	100.00%	95.12%	95.20%	95.11%	91.99%	97.64%	95.29%	96.44%	94.86%	95.30%	98.35%	95.65%	95.45%	96.17%







Treatment Targets Commentary

Due to early Trust Board, position is not currently available. A verbal update will be given at Trust Board, it is expected that all 3 RTT will be achieved however.

Cancer targets have been achieved for November and it is now likely that the quarterly target will be achieved.

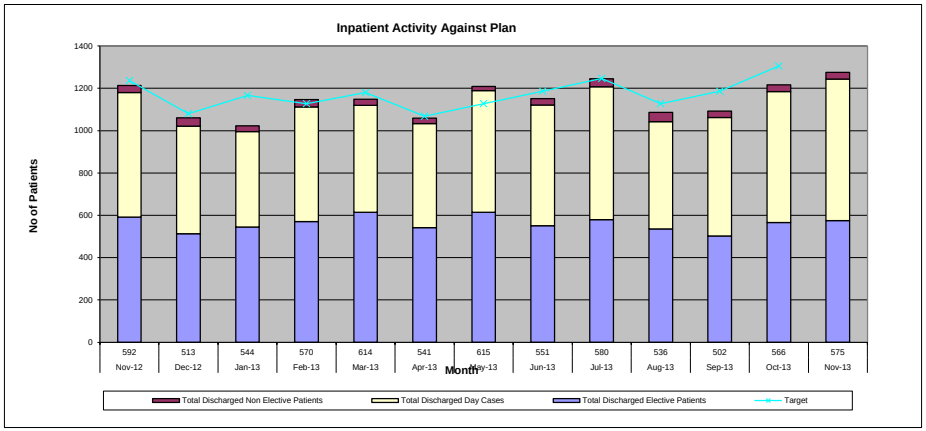
1 patient breached 52 weeks November but has been treated in early December. This was a complex case with input required from vascular surgeon from another centre, due to whose unavailability the case was cancelled in month.

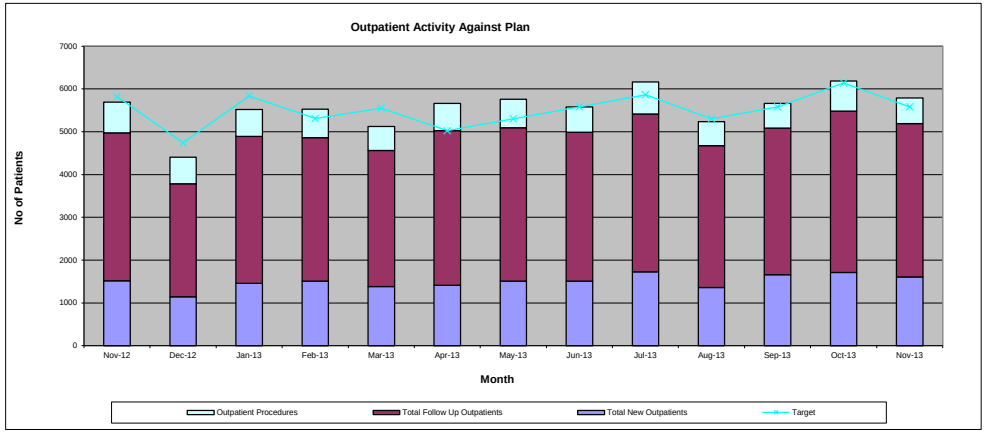
Quarterly Detailed Report
Activity Targets as at November 2013

Headlines

- Elective inpatients underperformed by 30 cases or 5% in November
- Day case activity was extremely high for the month with an over performance of 23% or 125 cases
- New outpatients continue to significantly overperform (14% in November)

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Activity			4	Total Discharged Elective Patients	592	513	544	570	614	541	615	551	580	536	502	566	575	4466
			4	Total Discharged Non Elective Patients	34	39	27	35	29	25	20	30	38	44	30	33	32	252
			4	Total Discharged Day Cases	588	508	451	542	506	493	574	570	627	506	560	618	669	4617
			4	Total New Outpatients	1517	1146	1455	1510	1381	1416	1513	1508	1728	1359	1661	1713	1609	12507
			4	Total Follow Up Outpatients	3458	2641	3435	3356	3179	3611	3583	3481	3691	3314	3428	3774	3581	28463
			4	Outpatient Procedures	716	622	631	662	562	635	662	594	743	560	575	697	604	5070
			4	Elective as % Against Plan	95.2%	94.4%	92.8%	100.5%	108.3%	99.43%	107.1%	91.1%	91.4%	93.3%	83.0%	85.1%	95.1%	92.92%
			4	Non Elective as % Against Plan	81.0%	106.3%	68.2%	91.4%	75.8%	72.4%	54.8%	78.1%	94.3%	120.6%	78.1%	78.1%	83.4%	82.57%
			4	Day Cases as % Against Plan	102.7%	101.5%	83.5%	103.8%	96.9%	100.7%	111.1%	104.8%	109.8%	97.9%	103.0%	103.3%	123.0%	106.78%
			4	% New Outpatients Against Plan	101.7%	94.3%	97.3%	111.0%	101.5%	111.1%	112.5%	106.5%	116.2%	101.0%	117.3%	110.0%	113.6%	111.11%
			4	% Follow Up Outpatients Against Plan	97.1%	91.0%	96.2%	103.3%	97.8%	114.2%	107.4%	99.1%	100.1%	99.3%	97.6%	97.7%	101.9%	101.93%
			4	% Outpatient Procedures Against Plan	93.6%	99.8%	82.3%	94.9%	80.6%	107.6%	106.3%	90.6%	108.0%	89.9%	87.7%	96.7%	92.2%	97.30%





Activity Commentary

Activity in November was higher than in any other month in the previous 12 months however the Trust continued to underperform against elective cases and over perform against day cases. Whilst this can be explained in part due to changes in practice from switch to DC from 1 night stay, further analysis of case mix is required.

Rectification plans for 4 directorates are in place and activity is being monitored on a daily basis.

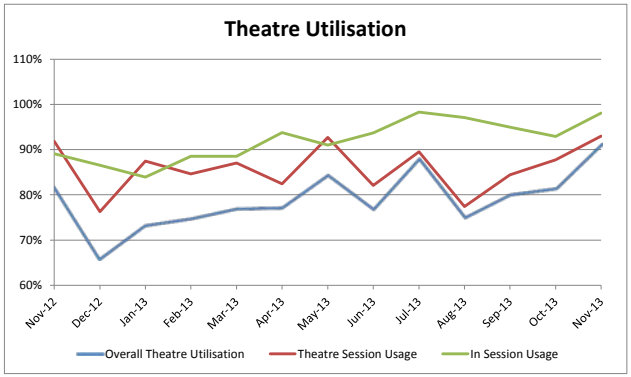
New OP continue to over perform against plan (by 11% YTD) which indicates a strong order book.

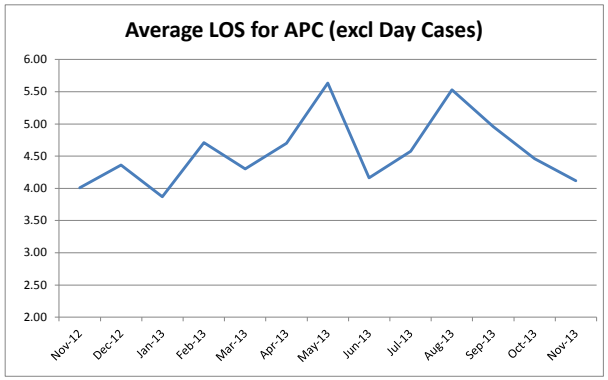
Quarterly Detailed Report
Efficiency Indicators as at November 2013

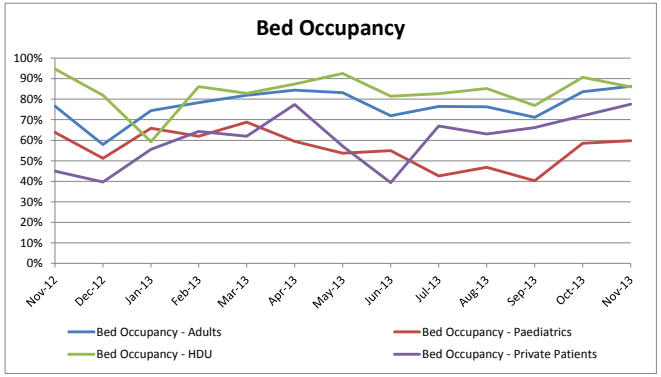
Headlines

- Theatre utilisation indicators are green for November
- Bed utilisation remains at a higher than average level for the year
- The number of cancelled operations has increased significantly in November

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Efficiency			4	Overall Theatre Utilisation	81.8%	66.0%	73.4%	74.9%	77.0%	77.30%	84.41%	76.95%	87.98%	75.15%	80.19%	81.51%	91.23%	80.80%
			4	Theatre Session Usage	91.85%	76.30%	87.50%	84.60%	87.07%	82.45%	92.72%	82.09%	89.50%	77.38%	84.42%	87.73%	93.02%	84.86%
			4	In Session Usage	89.1%	86.5%	83.9%	88.5%	88.5%	93.76%	91.04%	93.73%	98.31%	97.11%	94.99%	92.92%	98.07%	95.21%
			4	Unused Theatre Sessions	37	92	57	63	53	76	30	77	50	102	67	61	30	233
			4	Number of Cases per Theatre Session	2.79	3.45	2.46	3.13	3.11	2.82	3.01	3.08	2.79	2.95	2.90	2.67	2.95	2.89
			4	Total Cancelled Operations (On Day or Day Before)	91	95	108	78	52	91	72	63	88	58	62	82	120	314
			4	Total Cancelled Operations (On Day or Day Before) - Avoidable														
			4	Total Cancelled Operations (On Day or Day Before) - Unavoidable														
			4	Total Cancelled Operations by Hospital (On Day)	6	6	5	4	2	4	5	5	11	14	4	2	11	56
			4	% Cancelled Operations by Hospital	0.52%	0.59%	0.51%	0.37%	0.18%	0.40%	0.43%	0.46%	0.93%	1.36%	0.38%	0.17%	0.76%	0.61%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.49	2.51	2.63	2.30	2.59	2.76	2.44	2.53	2.24	2.53	2.36	2.32	2.35	2.48
			4	Pain Review-To-New Ratio	3.99	3.83	3.65	3.70	2.99	3.53	4.65	2.90	4.02	4.24	1.89	3.59	2.70	3.69
			4	Outpatient DNAs	8.91%	9.37%	10.51%	9.05%	10.52%	7.70%	8.79%	9.23%	8.70%	9.33%	8.49%	8.46%	8.34%	8.63%
			4	Bed Occupancy - Adults	76.67%	57.92%	74.44%	78.34%	81.96%	84.37%	83.16%	71.91%	76.53%	76.26%	71.19%	83.58%	86.36%	79.12%
			4	Bed Occupancy - Paediatrics	63.89%	51.18%	65.86%	61.90%	68.89%	59.44%	53.76%	55.00%	42.71%	46.77%	40.28%	58.60%	59.72%	51.97%
			4	Bed Occupancy - HDU	94.68%	81.99%	59.35%	86.06%	82.89%	87.36%	92.53%	81.44%	82.76%	85.15%	77.01%	90.67%	85.92%	87.34%
			4	Bed Occupancy - Private Patients	44.90%	39.63%	55.64%	64.29%	61.91%	77.47%	57.14%	39.29%	66.96%	63.13%	66.19%	71.89%	77.62%	65.73%
			4	Admissions on the Day of Surgery	429	357	384	400	457	381	433	403	417	372	370	417	392	1634
			4	AVLOS for APC (excl day cases)	4.01	4.36	3.87	4.71	4.30	4.70	5.63	4.16	4.58	5.53	4.96	4.46	4.12	4.75







Efficiency Commentary

Theatre utilisation was the highest recorded in previous 12 months with average LOS dropping to its lowest since January 13.

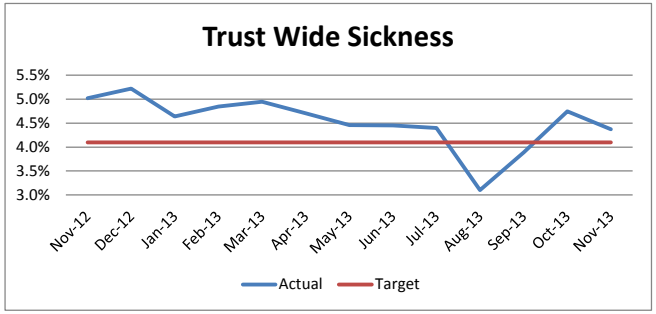
Cancelled operations on the day or day before surgery however increased to the highest level in the last 12 months, this is thought to be due to improved data collection. There are now 3 work streams in place to address the key issues related to cancellations: oncology pre-op pathway, spinal emergency pathway and pre-admission pathway. All work is being reported back through the Clinical Programme Board which meets monthly and is Chaired by the Director of Operations.

