The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Trust Board Meeting
held in public on Wednesday 18th December 2013 in the Boardroom

Present:
Trust Board
Dr Bryan Jackson, Chairman (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Interim Director of Nursing & Governance (after First item, Nurse Director Appointment)
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
Mrs Frances Kirkham, Non-Executive Director

In attendance:
Mr Graham Bragg, Deputy Chief Executive
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development

ACTION

12/13/1522 **Apologies and welcomes**
Apologies were received from Ms Elizabeth Mountford

12/13/1523 **Introductions & Welcome**
The Chairman reported that the interview panel wished to recommend Helen Shoker as Director of Nursing, subject to final paperwork. This was agreed unanimously and Mrs Shoker was invited to join the meeting in her capacity as Interim Director of Nursing.

12/13/1524 **Declarations of Interest**
No other Declarations of Interest than those registered previously.

12/13/1525 **Minutes of the Trust Board meeting held on 27th November 2013**
The minutes were approved as a correct record.

12/13/1526 Action Points

The action notes were updated (see separate sheet).

12/13/1527 Chairman's & Chief Executive's Update

- Jo Chambers reported that she felt warmly welcomed and had benefited from some of the Trust's Christmas activities. JC has spoken with Monitor who had set out their expectations via the new regulatory requirements such as exception reporting and their approach to triangulating information on trusts from other areas. Monitor welcomed the positive feedback on staff appointments.
- JC had met with CQC local team and the Trust will get a visit before the end of March under transitional arrangements. The issues of paediatric facilities will not be resolved at the point of such a visit.
- JC had attended a meeting of CEOs which had focused on the Better Care Fund which looks at continuity of care and emergency care.
- NHS had issued guidance on funding for new models of care and Monitor will issue new guidance, and the final elements of the Health & Social Care Act were being wrapped up. All of this will need to be taken account of during strategic planning.
- BJ reported that he wanted significant NED focus on strategic planning. The New Year would face challenges – for example patient feedback on appointments and after care remaining less good than the clinical care.

12/13/1528 Medical Director's Report

AP presented the Medical Director's Report.

The Board noted the update.

12/13/1529 Medical Staff Committee Update Report

JC presented the Medical Staff Committee (MSC) report following the MSC meeting held on the 22nd November 2013.
GB drew particular attention to the red line in place to support control of infection where doctors were now supportive. The mood was felt to be much more positive than it had been a year ago.
AM had spent time in Spinal House looking at how long it took to get letters out and advised that this was a very disjointed process which would be aided by digital dictation. AP confirmed that there were significant time delays which may also be ameliorated by both digital dictation and electronic discharge letters to GPs.
AMe asked about patients coming from the Middle East and AP amplified that the Trust had a middle man working to bring patients from the Middle East.
BJ asked that the work on administration issues be fed back to MSC. **It was agreed that AM write to Ronan Treacy to confirm this**.

The Board noted the update from MSC.

12/13/1530 **Nursing Staff Report**

HS presented the Nursing Staff Report and highlighted the following:
The new style report represents the whole nursing team and as the report had been tabled, it was asked that Directors read and feed back any comments to HS.

HS drew attention to the leadership development work that was underway.

GB reminded the Board that the report was the opportunity for nursing staff to comment directly to the Board. HS advised that the report had been tabled late because she wanted to ensure comments from all staff and some had felt themselves too busy.

The Board discussed the changes to CQC monitoring within the Trust and AMe asked that consideration be given to merging the NED link area role into this approach. **HS agreed to review this.**

The Board noted the report.

12/13/1531 **Francis Report**

HS introduced this as a two stage report – the circulated paper provides a refresh on the Francis Report and updates on government and professional body responses. The paper in January would highlight the Trust's response to the recommendations.
HS and JS will draft something for the website to confirm the trust's actions.

The Trust is already considering how to report on nursing staff levels.

Duty of candour will be a major point to consider in January. The fit and proper persons test would be reviewed as would named consultant and nurse information above the bed.

The Trust Executives have led work teams and those aspects of the recommended actions which apply to the trust will be detailed in January.

TS suggested that the Trust continue to tie activity to Francis recommendations. TP suggested that the response needed to be very clearly ROH's not just in response to Francis. TP suggested that the trust publish and publicise its work in this arena in a very public way – giving information to patients.

FK commented that the very nature of the Francis report was going to necessitate a change of culture and gave the example of her participation in a discussion on duty of candour. This may even need to be reinforced in terms and conditions for staff. AC commented that the organisation development strategy would need to include these things.

TP felt that cultural change was a lengthy process, time consuming and expensive and had to be done professionally. AP commented that he remained frustrated that not all consultants did post-operative ward rounds and he was championing change, but it was an uphill battle.

BJ gave examples of behaviour change work he had experience of elsewhere as did TP and AMe and all agreed this was a huge challenge.

1. Publish a statement on the Trust intranet site by the end of December 2013, with quarterly updates thereafter
2. Publish a statement on the internet for staff, with quarterly updates thereafter
3. Publish a press release
4. Provide an action plan to measure progress and outcomes
5. Provide a quarterly progress paper to Trust Board and Board of Governors
6. Incorporate all the specific actions into the day to day business of the organisation, for example explicit reference to actions within Governance Committee, Directorate Team, ward and department team meetings to support transference of learning
7. Incorporate the actions into Care Quality Commission activities across the organisation
8. Regular communication across the organisation
9. Share plans with the Clinical Commissioning Group and other stakeholders, such as members
10. Use NHS Change Day 2014 to hold an 'I commit' ROH staff event

The Board approved the recommendations

Strategy and Organisation Development

12/13/1532 **Presentation of Draft Timetable/Framework**

JC presented her indicative suggestions for timetabling strategic planning. The first element was the currently agreed strategic framework.

JC then presented a timetable which covered a six month period to June 2014 and included workshops fro the Board and Council of Governors. The timetabling of the internal 2 year business planning process was outlined with an idea of work to run

strategic thinking in parallel but with reconciliation points along the way.

AMe queried the agreed strategy objective which determines the Trust as independent – was this fully tested as in the best interest of the patients? BJ commented that this had been discussed at length and had been agreed, but if the strategic planning indicated this direction was not right, then things may be modified. This allowed the first choice vision to be tested. TS felt that the word independent could be interpreted in a number of ways. If independence compromised patient care that would be wrong.

TP felt Board and NED involvement should be from the beginning. This allows full discussion about how radical we want to be, what metrics sit behind the objectives and then what strategy should be. TS agreed to early involvement as did FK and AMe.

BJ suggested a workshop in January. JC felt that context setting in advance would be helpful – both internal and external. TP felt a fact pack would be helpful, with SWOT, PESTLE and market analysis. AMe felt an extrapolation from today's base would be helpful. Identifying what questions the strategy has to address would come out of the first session.

TS felt that the qualitative elements of patient care must be accounted for in this process.

FK felt that a reference group of governors was potentially divisive. BJ suggested JC touch base with the lead governor.
Workshop to be held after January Board.

Performance Management/Assurance Reports

12/13/1533 **Corporate Performance Report & Programme Board Update**

AM gave a presentation on activity recovery work to date. Admitted activity in November had risen and was the highest since October 2011 (when BMI ward was open off site with use of an extra theatre). Day case activity was highest since March 2011. Inpatient activity had risen but remained below plan. Patients continued to be treated in order of their time on the waiting list but at a faster rate than in previous months.
AMe noted the very significant improvement in large joint performance.

Under the rectification plan, year-end outturn for elective inpatients will be 91 cases below plan but for day case will be 460 above plan.

The plan to year end was shown, and it allowed for the closure of three theatres for three weeks (oncology and small joints were primarily affected by this and have Saturday lists to offset impact). Additional ward capacity is being opened (10 beds on Ward 7) to accommodate the growth in inpatient activity – only at the planned heights in the past when BMI was open. Additional weekend support from imaging would help secure shorter length of stay for patients in over the weekend.

PA indicated that the trust would have income near to planned levels but additional costs would be incurred. If the rectification plan is delivered the planned year outturn will be very close to target.

BJ asked what the strain on the staff was. AM it was tough – ADCU had to be open three nights. AM had to chair a bed session and ensure discharges took place to accommodate a throughput of patients. BJ said this tension in the system was valuable for asking people what the issues were and this would be useful for the future. BJ asked if people felt they could just make sensible changes and was advised that they were not used to this yet. HS gave an example of how the matron in ADCU had been a good role model and helped her team and how other matrons had helped at the end of the evening. Learning from the day had been applied.

AMe commented that there must be a temptation to get to the end of March and breathe a sigh of relief, but let the same happen again. AM felt that this must not happen and that pace and good planning should make things smoother. HS referred to a trust which was pulling as much elective activity into the first two quarters in order to allow for winter pressures.