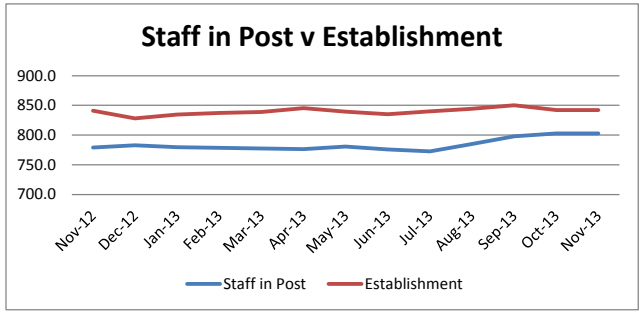
Monthly Report
Workforce Indicators as at November 13

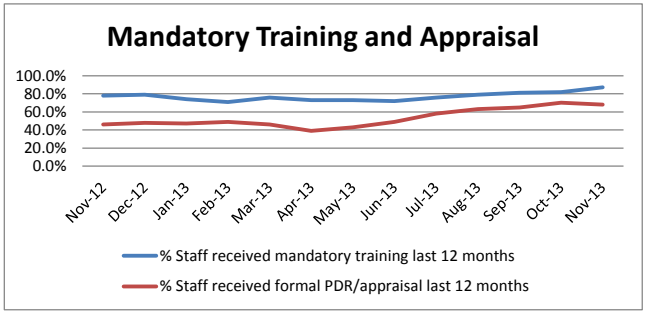
Headlines

- The number of staff employed by the Trust is consistent with the previous month
- Sickness has reduced to 4.4% in November
- Mandatory training levels continue to increase but there has been a slight reduction in appraisal and safeguarding training levels

	Monitor	National	CQC Standard		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	13/14 Full Year Position
Workforce			13	Total WTE Employed	779.0	782.6	779.6	778.6	777.5	776.5	780.5	775.8	772.5	784.9	797.7	802.6	802.9	789.4
			13	Total WTE Employed as % of Establishment	92.6%	94.5%	93.4%	93.0%	92.7%	91.8%	93.0%	92.9%	92.0%	92.9%	93.8%	95.3%	95.4%	93.7%
			13	Staff Turnover (%)	10.4%	10.4%	11.1%	12.6%	12.7%	11.6%	12.0%	12.6%	12.5%	12.5%	12.7%	12.8%	12.9%	12.6%
			13	% of Sickness - Trust wide	5.0%	5.2%	4.6%	4.9%	5.0%	4.7%	4.5%	4.5%	4.4%	3.1%	3.9%	4.8%	4.4%	4.2%
			13	Agency % of Staff Cost	4.2%	4.2%	5.6%	6.4%	8.7%	6.1%	8.0%	8.4%	6.1%	6.5%	6.4%	6.2%	5.6%	6.5%
			13	Temporary staffing hours as a % of establishment														
			13	% Staff received mandatory training last 12 months	78%	79%	74%	71%	76%	73%	73%	72%	76%	79%	81%	82%	87%	80%
			13	% Staff received formal PDR/appraisal last 12 months	46%	48%	47%	49%	46%	39%	43%	49%	58%	63%	65%	70%	68%	62%
			13	% of required staff receiving safeguarding training						33%	30%	21%	51%	51%	54%	60%	58%	49%
			13	Qualified Nurse / Bed ratio														
			13	Staff Net Promoter score						3.84								







Workforce Commentary

Sickness has reduced in the majority of directorates/departments, with Facilities, Estates and Medical Secretaries being areas of concern.

Mandatory and statutory training has increased in month due to continued high levels of attendance at programmes.

Levels of appraisal have reduced in month and each Directorate/Department have been asked to produce an updated plan to ensure performance improves to 90%+ by the end of March. This will be reviewed monthly by the Director of Workforce and Director of Operations.

The cause of the reduction in levels of safeguarding training is being explored and a verbal update will be provided at the Board.

Quarterly Detailed Report
Financial Performance as at November 2013

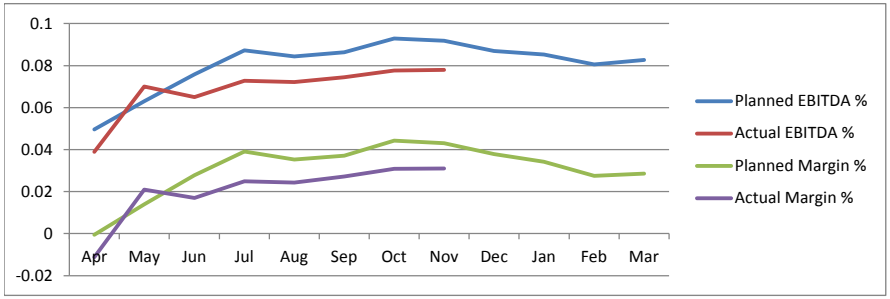
Headlines

- The Trust has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000.
- In the month of November the financial position was in line with plan which was driven by increased activity levels
- CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after Month 8.

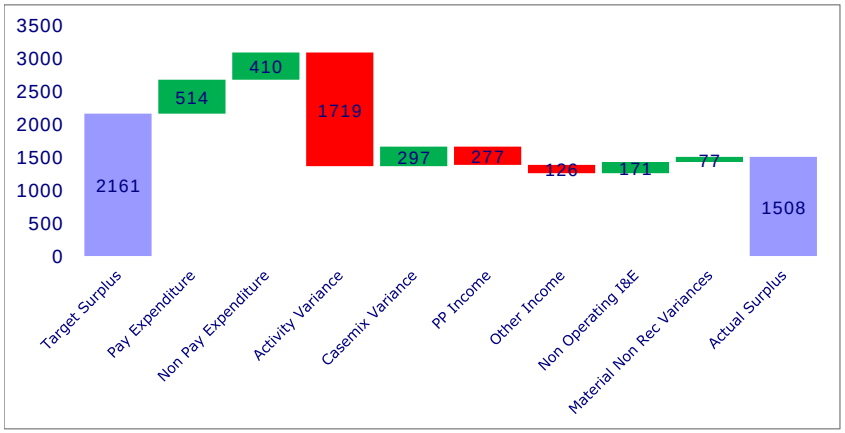
Trust Financial Metrics

	Year to Date		
	Actual	Plan	Risk Rating
Capital Servicing Capacity	4.2	5.2	4
Liquidity Ratio	86.0	76.4	4
Overall Continuity of Services Rating			4

Planned v Actual EBITDA & Margin Graph



Trust Performance Bridge Graph



Executive Financial Summary

Overall Performance

For the month of November the Trust made a surplus of £203,000 against a planned surplus of £220,000. The Trust therefore now has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. The normalised surplus having excluded material non recurrent income and expenditure is £1,431,000.

It is forecast that the Trust has a Monitor Continuity of Service Risk Rating of 4 (compared to a plan of 4 – note 4 is the highest rating available).

Income

November was an improved month for activity and associated income. Although inpatient activity continued to underperform this reduced to 6% or 36 cases in November which is the highest percentage compared to plan since May 2013. Day cases increased dramatically and overperformed by 115 cases or 23%. Rectification plans have been developed by underperforming Directorates to move to contracted levels by the end of the financial year.

Private patients remain a concern and are now under recovering by £277,000 or 39%. Bed occupancy levels have however increased mainly with long stay bone infection patients.

Pay

The paybill has increased slightly again in November and is £76,000 or 2% higher than 12 month average. The substantive paybill has increased for the past 2 months which is consistent with the reduction in vacancies we have seen in the Trust in recent months. It is encouraging to see a reduction in both bank and agency spend in the month but this needs to continue to offset the increase in substantive staff costs.

Compared to the Monitor plan we are spending less on pay than predicated. When the Monitor plan was set we were anticipating activity over performance to meet the £1.1m income CIP target. This and the associated costs are yet to materialise which shows as a negative activity variance and a positive pay variance on the Performance Bridge Graph.

Non Pay

Non pay spend was relatively high for the month (£83,000 or 3% more than the average for the first 7 months) which is consistent with the higher than average levels of activity for the month. As with pay we are now showing a positive variance which is driven by the general underperformance plus not achieving planned activity growth.

CIP

CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after month 8.

Balance Sheet & Cash Flow

The Statement of Position is broadly in line with plan as month end. Cash balances remain healthily but is £1.9m behind plan which is consistent with the previous month.

Quarterly Detailed Report

CQUIN & Financial Efficiency Indicators as at November 13

Headlines

- The paybill is above the monthly average for this financial year and it is at its highest since July this year.
- Agency costs were the lowest this financial year
- Both the Trust surplus and CIP performance remain below planned levels

		Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Cost of Staffing	Total Paybill	£3,071,000	£3,069,000	£3,168,095	£3,247,000	£3,388,000	£3,217,000	£3,313,000	£3,259,000	£3,324,000	£3,252,000	£3,234,000	£3,279,000	£3,311,000
	Substantive Pay	£2,723,000	£2,713,000	£2,800,783	£2,813,000	£2,841,000	£2,810,000	£2,852,000	£2,822,000	£2,864,000	£2,806,000	£2,805,000	£2,861,500	£2,919,000
	Bank Pay	£214,000	£222,000	£183,483	£226,000	£246,000	£203,000	£187,000	£197,000	£252,000	£230,000	£214,000	£208,000	£195,000
	Overtime Pay	£4,000	£5,000	£5,665	£4,000	£5,000	£10,000	£4,000	£4,000	£4,000	£5,000	£8,000	£5,500	£4,000
	Agency Pay (excluding Medical Locums)	£66,000	£75,000	£140,543	£123,000	£234,000	£140,000	£241,000	£191,000	£150,000	£144,000	£138,000	£177,000	£133,000
	Medical Locum Pay	£64,000	£54,000	£37,621	£80,000	£62,000	£54,000	£28,000	£81,000	£54,000	£67,000	£68,000	£52,000	£60,000
	ADH Payments - Surgical	£20,000	£25,000	£28,000	£45,000	£40,000	£26,000	£38,000	£20,000	£17,000	£26,000	£23,000	£22,000	£31,000
	ADH Payments - Clinics	£10,000	£7,000	£14,000	£20,000	£17,000	£11,000	£14,000	£7,000	£17,000	£9,000	£13,000	£15,000	£19,000
	ADH Payments - Anaesthetics	£25,000	£27,000	£35,000	£48,000	£84,000	£46,000	£47,000	£48,000	£63,000	£46,000	£53,000	£48,000	£53,000
	ADH Payments - Spot Work & Strategy	£1,000	£1,000	£1,000	£1,000	£0	£0	£0	£0	£0	£0	£0	£0	£0
Income & Efficiency	Trust Surplus	£2,485,000	£2,350,000	£2,033,000	£2,074,000	£2,203,000	-£66,000	£250,000	£305,000	£602,000	£729,000	£978,000	£1,305,000	£1,509,000
	Normalised Surplus	£1,740,000	£1,605,000	£1,397,000	£1,409,000	£1,853,000	-£66,000	£250,000	£443,000	£891,000	£912,000	£977,000	£1,228,000	£1,431,000
	Total Income	£6,032,000	£5,815,000	£5,395,000	£5,727,000	£6,409,000	£5,910,000	£6,135,000	£5,914,000	£6,575,000	£5,515,000	£5,884,000	£6,429,000	£6,202,000
	CIP	£3,531,000	£3,579,326	£3,630,122	£3,679,000	£3,820,000	-	£339,000	£561,000	£869,000	£1,125,000	£1,260,000	£1,537,000	£1,787,000

Summary

The paybill is above the monthly average for this financial year.

Agency expenditure is higher than plan but it has is at its lowest level this financial year.

The Trust has a year to date surplus of £1,508,000 against a plan of £2,161,000 which is a shortfall of £653,000. The normalised position having excluded material non recurrent income and expenditure is £1,431,000

CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after Month 8.