AP commented that the opening of ADCU had been a factor as had the earlier failure to enforce six weeks' notice of holiday. Spinal surgeons all going to conference at the same time was also something that would in future be challenged.

TP felt that the case mix change should be factored in to strategic planning.
TS wondered if the re-branded NHS change day could become a celebration and thank you for staff as it was to be in March.

AM updated the Board on the move of paediatrics for 6 months.

The Chairman asked that the Board's thanks be recorded and passed on to staff.

PA updated the Board and highlighted a trend of reduction in complaints. The workforce performance had resulted in an amber rating- the first time for several months when this has not been red. AC reminded the Board that appraisals would in future be linked to pay progression – in year one as simple as an appraisal having happened, later it would be linked to the individual's performance as included in the appraisal.

AP advised that ROH was ahead of many organisations in terms of doctor appraisals. TP felt that sickness was high, but turnover was quite low compared to businesses.

The surplus was slightly below plan and outturn was probably on target. CIPs remained behind plan but may be mitigated to some degree by reduction in fines, for which provisions had been made.

AMe asked for a P&L and Balance sheet. PA said this would be produced quarterly, but was available monthly.

The Board noted both the CPR report and the Programme Board update report.

12/13/1534 **Patient Safety Report**

HS introduced the Patient Safety Report and highlighted the following:

- HS had shared information on SIRIs and incidents with medical staff and staff welcomed continuation of this. BJ asked for assurance that the screensaver on medication errors were not seen by patients.
- Pressure ulcers had occurred and BJ reported that he had seen an article which showed whether tissue was vulnerable to ulcers.
- VTE targets had been met
- Falls data was under review as the re-assessment figures , which are the most appropriate for ROH, were still less than 90%.
- ROH remained at the top of the league table with a net promoter score of 90%.
- Ward KPIs were not yet available at this point in the cycle.

The Board noted the Patient Safety Report

12/13/1535 **ROH Emergency Plan**

AM introduced the report which contains a self-assessment within which 2 areas are red- complete site evacuation plan and management of patients and relatives. Executives on-call will be given training in early 2014. The plan will be further reviewed in 2014.

BJ commented that assurance would only come from putting this into practice and AM commented that the fire at the hospital in 2012 was an example and decants of wards do test business continuity.

AMe asked how the plan linked to risk, as it clearly does, and AM replied that as yet the connections had not been made, but they would be.

The Board noted the self-assessment for emergency planning readiness.

12/13/1536 Clinical Governance Committee Report

TS circulated the report on the work of his committee.
The Committee workplan will be considered in January.
TP asked when the trust would go above the 75% threshold and AP advised that it was now at 83% and TS added that there will be work done in theatres to improve things still further.
The Board noted the report

12/13/1537 Audit Committee Report

AMe presented an update report following the last Audit Committee meeting held on the 19th November 2013.
He updated that the Internal Audit contract had been tendered and two bids had been received. The recommendation was that Baker Tilley continue.

The Board noted the report

12/13/1538 Trust Board Risks

The likelihood and consequence ratings at the start needs to be changed.

This item need not come back to future meetings.

Board Committees & ad-hoc Groups not covered elsewhere

12/13/1539 Remuneration Committee

The report of the committee concerned the proposed appointment of Mrs Helen Shoker as Director of Nursing and Governance.

12/13/1540 Items for Executive Question Time/CEO Briefing

- Possible CQC visit Jan-March
- Better Care Fund
- Red Line in Theatres
- Treating the patients we promised to treat
- Francis report
- Appraisals are a priority

- Emergency plan
- Thanks to staff for their work.

12/13/1541 <u>Any Other Business</u>
None

12/13/1542 <u>Date and Time of Next Trust Board Meeting</u>
Trust Board meeting to be held on Wednesday 29th January 2014 at 8.30 am in the Board Room (to be followed by a workshop)

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.