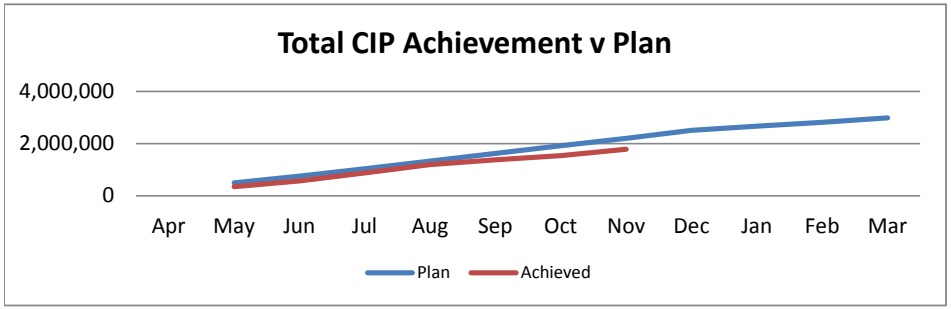
Monthly Report

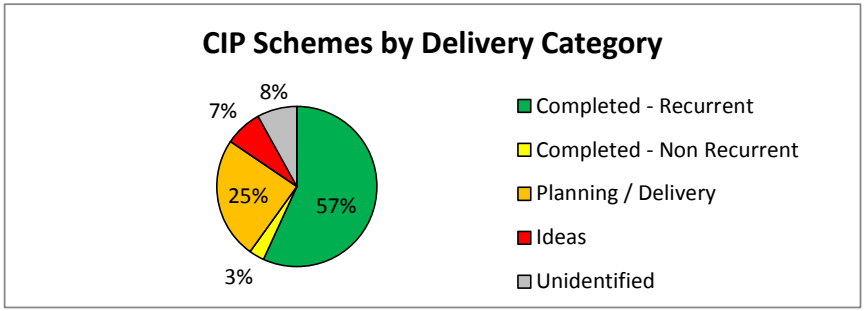
Cost Improvement Programme Indicators as at November 13

Headlines

- CIP achievement currently sits at £1,787,000 of which 95% is recurrent. This is £420,000 behind the target after Month 8.
- To date 60% of the required CIP value is completed and implemented. 15% is not identified or ideas at this stage
- No medium of high risk quality issues have been raised or identified

Cost Improvement Programme	Annual Performance					YTD Performance		
	Target £'000	Completed £'000	Planning / Delivery £'000	Ideas £'000	Unidentified £'000	Target £'000	Completed %	Shortfall £'000
Clinical Directorates	1,108	663	33	213	200	907	73%	244
Corporate Areas	774	624	99	10	40	627	100%	3
Income	1,100	500	600	0	0	673	74%	173
Total	**2,982**	**1,787**	**732**	**223**	**240**	**2,207**	**81%**	**420**



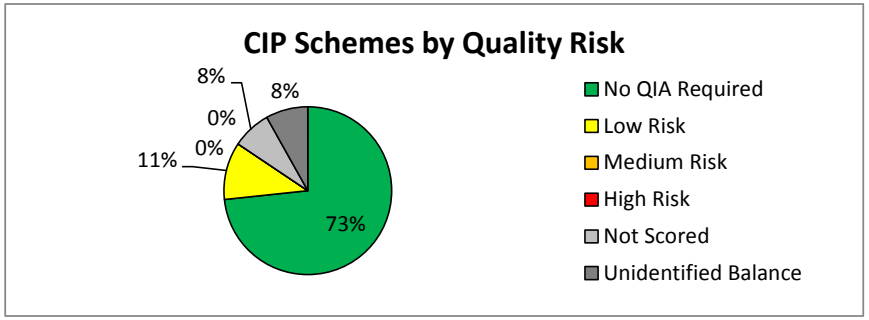


Significant Exceptions

Theatres & Anaesthetics. To date only 19% of the £473k target has been implemented. 32% requires further significant reduction in agency spend and 42% is unidentified at this stage.

Income. To date only 45% of the £1.1m plan has been implemented. The remaining requires the Trust to deliver activity levels over and above baseline contract which we are failing to achieve.

Management. To date 28% is yet to be identified and this is under discussion at Senior Management Team



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 18th December 2013 **ENCLOSURE NUMBER: 8**

SUMMARY OF REPORT TO TRUST BOARD

Director Lead:	Helen Shoker, Interim Director of Nursing & Governance
Authors:	Lisa Pim, Interim Deputy Director of Nursing & Governance Alison Braham, Governance Manager
SUBJECT:	**Patient Quality, Safety and Experience Report**

SUMMARY

This paper will provide Trust Board with an update on patient quality, safety and experience activity during November 2013. The format of this paper will be developed from next month with the aims of providing the Trust Board with a succinct and collaborative safety report.

RISKS

Patient quality, safety and experience must remain a high priority for the organisation and it is anticipated this report will assist the Trust Board in bringing together several key quality issues.

RECOMMENDATIONS

The Board is asked to:

- **discuss** the Patient Quality Safety and Experience report
- **identify** areas of risk requiring further assurance
- **identify** any other patient safety and experience issues for inclusion in future reports
- **note** the proposed report changes for next month

1. Serious Incidents requiring investigation (SIRI)

There have been 5 SIRIs reported in November; compared to 2 reported during the previous month (see appendix 1).

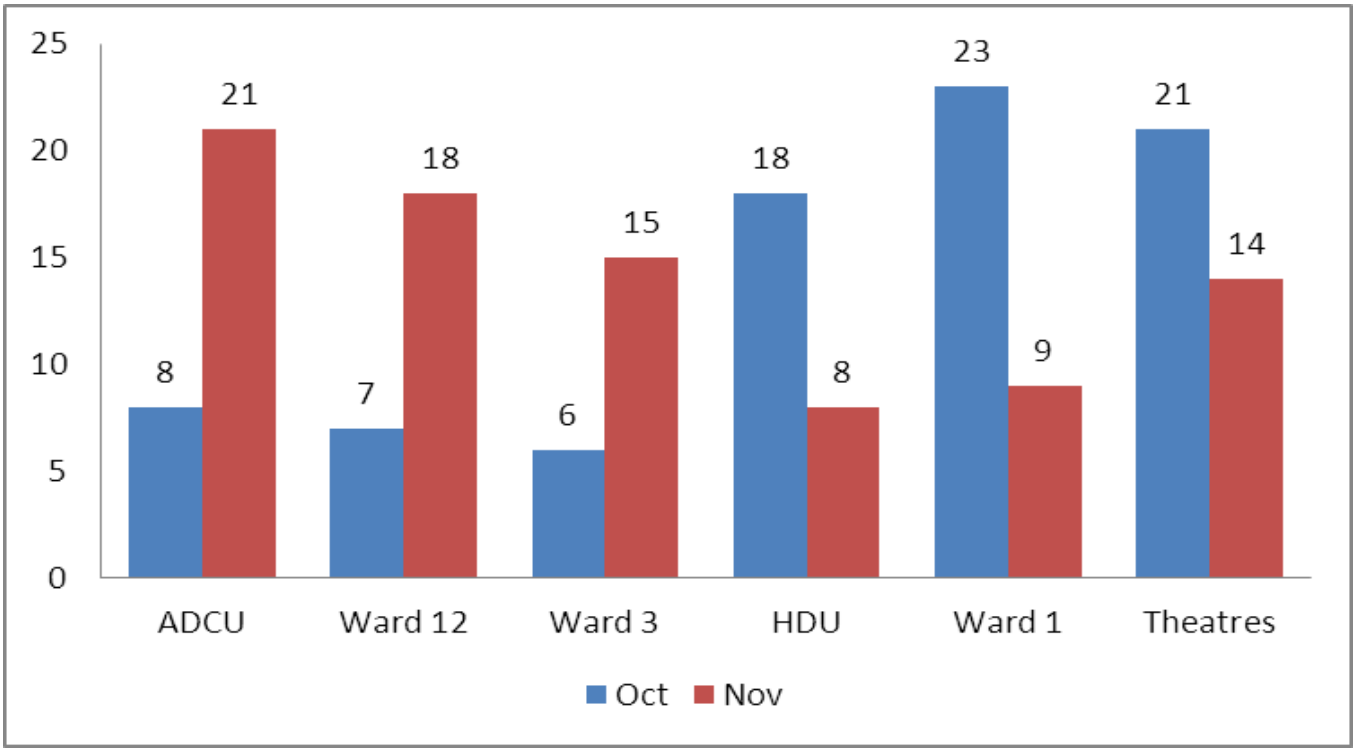
2. Deaths

There have been no deaths during November.

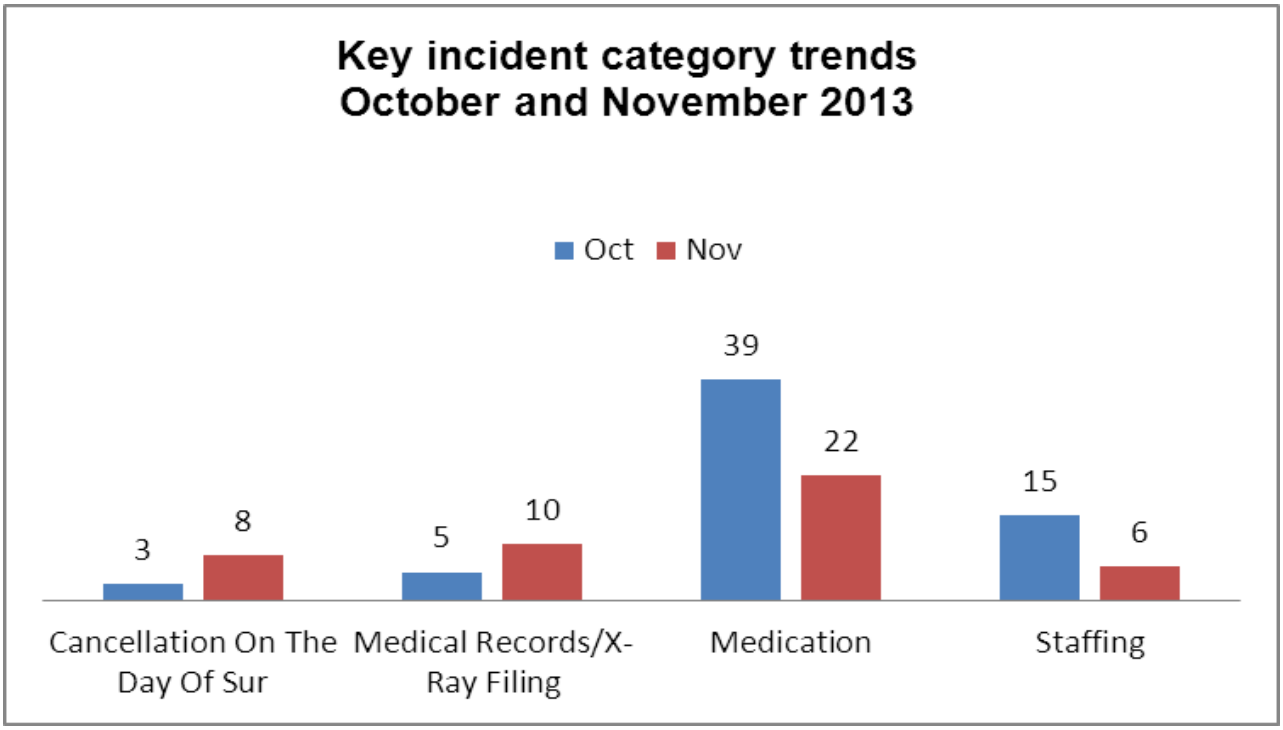
3. Incident trends

A total of 181 incidents were reported during November, compared to 183 incidents reported during October. Although there has been no substantial increase in incidents reported (when compared to the previous month) specific areas have seen significant increases and decreases, details are outlined in the graph below.

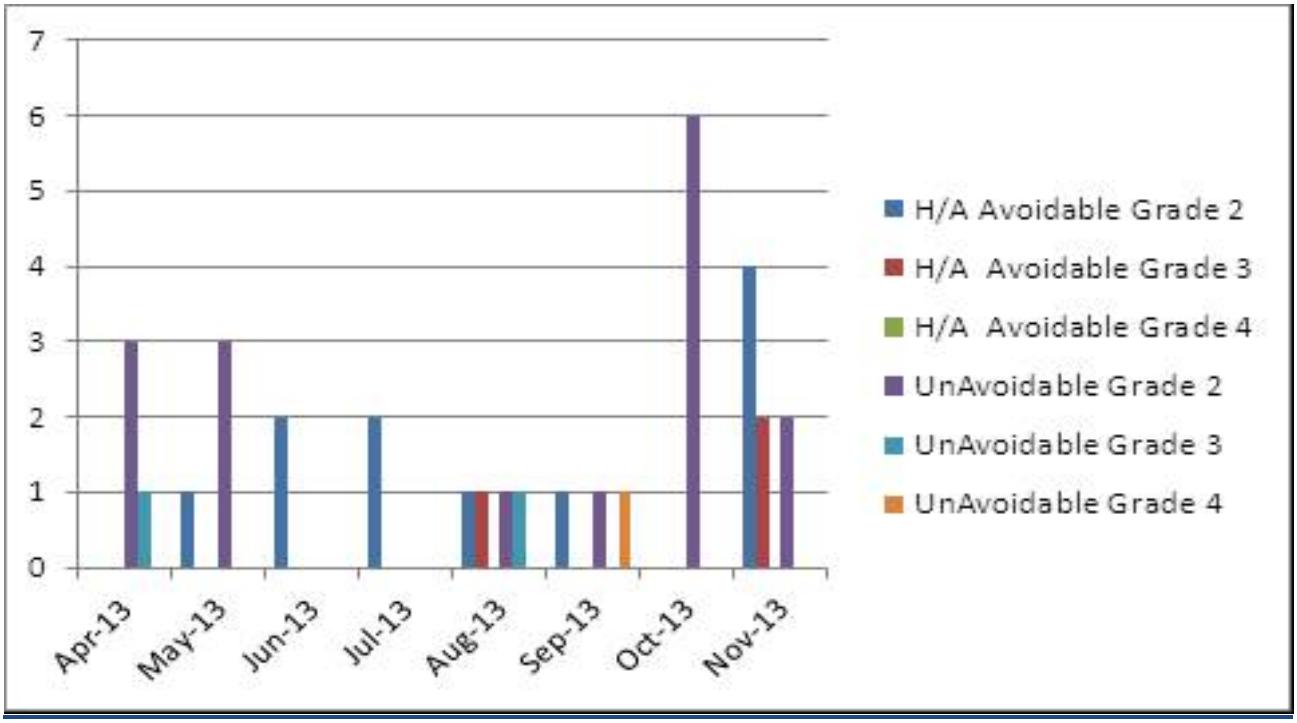
Key incident trends (by department)
October and November 2014



In terms of incident categories medical records incidents and cancellations on day of surgery have seen a rise when compared to October, whilst medication and incidents have reduced, see below:



4. Pressure Ulcers



In November a total of six grade 2 pressure ulcers were reported, with two confirmed as unavoidable and the remaining four currently being investigated. Two avoidable grade 3 pressure ulcers were reported and investigated. The wards will participate in a future Patient Harm meeting.

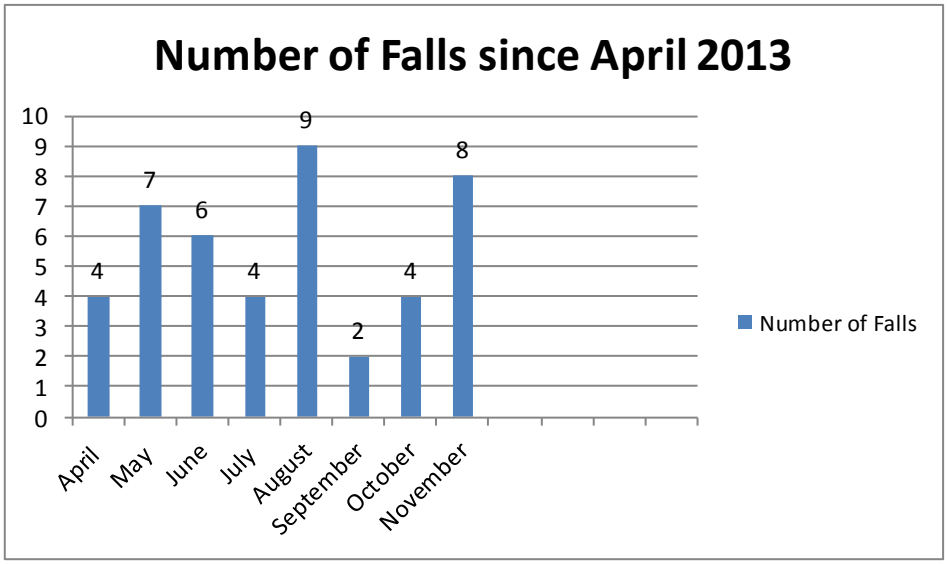
5. VTE risk assessment

The trust has achieved the CQUIN target for October in relation to VTE with 96.6% compliance against the agreed target of 95%.

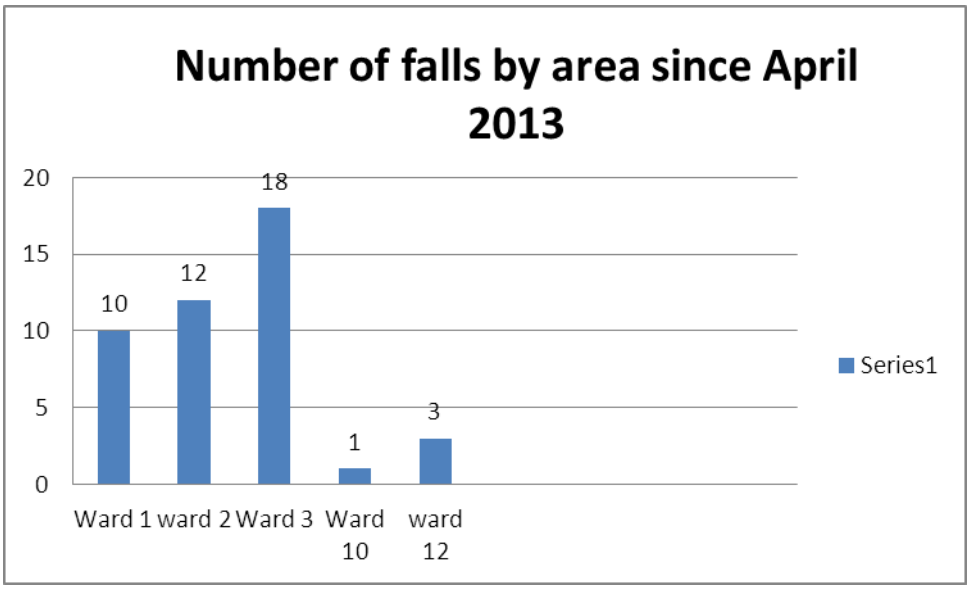
6. Falls

Fourteen incident forms received for the month of November (categorised as (adult) falls, slips or trips) and **8 of the 14** were identified as **reportable falls**. Rationale for the removal of the **6** remaining falls from the report is shown at the end.

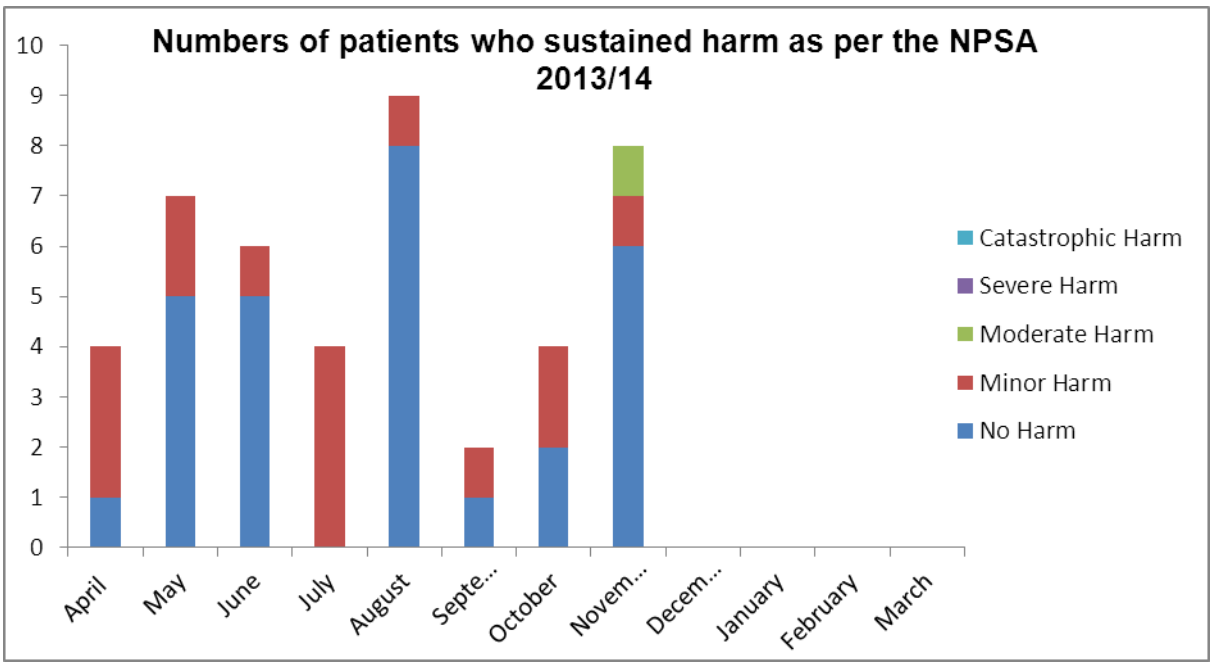
Number of Inpatient Adult falls since April 2013



Falls by Area since April 2013



The number of patients who have sustained harm as a result of a fall

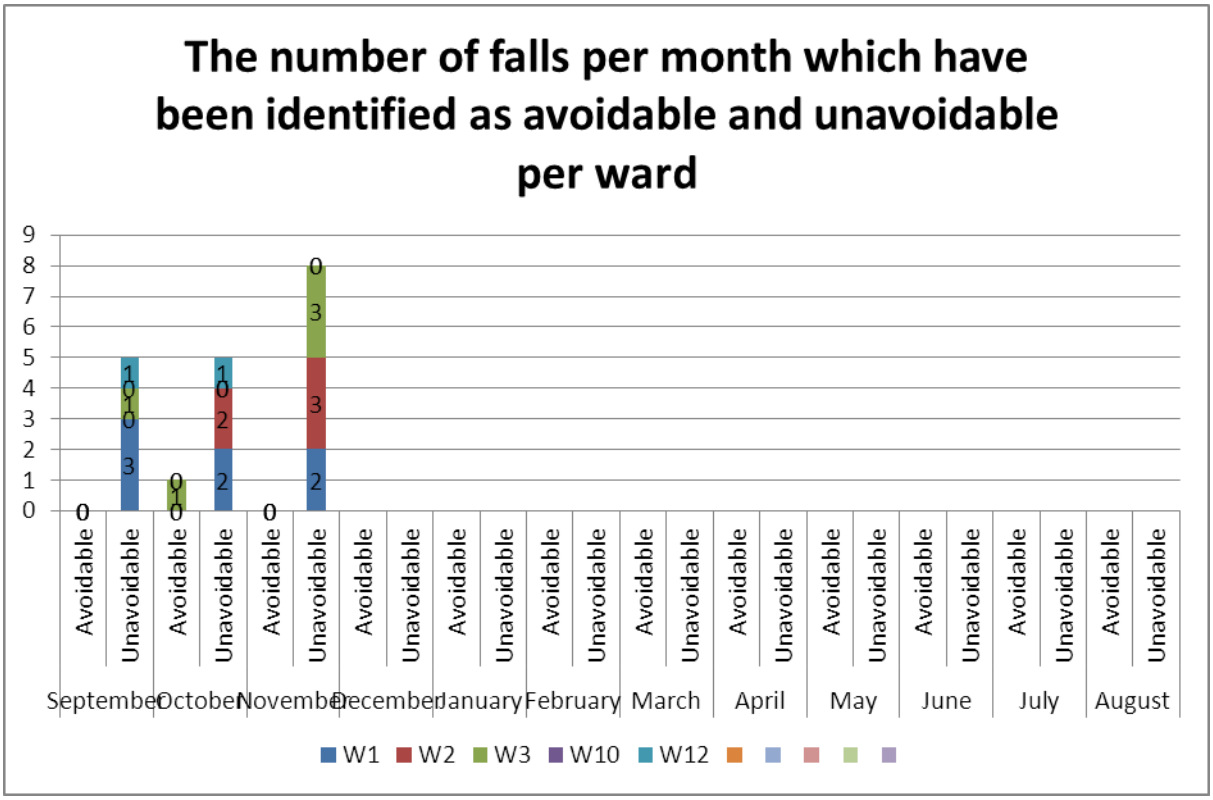


Number of falls, slips or trips reported in each area during November

Location of Falls	Number of falls per area
Ward 1	4
Ward 2	3
Ward 3	5
Ward 10	0
Ward 12	1
Physio Gym	1

Out of the 14 reported falls only 8 were reportable as inpatient adult falls. Details of the excluded incidents below:

Area	Incident Number	Detail
Ward 3	**11841**	Faint not fall
Ward 1	**11842**	Slip not fall
Ward 12	**11870**	Fit not fall
Ward 3	**11884**	Controlled sit to the floor
Ward 1	**11967**	Slip not fall
Physio Gym	**11982**	Faint not fall (visitor not patient)



Quality indicator requirements

Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	**91%** compliance required each month by ward
If the patient is identified as high risk is a care plan in place? Yes/ N/A	**91%** compliance required each month by ward

Documentation audit results taken from Wards 1, 2, 3, 10 and 12 (Adult in- patient wards). The wards have audited their own documentation.