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 16th DECEMBER 2013

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
07/13/1446	Spinal Deformity Presentation GB to review the situation with outcomes data.	GB	September 2013		CD recommendation is for an off the shelf widely used system – Bluespeare. Noted that this may be used across other services. COEC is following this up
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
07/13/1447	Proposal for Option Appraisal Commercial Tissue Requests Process to be fully explained to theatre staff.	ED	Sep 2013		Outstanding. AP to contact ED and update in January 2014.
11/13/1517	.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.	TS/FK/AP	January 2014	✓	Meeting held and recommended electronic ways of delivering TBALD material. AP to develop.
11/13/1519	Business Planning Timetable 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

Date of Trust Board: 29 January 2014 **ENCLOSURE NUMBER:**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Chief Executive's Report**

SUMMARY

To update the Board on matters not covered elsewhere on the agenda

IMPLICATIONS

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

The Board is asked to endorse the Chairman's approval of funding for the works to the paediatric facilities on Ward 11.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To brief the Board on matters not covered elsewhere on the agenda
Recommendation	The Board is asked to note the contents of the report and discuss items as appropriate. The Board is asked to endorse the Chairman's approval of funding for the works to the paediatric facilities on Ward 11.

This CEO report provides Board members with an overview of key issues in relation to the Trust and new policy guidance.

1 Care Quality Commission (CQC) unannounced inspection

A Care Quality Commission (CQC) unannounced inspection took place on 14 and 15 January 2014 as part of its scheduled work programme. The full report will be available to the Board when received.

The CQC found the Trust to be compliant in the four domains that were being particularly inspected, namely:

- Outcome 4: Care and welfare of people who use services
- Outcome 7: Safeguarding people who use services from abuse
- Outcome 14: Supporting workers
- Outcome 16: Assessing and monitoring the quality of service provision.

This represents a considerable achievement for the Trust and an improvement from the last inspection. The inspection was conducted in a very constructive manner and Trust staff responded well and engaged fully in the process.

It was particularly pleasing to achieve full compliance in respect of the transitional arrangements for paediatric services pending completion of the improvement works on Ward 11, which had previously been non-compliant.

Areas for continuing improvement will be considered upon receipt of the full report.

2 Approval of works for the Paediatric Ward 11

The previous CQC inspection raised a number of concerns with the Paediatric layout and facilities on Ward 11, a project team was established and agreed a series of re-modelling works to the ward area, this included the infilling of the balcony area and the building of two small extensions, one of which would incorporate a new Playroom facility.

The Trust engaged a professional team and developed drawings/documentation which was tendered to a selected number of contractors. A tender evaluation recommended Sandy and Co Limited as our preferred supplier, with the total scheme costing £413,523 + VAT. Funding for the works was identified from the 2013/14 capital programme together with £80,000.00 from the 'Project Playroom' charity fund.

To avoid any further delay in the project the Chairman, with advice from the Chair of the Audit Committee, approved the placement of an order for the works on behalf of the Trust Board. The works commenced in January 2014 and is due to complete in June 2014. **The Trust Board is asked to note and endorse the Chairman's approval of funding for the works to the Paediatric facilities on Ward 11.**

3 New strategic planning guidance from Monitor

Monitor has issued guidance to all NHS Foundation Trusts in relation to meeting the needs of patients through improved strategic planning (www.monitor-nhsft.gov.uk/strategicplanning) and specific guidance for the Annual Planning Review 2014/15 (www.monitor-nhsft.gov.uk/APR1415guidance).

Monitor's guidance is based on the findings of a recent review commissioned by Monitor and undertaken by PWC which concluded that there are significant opportunities to improve strategic planning at the majority of foundation trusts. The guidance sets out the minimum steps considered to be necessary to develop a robust strategic plan.

The Executive Team met to consider the new guidance and have developed a suggested approach and programme of work for further discussion and development with the Board.
Key changes include the need to ensure sufficient and appropriate engagement with key stakeholders within the local health economy; more detailed analysis and risk assessment, supported by options, initiatives and a delivery plan. Additionally, there is a suggested self-assessment tool to support the strategic planning process.

The submissions will occur in two phases:
Phase 1 – 4 April 2014 – for review by Monitor April to May 2014
Phase 2 – 30 June 2014 – for review July to September 2014

Phase 1 will concentrate on the next two years operational plan with some strategic overview, and phase 2 will set out a five year strategic plan.

The Board has a workshop scheduled on 29 January 2014 to agree the process, context and baseline information.
Some resources will be required to support the Trust's strategic planning.

In the short-term this is likely to be bespoke support and/ or backfill time because of the time limits for completing the work, however, over the longer-term the guidance suggests that foundation trusts are expected to make dedicated resources available to support strategic and commercial development.