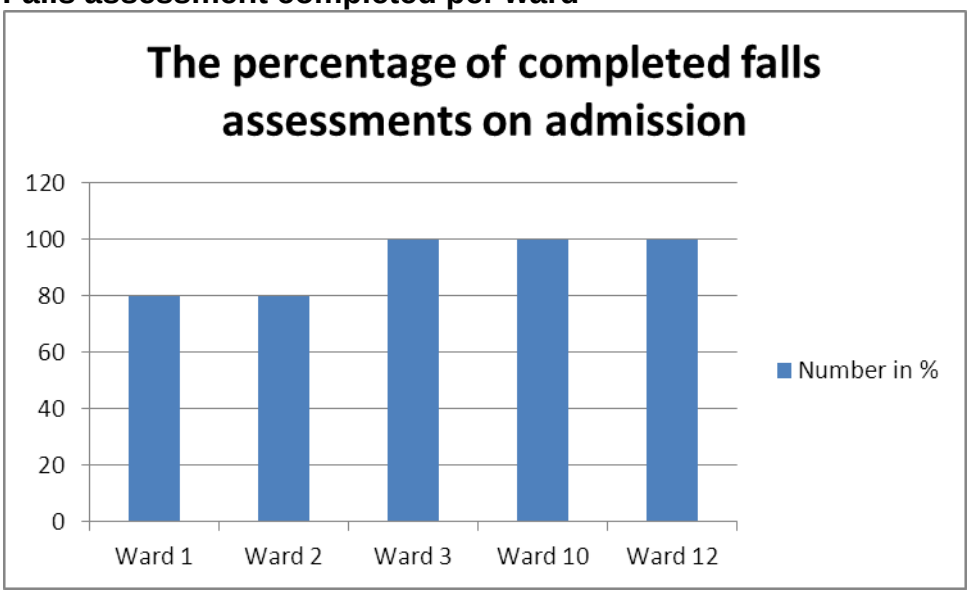
Audit results are from data obtained in the month of **November 2013.**

Overall Results

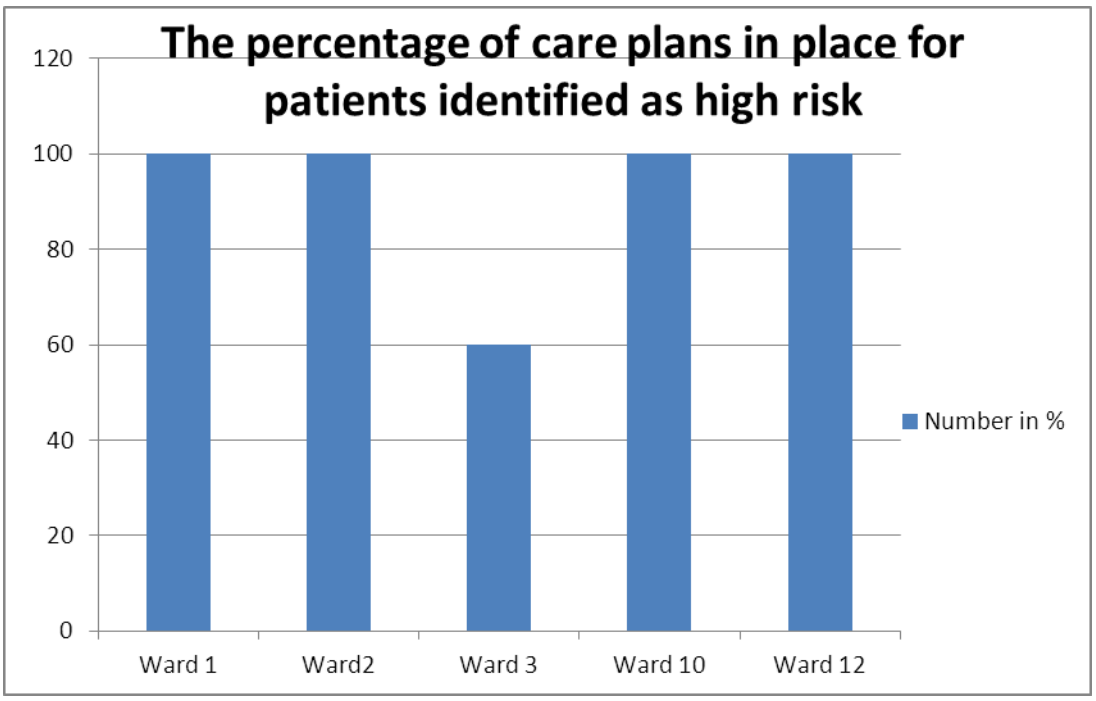
		April	May	June	July	Aug	Sept	Oct	Nov	Dec
Q1.	**Has the falls assessment been completed within 6 hours of admission?**	100 %	100 %	95%	96%	96%	88% 98%*	92%	92%	
Q2.	**If the patient is identified as high risk is a care plan in place?**	95%	95%	95%	92%	84%	74% 96%*	81%	92%	
Q3.	**Has the falls assessment been reviewed as per risk assessment**						96%	88%	88%	

*** Repeat audit**

Falls assessment completed per ward



The percentage of care plans in place for patients identified as high risk.



7. Compliments, Complaints and PALS

COMPLIMENTS

There have been 124 recorded compliments this month. Several areas have not submitted the data and have been reminded of the importance of this positive measure of our patients experience

The majority of compliments this month have been for care given

Directorate	Compliments November 2013
Clinical Support	16
Small Joint	8
Large Joint	61
Oncology	5
Paediatrics	20
Spinal	1
Corporate	5
Theatres	8

COMPLAINTS
There have been 8 complaints (7 formal) received in the month, which is a reduction of 42% on last month (12).
Ninety percent (9/10) of complaints were responded to within the agreed timescale in November, this is above the KPI of 80%. The 1 complaint that is overdue was as a result of a process delay in the public and patient service team as a result of unexpected absence and an increased volume of PALS.

Areas for formal complaints received this month are broken down as follows:

- Clinical care and/or outcome of surgery x 3
- Communication and administration x 2
- Nursing care x 2

PALS:
PALS contacts up this month from 79 to 112 (an increase of 26%)
In addition to new service users of this service a large number of patients known to the service have returned to us for help and support. The needs expressed include long standing problems, new treatment plans, need help coordinating admissions etc. all of which has taken a large amount of time to support.

- Numbers of PALS received by Directorate:

Corporate	14
Small Joint	5
Large Joint	18
Oncology	9
Clinical Support	26
Paediatrics	3
Spinal	32
Theatres	5
Total	**112**

Highest areas of concern:

- Delays in spinal admin – patients unsure of plans for care and treatment
- Metal on Metal queries
- Orthotics – waiting times to get appointment for treatment
- Appointment queries: repeated changes, cancelled and not informed and cannot get through
- Work experience requests
- Parking problems
- Having an injection – lack of information on what to bring, waiting for date to be scheduled

Please note the Ward and Theatre KPI are not available at this time, the report mechanism for the KPI process closes at ward level on the 10th of the month. It will be circulated on email at a later date.

APPENDIX 1

New SIRIs November 2013

Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final report due
11829	30/10/2013	5/11/2013	Patient received x 2 radiation doses (x-rayed twice)	Minor	OPD & Spinal	Investigation underway	10/01/2014
11847	2/11/2013	4/11/2013	Medical device unavailable	Minor	Paediatric	Downgrade request submitted to commissioners	N/A
11958	05/11/2013	21/11/2013	Grade 3 pressure ulcer	Minor	Large Joints	Investigation underway	03/02/2014
11936	18/11/2013	27/11/2014	Grade 3 Pressure Ulcer	Minor	Large Joints	Investigation underway	03/02/2014
11994	25/11/2014	27/11/2014	Grade 3 Pressure Ulcer	No harm	Theatre & Anaesthetics	Investigation underway	05/02/2014

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to Trust Board

Date: 18.12.13 **Enclosure 9**

Report Title: Emergency Planning Resilience and Response Organisational Assurance to the Local Area Team
Report By: Suzanne Nicholl **Directorate Manager and Emergency planning Lead**
Report Presented by: Suzanne Nicholl
Purpose of the Report: **To inform the Board of the Trust's self-assessment against the EPRR Core Standards. For the Board to endorse the assessment and improvement actions**
Recommendation: **To endorse the self-assessment and improvement plan**

1.0	**Summary / Background** The Trust has been asked by NHS England – Birmingham, Solihull & Black Country Area Team to complete a self-assessment and improvement plan against the EPRR Core Standards launched in April 2013 (app 1). This assessment needs to be approved by the Accountable Emergency Officer and endorsed by the Trust Board by the end of December 2013
2.0	**Detail** This is the first time since the introduction of the revised EPRR Core Standards that Trusts have been asked to assess their arrangements and in doing so has provided the opportunity to robustly benchmark our emergency planning service against national standards. The self-assessment in appendix 1 is rated as follows: Green – Arrangements currently in place Amber - Arrangements scheduled to be completed by December 2013 Red - Arrangements not in place by December 2013 Timescales for improvement plans are to be determined and agreed by individual Trusts. Annual reassessment is likely and will occur May/June 2014 There are 2 standards that are currently requiring action. Where this is the case the improvement plans indicate the actions to be taken and the timescale for completion.

	8.2 Detailed Evacuation plans 8.3 Plans for managing patients a relative for a period of time Improvement Plan Currently the Trust has detailed departmental evacuation plans in the event of fire. However the Trust does not have a total hospital evacuation plan which would detail the management and shelter of patients and relatives. This will be completed & ratified by April 2014 Completion of these actions will provide full compliance by reassessment. Progress will be monitored through the Emergency Planning Group and reported to EMT. The Local Area Team (LAT) is establishing peer review of EPRR arrangements for 2014, however the ROH EP lead has agreed an informal peer review with the EP officer for South Birmingham Community Trust in Feb 2014. The Emergency planning lead has offered assurance to the LAT that the Trust will be fully compliant with the core standards by April 2014.
8.0	**Conclusion and Recommendations** The EPRR self-assessment identifies areas for improvement required by the Trust. The Board is asked to endorse the assessment and improvement plan.

Report attachments – Appendix 1 Core Standards Self-Assessment

Signed: Date: **12.12.13**

Insert Organisation name The Royal Orthopaedic NHS Foundation Trust
Insert Organisation type(s) Specialist Orthopaedic Hospital
Insert name of completing officer Suzanne Nicholl
Insert name of authorising officer Amanda Markell
Insert submission date 18.10.13 revised 2.12.13 & 5.12.13

Select your organisation type using Autofilter dropdown arrow(s)

		Cat 1				Cat 2	Incategoris	
	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	**Acute trusts**	**Ambulance trusts**	**NHS England area teams**	**NHS England regional &**	**CCGs**	**Community providers**	**Mental health**
1	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	X	X	X	X	X	X	X
2	**All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency.**	X	X	X	X	X	X	X
3	**All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	X	X	X	-	X	X	X
3 . 1	director-level representation at the LHRP; and	X	X	X	-	X	X	X
3 . 2	representation at the LRF.	-	X	X	-	-	-	-
4	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	X	X	X	X	X	X	X
4 . 1	Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme must link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X
5	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	X	X	X	X	x	x	x
5 . 1	be based on risk-assessed worst-case scenarios;	X	X	X	X	X	X	X
5 . 2	make sure that all arrangements are trialled and validated through testing or exercises;	X	X	X	X	X	X	X
5 . 3	make sure that the funding and resources are available to cover the EPRR arrangements;	X	X	X	X	X	X	X
5 . 4	plan for the potential effects of a significant incident or emergency or for providing healthcare services to prisons, the military and iconic sites; and	X	X	-	X	-	X	X
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X	X	-	X	-	X	X
	Incident response plans must be in line with published guidance, threat-specific plans and the plans of other responding partners. They must:	X	X	X	X	X	X	X
5 . 6	refer to all relevant national guidance, other supporting and threat-specific plans (eg pandemic flu, CBRN, mass casualties, burns, fuel shortages, industrial action, evacuation, lockdown, severe weather etc) and policies, and all other supporting documents that enhance the organisation's incident response plan;	X	X	X	X	X	X	X
5 . 7	refer to all other associated plans identified by local, regional and national risk registers;	X	X	X	X	X	X	X
5 . 8	have been written in collaboration with all relevant partner organisations;	X	X	X	X	X	X	X
5 . 9	refer to incident response plans used by partners, including LRF plans;	X	X	X	X	X	-	-
5 . 10	have been written in collaboration with PHE;	X	X	X	X	X	-	X
5 . 11	have been written in collaboration with all burns, trauma and critical care networks; and	X	X	X	X	X	X	-

GREEN - arrangements in place now,		GREEN - Assured
AMBER - draft or scheduled on action		AMBER - Partially assured, seeking clarification/ draft
RED - arrangements not in place or		RED - Not assured; insufficient evidence provided
N/A - Not applicable to organisation		N/A - Not applicable to organisation
N/R - Not rated by reviewing team		N/R - Not rated by reviewing team

	Commentary/ References to Evidence Supplied	**Self Assessment**	**Improvement plan**	**Review Team Comment**	**Review Team Assessment**
1	Emergency Planning lead - Suzanne Nicholl - Directorate manager				
2	Mutual aid is referred to in the major incident plan. MOU exist with other local Trusts; Attendance and agreement with the LAT expectations of mutual aid.				
3					
3 . 1	Emergency Accountable officer will have regular attendance at the LHRP				
3 . 2					
4	Comms exercises: October 2012 x2 & April 2013 Exercises: 30.12.12 - live ward fire. Debrief: Jan 2013				
4 . 1	Work plan contains the recommended information				
4 . 2	Pertinent risks are on Trust CRR				
5					
5 . 1	Detailed in MI Plan				
5 . 2	Comms exercises: October 2012 x2 & April 2013 Exercises: 30.12.12 - live ward fire. Debrief: Jan 2013				
5 . 3	Provided as required				
5 . 4	Outlined in the Major incident plan				
5 . 5	Estates & Facilities are integral part of the EPRR group; Business continuity plans are held for all core services & departments				
5 . 6	Major Incident plan				
5 . 7	Major Incident plan				
5 . 8	Major Incident plan				
5 . 9	Major Incident plan				
5 . 10	N/A				
5 . 11	N/A				

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
5 . 12	define how the organisation will meet the Prevent strategy's objectives for health (1. prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and 2. work with sectors and institutions where there are risks of radicalisation which we need to address, and the wider CONTEST strategy).	X	X	X	-	X	X	X		N/R			N/R
	Incident response plans must follow NHS governance arrangements. They must:	X	X	X	X	X	X	X					
5 . 13	be approved by the relevant board;	X	X	X	X	X	X	X	Major Incident plan				
5 . 14	be signed off by the appropriate Senior Responsible Officer;	X	X	X	X	X	X	X	Major Incident plan				
5 . 15	set out how legal advice can be obtained in relation to the CCA;	X	X	X	X	X	-	X	Details not currently included in plan, however in practice this is available via Trust solicitors				
5 . 16	identify who is responsible for making sure the plan is updated, distributed and regularly tested;	X	X	X	X	X	X	X	Major Incident plan				
5 . 17	explain how internal and external consultation will be carried out to validate the plan;	X	X	X	X	X	X	X	Major Incident plan				
5 . 18	include version controls to be sure the user has the latest version;	X	X	X	X	X	X	X	Major Incident plan				
5 . 19	set out how the plan will be published – for example, on a website;	X	X	X	X	X	X	X	The plan is available on the Trust website , On-call pack, Bleep holders file and p drive				
5 . 20	include an audit trail to record changes and updates;	X	X	X	X	X	X	X	Major Incident plan				
5 . 21	explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	X	X	X	X	X	X	X	This facility is available in practice and has been enacted twice in the last 4 years without difficulty				
5 . 22	demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.	X	X	X	X	X	X	X	The EPG reviews and escalates related risks to the CRR/BAF: Flu; Heat wave management & Industrial action . In additions all core services have risk assessments relating to their Business continuity plans				
	Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.	X	X	X	X	X	X	X					
5 . 23	Key staff must know where to find the plan on the intranet or shared drive.	X	X	X	X	X	X	X	Training records				
5 . 24	There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.	X	X	X	X	X	X	X	Debrief from exercises; feedback from training				
5 . 25	Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rotas must meet NHS published competencies.	X	X	X	X	X	X	X	Training records				
5 . 26	It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).	X	X	X	X	X	X	X	Training records & feedback				
5 . 27	It must be clear how key staff can achieve and maintain suitable knowledge and skills.	X	X	X	X	X	X	X	Training is available to key individuals on an annual and bespoke basis				
	Set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols.	X	X	X	X	X	X	X					
5 . 28	Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X	X	X	X	X	X	X	major Incident plan				
5 . 29	Set out the procedures for escalating emergencies to NHS England area teams, regions, national office and DH	-	-	X	X	-	X	-					
5 . 30	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	X	X	X	X	-	X	-	Established and robust on-call rota in situ. Call out protocol included in MI plan				
5 . 31	Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X	X	X	X	X	X	X	Admin role assigned to system				
5 . 32	Set out the responsibilities of key staff and departments.	X	X	X	X	X	X	X	Major Incident plan				
5 . 33	Set out the responsibilities of the appropriate Senior Responsible Officer or nominated Executive Director.	X	X	X	X	X	X	X	Major Incident plan				
5 . 34	Explain how mutual aid arrangements will be activated and maintained.	X	X	X	X	X	X	X	Major Incident plan				
5 . 35	Identify where the incident or emergency will be managed from (the ICC).	X	X	X	X	X	X	X	Major Incident plan				

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5 . 36	Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.	X	X	X	X	X	X	X	Major Incident plan				
5 . 37	**Best Practice:** Use an electronic data-logging system to record the decisions made.	X	X	-	-	-	-	-	Not considered to be necessary to the safe and effective management of an incident within a specialist Trust with no A&E				
5 . 38	**Best Practice:** Use the National Resilience Extranet.	X	X	X	X	-	X	-					
5 . 39	Refer to specific action cards relating to using the incident response plan.	X	X	X	X	X	X	X	MIP & action cards				
5 . 40	Explain the process for completing, authorising and submitting NHS England standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X	X	X	X	X	X	X	In practice as an incident unfolds or preparations are made the operations team establish the reporting mechanism, as demonstrated during the Workforce strikes 30.10.11				
5 . 41	Explain how extended working hours will apply and how they can be sustained. Explain how handovers are completed.	X	X	X	-	X	X	X	This has been managed successfully during actual incidents in Dec 2012 and Sept 2009.				
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X	X	X	X	X	X	X	During incidents the Trust has posted messages on our web site to inform patients and visitors eg the fire in Dec 2012. The MI plan has an action card for our communications officer to ensure effective and timely communication with				
5 . 43	Have agreements in place with local 111 providers so they know how they can help with an incident	X	X	X	X	X	X	-	As a specialist Trust the role the ROH will play within a MI will be informed by the LAT requirements and mutual aid agreements				
5 . 44	Consider using helplines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	X	X	X	X	X	X	X	As a non receiving acute organisation the relevance of helplines is minimal. The Trust will respond as directed by the co-ordinating body				
5 . 45	Describe how stores and supplies will be maintained.	X	X	-	-	X	X	X	Contained within the BCP				
5 . 46	Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	X	X	-	-	-	X	X	Casualties will be transferred to local A&E as required				
5 . 47	Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.	X	X	-	X	-	-	X	Action cards				
5 . 48	Explain the process of recovery and returning to normal processes.	X	X	X	X	X	X	X	Action cards				
5 . 49	Explain the de-briefing process (hot, local and multi-agency)at the end of an incident.	X	X	X	X	X	X	X	Debriefing post incident is routine practice at ROH and informs the incident report and learning				
5 . 50	Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	X	X	X	X	X	X	X	The MI plan includes facility for a relative centre and support from chaplaincy in and after an incident. In house occupational health facility is also available				
	Set out how surges in demand will be managed.	X	X	X	X	X	X	X					
5 . 51	Explain who will be responsible for managing escalation and surges.	X	X	X	X	X	X	X	In additional to routine capacity management arrangements an escalation process can be activated which ensures minimal disruption to patient services				
5 . 52	Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X	X	X	X	X	X	X	N/A				
	Link the Incident Response Plan to threat-specific incidents	X	X	X		X	X	X					
5 . 53	CBRN incidents;	X	X	-	-	-	X	X	N/a				
5 . 54	mass casualty incidents;	X	X	-	-	-	X	X	N/A				
5 . 55	pandemic flu;	X	-	X	-	-	X	X	N/A				
5 . 56	patients with burns requiring critical care; and	X	-	-	-	-	X	X	N/A				

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5 . 57	severe weather.	X	X	X	-	X	X	X	N/A				
6	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This must include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	X	X	X	X	X	X	X	Primary and secondary Incident control rooms				
6 . 1	There must be a plan setting out how the ICC will operate.	X	X	X	X	X	X	X	ICR - set up document				
6 . 2	There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	X	X	X	X	X	X	X	ICR - set up document				
6 . 3	There must be a plan setting out how the Incident Coordination Team will be called in and managed over any length of time	X	X	X	X	X	X	X	ICR - set up document				
6 . 4	Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.	X	X	X	X	X	X	X	ICR - set up document; audit document				
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	X	X	X	X	X	X	X					
7 . 1	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	X	X	X	X	X	X	Not currently included				
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X	X	X	X	X	X	X	Not currently included				
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X	X	X	X	X	X	X	BCP & stand alone plans - IT & Estates				
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X	X	X	X	X	X	X	BCP				
	Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.	X	X	X	X	X	X	X	BCP				
7 . 5	Each organisation's BCMS must be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X	X	X	X	X	X	X	BCP				
7 . 6	Organisations must establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X	X	X	X	X	X	X	BCP				
7 . 7	Organisations must make clear how their plan will be published, for example on a website.	X	X	X	X	X	X	X	Not currently included				
7 . 8	The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the appropriate Senior Responsible Officer.	X	X	X	X	X	X	X	BCP				
7 . 9	There must be an audit trail to record changes and updates such as changes to policy and staffing.	X	X	X	X	X	X	X	BCP				
7 . 10	The planning process must take into account nationally available toolkits that are seen as good practice.	X	X	X	X	X	X	X	**BCP**				
	Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.	X	X	X	X	X	X	X					
7 . 11	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X	X	X	X	X	X	X	BCP & Dept. BCP				
7 . 12	Plans must be maintained based on risk-assessed worst-case scenarios.	X	X	X	X	X	X	X	BCP & Dept. BCP				
7 . 13	Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heat wave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	X	X	X	X	X	X	X	Dept. BCP				
7 . 14	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	X	X	X	X	X	X	BCP				
7 . 15	They must identify all critical activities using a business impact analysis. This must set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	X	X	X	X	X	X	X	BCP				
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	X	X	X	X	X	X	BCP				
	Business continuity plans must set out how the plans will be called into use, escalated and operated.	X	X	X	X	X	X	X					
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	X	X	X	X	X	X	X	Use of email address; shortwave radio and telephones				
7 . 18	Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X	X	X	X	X	X	X	Action card & plan				
7 . 19	the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	X	X	X	X	X	X	X	Action card				