Non-recurring reserves will be used to support the work between now and the end of March 2014 and a proposal will be put together for consideration from April 2014. The risks for the Board to consider are as follows:

- Insufficient Trust capacity to deliver a comprehensive strategic review in the timescale set out. This will be mitigated by utilising non-recurrent reserves to buy-in additional support as required.
- Disruption to Board membership and change of leadership resulting loss of continuous input to developing strategy. This will be mitigated by a structured programme of Board workshops, involvement and ownership of strategy development.
- Lack of engagement from key stakeholders during the process resulting in an inability to evidence commissioner and patient buy-in to our proposed strategic direction. This will be mitigated by developing an inclusive approach to strategic planning that is grounded in realistic assumptions.
- Local Health Economy financial constraints and higher priority issues resulting in lack of investment in services provided by the Trust. This will be mitigated by developing a clear understanding of the needs of the local population and providing evidence based outcome data which demonstrated the benefits to patients of treatment in a specialist orthopaedic centre.

4 Board Governance Reviews – Monitor's Consultation

Monitor has issued new proposals which recommend that each foundation trust Board should obtain an external review every three years of the way they are run by their Board.

Monitor authorises foundation trusts on the basis that they are well-led. Once a trust has been issued with a licence, the board is responsible for maintaining this standard of corporate oversight.

Monitor is consulting on new guidance that provides trusts with expert advice on the structure and steps required to enable them to conduct an effective review of their governance.

The proposals set out in the new guidance include:

- Board reviews should be conducted every three years - this is consistent with good corporate practice;
- Reviews should be robust, in-depth and tailored to cover the specific circumstances of a board; and
- Independent reviewers should carry out these reviews to ensure objectivity and provide maximum assurance.

Monitor's guidance incorporates and builds on its existing quality governance framework, which is used widely by NHS providers. The four elements of the framework are:

- Strategy and planning
- Capability and culture

- Processes and structure
- Measurement

The consultation ends on 7 March 2014 and details are available on Monitor's website. (http://www.monitor.gov.uk/sites/default/files/publications/GovernanceReview14Jan13.pdf)

The Company Secretary will prepare a response to the consultation on behalf of the Board and any comments should be sent to her by the end of February please.

5 Engagement with the Prince's Trust

The Trust has engaged with The Prince's Trust to support a scheme to give local young people the opportunity for work placements and basic work skills training.

In partnership with University Hospitals Birmingham NHS Foundation Trust, it is anticipated that we will welcome a cohort of 10 -15 young people aged between 18 and 25 in March 2014.

The Trust has an opportunity to support the local community as a significant employer in this area, help young people to develop skills and promote the wide variety of career options within the NHS.

Conclusion

The Board is asked to note the contents of this report and discuss as appropriate.

Recommendation

The Board is asked to endorse the Chairman's approval of funding for the works to the paediatric Ward 11.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Medical Director's Report to Board
Jan 2014

During the month of January, in addition to my role as Medical Director, I have performed the following activities.

Meetings

A. External

Strategic Orthopaedic Alliance
Phone conference

B. Internal

Enhanced Recovery Project Group

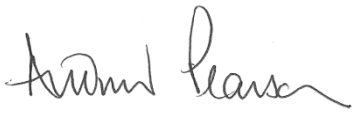
One to One Meetings

CD for Out Patients and Support Services
Director for Nursing & Clinical Governance
Deputy Medical Director