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7 . 20	24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X	X	X	X	X	X	X	cascade doc; Comms doc; admin role				
7 . 21	the responsibilities of key staff and departments;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 22	the responsibilities of the appropriate Senior Responsible Officer or Executive Director;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 23	how mutual aid arrangements will be called into use and maintained;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 24	where the incident or emergency will be managed from (the ICC);	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 25	how the independent healthcare sector may help if required; and	X	X	X	X	X	X	X	MOU with private provider				
7 . 26	the insurance arrangement that are in place and how they may apply.	X	X	X	X	X	X	X	Action Cards				
	Business continuity plans must describe the effects of any disruption and how they can be managed. Plans must include:	X	X	X	X	X	X	X					
7 . 27	contact details for all key stakeholders;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 28	alternative locations for the business;	X	X	X	X	X	X	X	BCP; Action Cards				
7 . 29	a scalable plan setting out how incidents will be managed and by whom;	X	X	X	X	X	X	X	Action Cards				
7 . 30	recovery and restoration processes and how they will be set up following an incident;	X	X	X	X	X	X	X	Action Cards; reference to MIP				
7 . 31	how decisions and meetings will be recorded during and after an incident, and how the incident report will be compiled;	X	X	X	X	X	X	X	Post incident report; action cares				
7 . 32	how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	X	X	X	X	X	X	X	Action cards				
7 . 33	how staff will be accommodated overnight if necessary;	X	X	X	X	X	X	X	Not currently included				
7 . 34	how stores and supplies will be managed and maintained; and	X	X	-	-	X	X	X	BC plan and stand alone doc				
7 . 35	details of a surge plan to maintain critical services.	X	X	X	X	X	X	X	N/A				
	Business continuity plans must specify how they will be used, maintained and reviewed.	X	X	X	X	X	X	X					
7 . 36	Organisations must use, exercise and test their plans to show that they meet the needs of the organisation and of other interested parties. If possible, these exercises and tests should involve relevant interested parties. Lessons learnt must be acted on as part of continuous improvement.	X	X	X	X	X	X	X	Comms exercises: October 2012 x2 & April 2013 Exercises: 30.12.12 - live ward fire. Debrief: Jan 2013				
7 . 37	Plans must identify who is responsible for making sure the plan is updated, distributed and regularly tested.	X	X	X	X	X	X	X					
7 . 38	Organisations must monitor, measure, analyse and assess the effectiveness of their BCMS against their own requirements, those of relevant interested parties and any legal responsibilities.	X	X	X	X	X	X	X	Report to IGC				
7 . 39	Organisations must identify and take action to correct any irregularities identified through the BCMS and must take steps to prevent them from happening again. They must continually improve the suitability and effectiveness of their BCMS.	X	X	X	X	X	X	X	Report to IGC; Post incident reports				
	Business continuity plans must specify how they will be communicated to and accessed by staff. Plans must include:	X	X	X	X	X	X	X					
7 . 40	details of the training provided to staff and how the training record is maintained;	X	X	X	X	X	X	X	Incident controllers training events and records				
7 . 41	reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);	X	X	X	X	X	X	X	Incident controllers are trained to a best practice standard				

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7 . 42	details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and	X	X	X	X	X	X	X	BCP training has largely through exercises , actual incidents and support to dept. owners via local BCP review		BCP workshops are to be held in Jan 2014. Awareness training available via induction and mandatory training from April 2014. Bespoke training and advise available as required		
7 . 43	details of how suitable knowledge and skills will be achieved and maintained.	X	X	X	X	X	X	X	a/a		BCP workshops are to be held in Jan 2014. Awareness training available via induction and mandatory training from April 2014. Bespoke training and advise available as required		
8	**NHS Acute Trusts must also include:**	X	-	-	-	-	-	-					
8 . 1	detailed lockdown procedures;	X	-	-	-	-	-	-	Stand alone doc				
8 . 2	detailed evacuation procedures;	X	-	-	-	-	-	-	Currently the Trust has departmental evacuation plans in place, however a total evacuation plan has not been developed		This is for development in Q4		
8 . 3	details of how they will manage relatives for any length of time, how patients and relatives will be reunited and how patients will be transported home if necessary;	X	-	-	-	-	-	-	Currently the Trust has departmental evacuation plans in place, however a total evacuation plan has not been developed		This is for development in Q4		
8 . 4	details of how they will manage fatalities and the relatives of fatalities; and	X	-	-	-	-	-	-	N/A				
8 . 5	**Best Practice:** reference to the Clinical Guidelines for Major Incidents.	X	X	-	-	-	-	-	N/A				
9	**NHS Ambulance Trusts must also:**	-	X	-	-	-	-	-					
9 . 1	refer to the National Ambulance Service Command and Control Guidance 2012 and any other relevant ambulance specific guidance relating to major incidents;	-	X	-	-	-	-	-					
9 . 2	manage up to four incidents at a time in urban areas and two in rural areas;	-	X	-	-	-	-	-					
9 . 3	have flexible IT and staff arrangements so that they can operate more than one control centre and manage any events required;	-	X	-	-	-	-	-					
9 . 4	have formal arrangements for recalling staff to duty if necessary;	-	X	-	-	-	-	-					
9 . 5	be able to provide a forward control team if necessary;	-	X	-	-	-	-	-					
9 . 6	have an on-call and an on duty loggist drawn from a wide pool of staff;	-	X	-	-	-	-	-					
9 . 7	have arrangements to communicate with and control resources from other ambulance providers;	-	X	-	-	-	-	-					
9 . 8	have a 24-hour specialist adviser for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support gold and silver command in managing these events;	-	X	-	-	-	-	-					
9 . 9	have 24-hour radiation protection supervisor arrangements in line with local and national mutual aid arrangements;	-	X	-	-	-	-	-					
9 . 10	make sure all commanders maintain a continuous personal development portfolio;	-	X	-	-	-	-	-					
9 . 11	have a Hazardous Area Response Team (HART) in line with the current national service specification, including a vehicles and equipment replacement programme;	-	X	-	-	-	-	-					
9 . 12	be able to respond to firearms incidents in line with National Joint Operating Procedures;	-	X	-	-	-	-	-					
9 . 13	have a Mobile Emergency Response Incident Team (MERIT) to cover the area in line with Department of Health guidance;	-	X	-	-	-	-	-					
9 . 14	be able to manage a casualty clearing station with large numbers of patients for a long period of time in line with Department of Health guidance;	-	X	-	-	-	-	-					
9 . 15	be able to identify the location and availability of assets across the organisation and the country;	-	X	-	-	-	-	-					
9 . 16	be able to respond with assets across the organisation and the country and provide situation reports to the National Ambulance Co-ordination Centre;	-	X	-	-	-	-	-					
9 . 17	be able to dispatch and receive assets following an agreed trigger mechanism, supported by a robust audit process;	-	X	-	-	-	-	-					
9 . 18	have a trigger mechanism for requesting mutual aid and a nominated person to agree to these requests, supported by a clear profile of what is required, what can be provided and how the response will be managed in the field;	-	X	-	-	-	-	-					
9 . 19	have systems to manage the media at Emergency Operational Centres, fall-back locations and across the organisation;	-	X	-	-	-	-	-					
9 . 20	have arrangements in place for routine public events, for example, demonstrations and public gatherings;	-	X	-	-	-	-	-					
9 . 21	attend safety advisory groups to reduce organisational risk during planning and at the actual event;	-	X	-	-	-	-	-					
9 . 22	have arrangements in place to deal with public disorder incidents;	-	X	-	-	-	-	-					
9 . 23	have arrangements in place to provide radiation protection supervisors;												
9 . 24	have arrangements in place to train voluntary and community first responders	-	X	-	-	-	-	-					

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9 . 25	have arrangements in place to provide training support to NHS partners in the use of personal protective equipment for chemical, biological, radiological, nuclear, hazardous material and casualty clearing.	-	X	-	-	-	-	-					
9 . 26	have processes and an audit trail which allow all staff to train with partner agencies;	-	X	-	-	-	-	-					
9 . 27	have arrangements in place to train with the voluntary sector;	-	X	-	-	-	-	-					
9 . 28	have arrangements in place to train with acute trusts;	-	X	-	-	-	-	-					
9 . 29	have arrangements in place to share the outcome of training and exercises with other ambulance trusts and government stakeholders across the country;	-	X	-	-	-	-	-					
9 . 30	have strong processes for profiling staff and managing facilities to accommodate EPRR and store assets in line with CCA requirements;	-	X	-	-	-	-	-		N/R			N/R
9 . 31	have arrangements in place for counselling and supporting staff, and advising on long-term clinical care following a traumatic or high-profile incident;	-	X	-	-	-	-	-					
9 . 32	have suitable IT arrangements in place to support a significant incident or any event that requires specialised IT;	-	X	-	-	-	-	-					
9 . 33	explain the systems for alerting, mobilising and co-ordinating all primary NHS resources necessary to deal with an incident on the scene (in coordination with NHS England area team gold command);	-	X	-	-	-	-	-					
9 . 34	list their key strategic, tactical and operational responsibilities as set out in the NHS Emergency Planning Guidance 2005 (or subsequent relevant guidance);	-	X	-	-	-	-	-					
9 . 35	explain how and when MERIT, HART and MIA (the Medical incident Adviser) will be used;	-	X	-	-	-	-	-					
9 . 36	identify how voluntary aid societies will be used;	-	X	-	-	-	-	-					
9 . 37	explain working arrangements with all emergency services;	-	X	-	-	-	-	-					
9 . 38	explain the arrangements for managing triage, treatment and transport for casualties;	-	X	-	-	-	-	-					
9 . 39	state who will represent the service at LHRP, LRF and similar groups;	-	X	-	-	-	-	-					
9 . 40	explain the roles of the Hospital Ambulance Liaison Officer (HALO) and Hospital Ambulance Liaison Control Officer (HALCO) in acute trusts;	-	X	-	-	-	-	-					
9 . 41	refer to other relevant plans such as REAP;	-	X	-	-	-	-	-					
9 . 42	explain how the Mobile Privileged Access Scheme (MTPAS) and Fixed Telecommunications Privileged Access Scheme (FTPAS) will be provided across the organisation; and	X	X	-	-	X	X	X					
9 . 43	describe how Airwave systems will be managed within the organisation and how talk groups will be used to communicate with the emergency services.	-	X	-	-	-	-	-					
10	**NHS England area teams must also:**	-	-	X	-	-	-	-					
10 . 1	make sure that the incident response plans for all providers in an LRF are co-ordinated and compatible;	-	-	X	-	-	-	-					
10 . 2	define when the NHS will take the leading role in a significant incident or emergency`;	-	-	X	-	-	-	-					
10 . 3	mobilise primary and secondary care resources to support acute and non-acute trusts;	-	-	X	-	X	-	-					
10 . 4	describe the arrangements for setting up a Science and Technical Advice Cell (STAC) in consultation with local Public Health England centres;	-	-	X	X	-	-	-					
10 . 5	identify who will attend the Strategic Co-ordination Group (SCG);	-	-	X	X	-	-	-					
10 . 6	provide a co-chair and secretariat for LHRPs;	-	-	X	-	-	-	-					
10 . 7	define the roles and responsibilities of LHRP; and	-	-	X	-	-	-	-					
10 . 8	develop plans which demonstrate the command and control of resources from all NHS organisations and providers of NHS funded care within an LRF area to respond to a significant incident or emergency; and	-	-	X	-	-	-	-					
10 . 9	outline how GP services will be delivered 24 hours a day – either directly or through out-of-hours services.	-	-	-	-	X	-	-					
11	**NHS England corporate and regional offices must also:**	-	-	-	X	-	-	-					