Items to Note

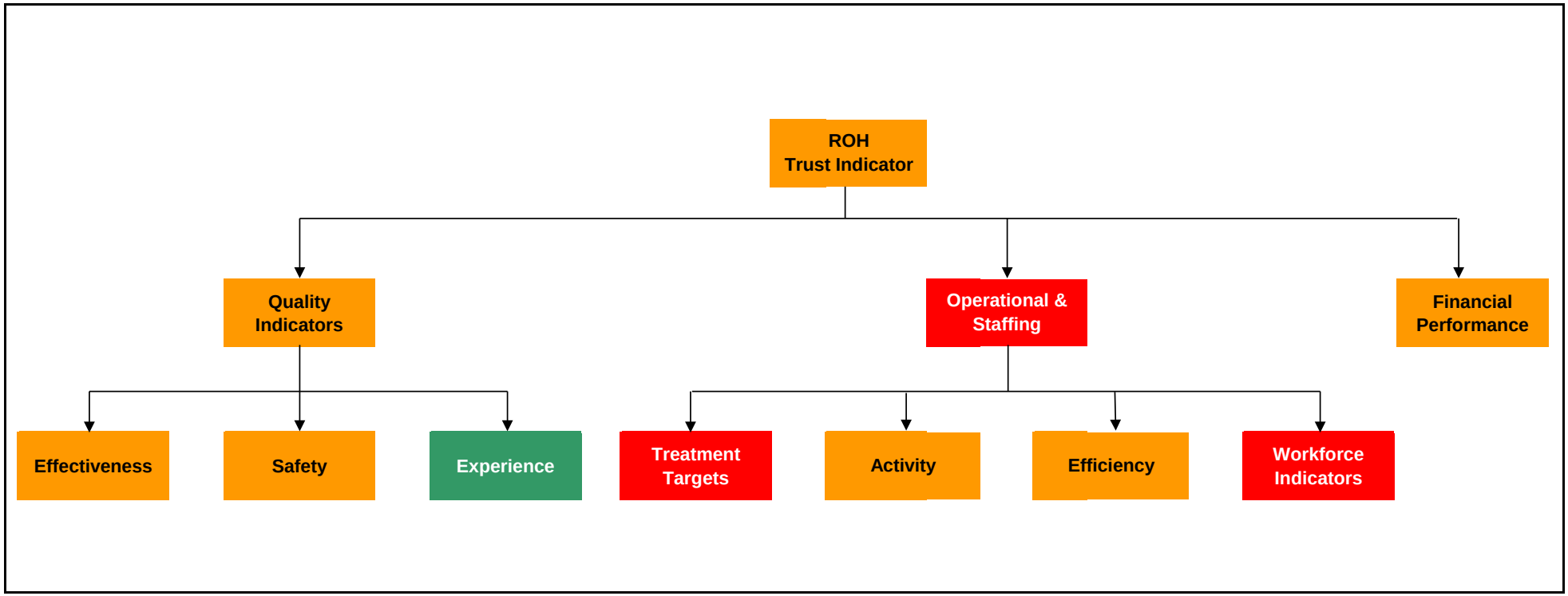
Case Manager - Investigation

New Consultant Anaesthetist commenced – Dr William Rae



Andrew Pearson
23rd January 3014

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



Quarterly Detailed Report

Executive Summary as at December 2013

Headlines

- The Trust has failed the Admitted Referral to Treatment Target for the month and the quarter. The 62 day cancer target was failed in the month but it is anticipated that the quarter target will be achieved
- For the month of December the Trust made a **surplus of £81,000** compared to a planned **deficit of £36,000**.
- Inpatient activity was below original plan but ahead of that expected as part of the rectification plan

Monitor Compliance Framework Targets	December 2013 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.12%	95.33%	0	6
Referral to treatment time - Admitted %	90%	85.18%	85.18%^	1	6
Referral to treatment time - Incomplete Pathways %	92%	92.12%	93.43%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	66.67%*	85.7%*	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)	1	1	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating	Minor CQC action regarding Outcome 4, Regulation 9 – Care and Welfare of People who use services. CQC review in January confirmed full compliance.				

* 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.
^ The performance for failed RTT targets is based upon the lowest month performance as per Monitor Guidance

Indicative Monitor Governance Risk Rating	**Green**
Indicative Monitor Continuity of Service Rating	**4**

Key Trust Targets		December 2013 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	3		3
	Complaints	<=12	7		4
	CQUINS	100%	90%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<400	574		6
	Incomplete 14 - 18 Week Waiters	<450	711		6
	Total Discharged Elective Patients vs Plan	100%	93%		7
	Unused Theatre Sessions	<44	0		8
	Sickness	3.7%	5.1%		9
Financial	Surplus	£2,125k	£1,599k		10
	CIP	£2,501k	£2,039k		10
	Agency Expenditure	£91k	£109k		11
	Locum Doctor Expenditure	£46k	£82k		11

Trust Summary

The Trust is Amber rated for December. This is consistent with the previous month. Concerns relating to treatment times, workforce, finance and quality exist.

The 18 week Referral to Treatment targets for Admitted patients has been failed for both the month and the quarter. This is due primarily to a drop in activity in August and September which corresponded with the highest number of patient pathways followed by high numbers of patients treated in November (a higher proportion of which were greater than 18 weeks). This "wave effect" has continued in December. In addition the backlog of patients waiting over 18 weeks has increased from 640 to 711 at the end of December.

The 62 day cancer target was failed in the month but it is anticipated that the quarter target will be achieved. There was one 52 week wait patiens remaining at the end of December. Unfortunately there was 1 cancelled operation which the patient was not readmitted within 28 Days.

The overall rating for quality remains amber due to 1 case of CDIF, 6 inpatient falls, 3 SIRIs and 1 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. Additional detail is provided in the Quality Report.

Workforce has deteriorated in December to red primarily due to the rise in sickness levels to 5.1% which is the highest level in 2013. Appraisal levels have improved significantly in December. Concerns about training levels still remain. The number of staff employed has slightly increased and the percentage of vacancies has remained fairly constant for the past quarter at c5%.

For the month of December the Trust made a surplus of £81,000 compared to a planned deficit of £36,000. The Trust therefore has a year to date surplus of £1,599,000 against a plan of £2,125,000 which is a shortfall of £526,000. 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).

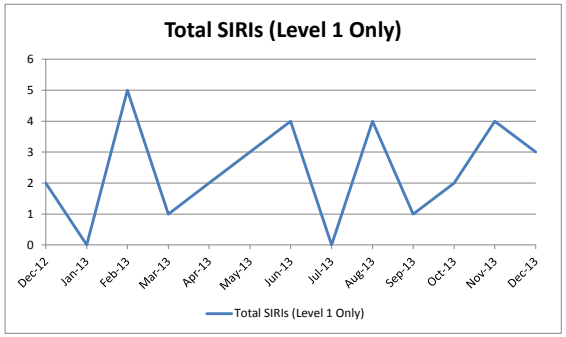
Inpatient activity was below original plan but ahead of that expected as part of the rectification plan and is in the context of 3 theatres being closed for a 3 month period in the month. Rectification plans are being implemented.

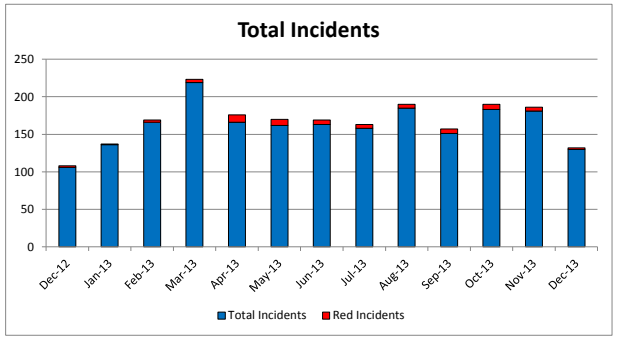
Quarterly Detailed Report
Safety Indicators as at December 2013

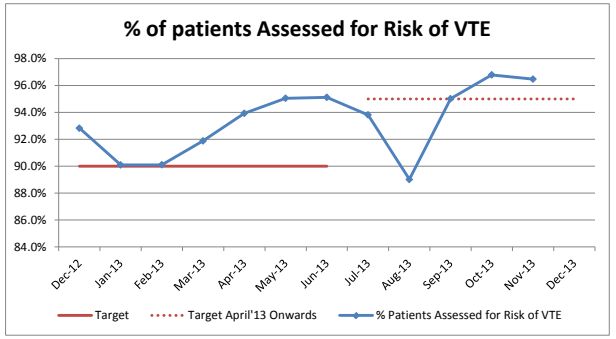
Headlines

- There were 6 reportable falls in the month
- There were 3 SIRIs in the month
- The number of drug errors in the month is significantly below previous levels

	Monitor	National	CQC Standard		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-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	5	1	2	3	4	0	4	1	2	4	3	23
			4,16	SIRI per 1000 bed days	0.84	0.00	1.36	0.34	0.62	1.12	1.32	0.00	1.27	0.36	0.62	1.39	1.01	0.83
			4,16	Total Incidents	106	136	166	219	166	162	163	158	185	151	183	181	130	1479
			4,16	Incidents per 1000 bed days	44.41	46.31	56.23	74.19	51.83	60.23	53.95	47.07	58.96	54.12	56.82	62.70	43.61	53.29
			4,16	Red Incidents	2	1	3	4	10	8	6	5	5	6	7	5	2	54
			9,16	Total Drug Errors	15	17	19	66	31	21	15	15	23	18	21	16	8	168
			9,16	Drug Errors per 1000 bed days	6.28	5.79	6.44	22.36	9.68	7.81	4.96	4.47	7.33	6.45	6.52	5.54	2.68	6.05
		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	92.83%	90.10%	90.11%	91.88%	93.94%	95.06%	95.13%	93.82%	89.02%	95.02%	96.80%	96.48%		94.46%
			9	Incidence of Hospital Related VTE	0	0	1	1	0	0	1	1	0	1	1	0	1	5
			4	Patient Falls - Inpatients	8	0	6	7	4	7	6	4	9	2	4	8	6	50
			4	Patient Falls per 1000 bed days	3.35	0.00	2.03	2.37	1.25	2.60	1.99	1.19	2.87	0.72	1.24	2.77	2.01	1.80
			4,16	% Harm Free Care	92.86%	97.22%	93.26%	93.26%	97.89%	96.19%	97.94%	98.90%	97.85%	98.70%	97.00%	98.90%	97.50%	97.50%