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
11 . 1	assign an NHS England area team to each LHRP or LRF;	-	-	-	X	-	-	-					
11 . 2	define how strategic EPRR advice and support will be given to these teams;	-	-	-	X	-	-	-					
11 . 3	make sure that area team incident response plans in a region are co-ordinated and compatible;	-	-	-	X	-	-	-					
11 . 4	outline the procedure for responding to incidents which affect two or more LHRPs or LRFs;	-	-	-	X	-	-	-					
11 . 5	outline the procedure for responding to incidents which affect two or more regions;	-	-	-	X	-	-	-					
11 . 6	define how links will be made between the NHS England, the Department of Health and PHE	-	-	X	X	-	-	-					
11 . 7	define how the NHS's ability to respond to emergencies will be measured and controlled;	-	-	-	X	-	-	-					
11 . 8	outline how the Department of Health will be supported in its emergency response role;	-	-	-	X	-	-	-					
11 . 9	outline how information relating to national emergencies will be co-ordinated and shared; and	-	-	X	X	-	-	-					
11 . 10	establish a link between the Regional Prevent Co-ordinator in the NHS England local area and those involved in Protect.	-	-	-	X	-	-	-		N/R			N/R
12	**CCGs will, in addition:**	-	-	-	-	X	-	-					
12 . 1	carry out their duties as category two responders under the CCA and provide details of how they will do this;	-	-	-	-	X	-	-					
12 . 2	**Core Standard 12.2 has been TRANSFERRED to 10.9 above.**												
12 . 3	make sure agreements with providers of NHS funded care include suitable EPRR provisions and categorise funds allocated to EPRR activities (for example, testing and exercising);	-	-	-	-	X	-	-					
12 . 4	**Core Standard 12.4 has been DELETED.**	-	-	-	-	X	-	-					
12 . 5	define a route for their commissioned providers to escalate issues 24 hours a day, supported by trained and competent people, in case they cannot maintain delivery of core services;	-	-	-	-	X	-	-					
12 . 6	outline how the CCG will carry out its supporting role during and after an incident;	-	-	-	-	X	-	-					
12 . 7	Demonstrate the annual plan for training and exercises as part of the duties of a category two responder; and	-	-	-	-	X	-	-					
12 . 8	those CCG's with ambulance Trust commissioning responsibilities must ensure, in relation to both planned and non-planned events, that specific EPRR-related services in response are itemised.	-	-	-	-	X	-	-					
13	**Community pharmacists must also:**	-	-	-	-	-	-	-					
13 . 1	explain how they will support essential care in the community during a significant incident or emergency;	-	-	-	-	-	-	-					
13 . 2	support hospitals, GPs and ambulance services during the treatment phase of an influenza pandemic or any other public health emergency;	-	-	-	-	-	-	-					
13 . 3	outline how they will give accurate and specific clinical advice;	-	-	-	-	-	-	-					
13 . 4	outline how they will share information with other relevant organisations; and	-	-	-	-	-	-	-					
13 . 5	describe how the police or other emergency services can get access to a key-holder list for any pharmacy.	-	-	-	-	-	-	-					
14	**NHS Logistics must also:**	-	-	-	-	-	-	-					
14 . 1	outline how healthcare products and supply chain services can be provided 24 hours a day in times of crisis; and	-	-	-	-	-	-	-					
14 . 2	explain how an efficient and effective procurement service can be maintained for NHS organisations.	-	-	-	-	-	-	-					
15	**NHS Protect must also:**	-	-	-	-	-	-	-					
15 . 1	refer to all relevant guidance that provides a safe and secure environment for NHS staff and resources	-	-	-	-	-	-	-					
15 . 2	define its aims for managing security issues across the NHS;	-	-	-	-	-	-	-					
15 . 3	outline how conflict resolution training can be used by all NHS organisations to prevent violence against staff and patients;	-	-	-	-	-	-	-					
15 . 4	outline how NHS organisations can manage risks relating to economic crime such as fraud, bribery and corruption;	-	-	-	-	-	-	-					
15 . 5	describe how their plans will be related to the national threat levels for counter terrorism security;	-	-	-	-	-	-	-					
15 . 6	explain how threat levels will be based on the broad nature of the threat but could include specific areas of business, geographic vulnerabilities, acceptable risk and specific events;	-	-	-	-	-	-	-					
15 . 7	describe how NHS sites can be locked down by managing site security and the security of staff, patients and visitors;	-	-	-	-	-	-	-					
15 . 8	outline how NHS organisations can access Project Artemis and Project Argus Health;	-	-	-	-	-	-	-					
15 . 9	outline how local security management specialists (LSMS) can advise on managing a security culture;	-	-	-	-	-	-	-					
15 . 10	outline how NHS organisations can manage specific security issues, for example, VIPs and bomb threats;	-	-	-	-	-	-	-					
15 . 11	explain how it will use effective communication strategies to work in partnership with EPRR stakeholders; and	-	-	-	-	-	-	-					
15 . 12	establish links with LSMS and Prevent leads in trusts.	-	-	-	-	-	-	-					

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Commentary/ References to Evidence Supplied	Self Assessment	Improvement plan	Review Team Comment	Review Team Assessment
16	**NHS Direct / 111**	-	X	-	-	-	-	-					
16 . 1	must also outline how they will support NHS organisations affected by service disruption, including communications and response procedures for significant incidents and emergencies (for example, informing the public and GPs if local emergency departments are closed).	-	X	-	-	-	-	-					
17	**Community providers must also:**	-	-	-	-	-	X	-					
17 . 1	take into account how vulnerable adults and children can be managed to avoid admissions, with special focus on providing healthcare to displaced populations in rest centres;	-	-	-	-	-	X	-					
17 . 2	outline how they can assist acute trusts and ambulance services during and after an incident (with reference to specific roles that support discharge from hospital);	-	-	-	-	-	X	-					
17 . 3	where relevant, set out detailed plans for lockdown, evacuation and managing relatives.	-	-	-	-	-	X	-					
18	**Mental healthcare providers must also:**	-	-	-	-	-	-	X					
18 . 1	co-ordinate and provide mental health support to staff, patients and relatives in collaboration with Social Services;	-	-	-	-	-	-	X					
18 . 2	outline how, when required, Ministry of Justice approval will be gained for an evacuation;	-	-	-	-	-	-	X					
18 . 3	identify locations which patients can be transferred to if there is an incident;	-	-	-	-	-	-	X					
18 . 4	support local acute trusts by managing physically unwell inpatients if there is an infectious disease outbreak; and	-	-	-	-	-	-	X					
18 . 5	make sure the needs of mental health patients involved in a significant incident or emergency are met and that they are discharged home with suitable support.	-	-	-	-	-	-	X					
19	**Urgent care centres must also:**	X	-	-	-	-	X	X					
19 . 1	outline how they can support NHS organisations affected by service disruption, especially by treating minor injuries to reduce the pressure on emergency departments. They will need to develop procedures for this in partnership with local acute trusts and ambulance and patient care transport providers.	X	-	-	-	-	X	X					

Date of Trust Board: 18th December 2013 ENCLOSURE NUMBER: 11

REPORT TO TRUST BOARD – Summary cover sheet

NAME OF DIRECTOR PRESENTING	**Andrew Meehan**
AUTHOR(S)	**Paul Athey**

TITLE	**Trust Board Feedback from the Audit Committee Meeting held on 19th November 2013.**

SUMMARY

The committee held a meeting on 19th November and the following key items were covered:

- The external audit plan for 2013-14 was received and accepted
- Internal Audit progress was noted and assurance was gained that any audits behind schedule would be addressed prior to February's meeting
- Counter Fraud progress was noted. Feedback from the review of HR personnel files was received, and Counter Fraud were asked to undertake additional sample testing with regards to photo identification.
- Changes to the Trust's accounting policies were approved. These included the changes required as a result of the consolidation of charitable funds accounts and updates to the treatment of capital assets and their depreciation.
- The Terms of Reference for the Audit Committee were formally approved with one amendment relating to the frequency of meetings which should read "no less than 5 per annum", rather than "6 per annum". Audit colleagues agreed this was in line with usual practice at other NHS organisations.
- The process for the appointment of Internal Audit and Counter Fraud Services from 2014/15 onwards was noted.
- The committee received a draft report on the Board Assurance Framework, in line with discussions that had been held between Andy Meehan, Paul Athey, Lisa Pim and Alison Braham. The committee were happy that the new format of the report would make the understanding of the Trust's key risks far clearer. Further discussions were to be held with other stakeholders to ensure the proposed process worked across all key assurance committees.

RISK & IMPLICATIONS

There are no risks from this report.

RECOMMENDATIONS

The Board are asked to note this report.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 18th December 2013 **ENCLOSURE NUMBER: 12**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Bryan Jackson, Chairman**
AUTHOR:	**Joy Street** **Company Secretary**
SUBJECT:	**Board Assurance Framework Risks 2013/14**

SUMMARY

The attached report gives details of the one Board Assurance Framework Risk managed via Trust Board. It has recently been updated and transferred to the electronic risk register database ('Ulysses Risk Register').

IMPLICATIONS

Scrutiny and challenge of BAF risks is essential to ensure that any risks are identified and managed.

RECOMMENDATIONS

The Board is asked to:

- **Note** the attached risk paying particular attention to the current risk score for Executive Director Continuity and Corporate Memory, which is now lower than in the previous month following the successful appointment of a new CEO.
- **Identify** any additional risks for inclusion onto the BAF/ CRR

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Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Risk Number & Version			
Risk Number & Version:	11 Ver 1	**Risk Level:**	2. BAF Prinicpal Risk

Risk Details			
Opened:	09/09/2013		
Status:	Static	**Strategic Objective:**	2.3 Manage People To Enable To
Risk Type:	BAF Related	**Source Of Risk:**	
Team/Project:		**Risk Category:**	
Directorate:		**Risk Owner:**	Bryan Jackson
Monitoring Committee:	EMT	**Operational Lead:**	Joy Street

Details of the Risk	
Risk Description:	Executive Director Continuity and Corporate Memory
Causes:	Executive Director Continuity and Corporate Memory. Old ref: 155
Consequences:	3.0

Initial Risk Rating

Likelihood	***Consequence***				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	***Score : 16***	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	Score : 4	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Initial Risk Rating:	High (Red)
Initial Risk Score:	16

Current Controls & Assurances

Control Details:	Board turnover very high from November 2012 to October 2013. Regularly reviewed by Board and mitigated by prompt recruitment, appropriate and timely interim arrangements and effective handovers
Adequacy of Controls:	Adequate
Independent Assurance:	Regular review by remuneration committee of board Review of risk at each board meeting

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Current Risk Rating

Likelihood	*Consequence* 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	Score : 4	***Score : 6***	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Current Risk Rating:	Low (Yellow)
Current Risk Score:	6

Additional Controls & Assurances

Priority:			
Action Lead:	Joy Street		
Person Accountable:			
Action Details:			
Progress:			
Outcome:	Closed	**Completion Date:**	20/09/2013

Priority:		**Start Date:**	16/09/2013
Action Lead:	Bryan Jackson	**Target Date:**	25/09/2013
Person Accountable:	Joy Street	**Reminder Date:**	22/09/2013
Action Details:			
Appointment of new CEO september 2013 - start dat early 2014 Interim Director of Nursing appointed end September 13 NED continuity for two ends of term being recommended to governors			
Progress:			

Priority:		**Start Date:**	15/10/2013
Action Lead:		**Target Date:**	07/10/2013
Person Accountable:		**Reminder Date:**	04/10/2013
Action Details:			
Interim Director of Nursing in place for 6 months having had one week handover.			
Progress:			

Single Risk Details

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Target Risk Rating

Likelihood	*Consequence*				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score : 5	Score : 10	Score : 15	Score : 20	Score : 25
4 Major	Score : 4	Score : 8	Score : 12	Score : 16	Score : 20
3 Moderate	Score : 3	Score : 6	Score : 9	Score : 12	Score : 15
2 Minor	Score : 2	***Score : 4***	Score : 6	Score : 8	Score : 10
1 Insignificant	Score : 1	Score : 2	Score : 3	Score : 4	Score : 5

Target Risk Rating:	Low (Yellow)
Target Risk Score:	4

Notifications

Date:	Notification Group:	Notified Staff Member:	Info Only:
16/09/2013	Additonal Notification	Joy Street	N

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
Notice of the Public Trust Board meeting to be held on Wednesday 18th December 2013 at 8.30 am in the Board Room

AGENDA

Apologies for absence:			To note	Time
Introductions & welcome			To note	**08.30**
Declarations of Interest	Register available on request from Company Secretary			
Minutes of the Trust Board meeting held on Wednesday 27th November 2013		Enc. 1	**For Board approval**	
Action Points		Enc. 2	To note	
Chairman's & Chief Executive's Updates	Bryan Jackson & Jo Chambers	Verbal	To note	**08.45**
Medical Director's Report	Andrew Pearson	Enc. 3	To note	
Medical Staff Committee Report (meeting held 22nd November 2013)	Jo Chambers	Enc. 4 (to follow)	To note	
Nursing Staff Report	Helen Shoker	Enc. 5 (to follow)	To note	
Francis Report	Helen Shoker	Enc. 6 (to follow)	**For Board Approval**	
Strategy and Organisation Development				**10.00**
Presentation of Draft Timetable/ Framework	Jo Chambers		To Note	
Break				**10.30**
Performance Management/ Assurance Reports				**10.45**
Corporate Performance Report & PMO	Paul Athey	Enc. 7	For discussion	

Director of Nursing & Governance Patient Safety Report	Helen Shoker	Enc. 8	For discussion	
ROH Emergency Plan	Amanda Markall	Enc. 9	To note	
Clinical Governance Committee Report – 22nd November 2013	Tauny Southwood	Enc. 10 (to follow)	To note	
Audit Committee Report – 19th November 2013	Andrew Meehan	Enc. 11	To note	
Trust Board Risks	Bryan Jackson	Enc. 12	For Discussion	
Board Committees & ad-hoc Groups not covered elsewhere				**12.00**
Remuneration Committee – 30th October 2013	Bryan Jackson	Verbal		
Items for Executive Question Time/ CEO Bulletin				
Any Other Business				**12.15**
Date and Time of Next Meeting Wednesday 29th January 2014 Trust Board Meeting				
Exclusion of the Press and Public The Board is asked to resolve 'that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.'	Chairman			