Safety Commentary

The VTE target was achieved for November. Note this is reported 1 month in arrears

There have been 3 SIRIs reported in December; compared to 5 reported during the previous month

There has been a slight decrease in incidents reported across the Trust with 130 incidents reported during December, compared to 181 incidents reported during November 2013.

14 Incident forms were received for the month of December categorised as (adult) falls, slips or trips. However, following the review of the incidents only 6 of the 14 were identified as reportable falls.

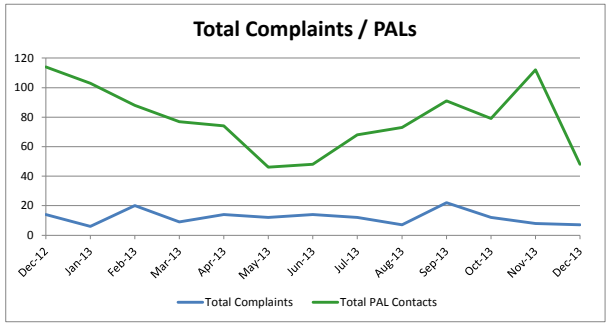
Additional information is available in the Quality Report

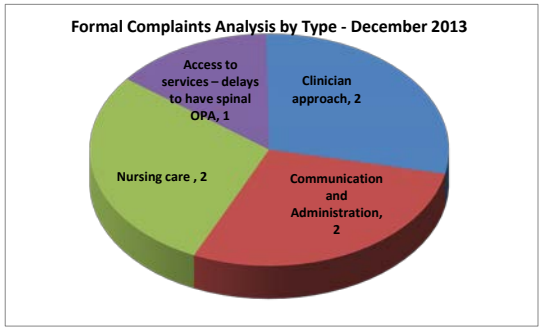
Quarterly Detailed Report
Experience Indicators as at December 2013

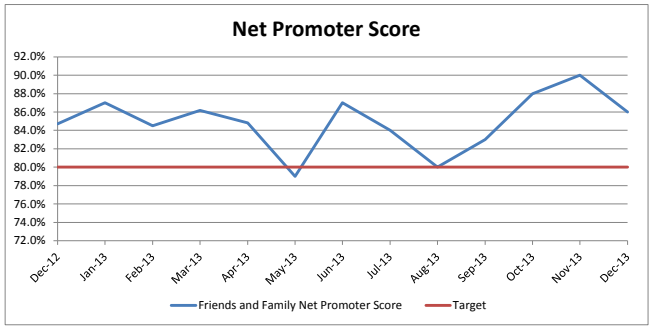
Headlines

- Both complaints and PALs contacts reduced in month
- The Food - Real Time Patient Survey score reached an all time high
- The Friends and Family Score fell from Novembers high

	Monitor	National	CQC Standard		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	13/14 Full Year Position
Experience			17	Complaints to Complements Ratio	1:33	1:63	1:20	1:46	1:25	1:25	1:29	1:32	1:46	1:14	1:34	1:16	1:63	**1:28**
			17	Total Complaints	14	6	**20**	9	14	12	14	12	7	**22**	12	8	7	**108**
			17	Complaints reverted to informal <48 hrs	0	0	1	0	1	0	1	1	3	3	0	1	0	**10**
			17	Formal	14	6	19	9	13	12	13	11	4	19	12	7	7	**98**
			17	Complaints per 1000 bed days	**5.87**	2.04	**6.78**	3.05	4.37	4.46	4.63	3.57	2.23	**7.89**	3.73	2.77	2.35	**3.89**
			17	Total PAL Contacts	**114**	**103**	**88**	**77**	74	46	48	68	73	**91**	**79**	**112**	48	**639**
			17	PALS Contacts per 1000 bed days	**47.76**	**35.07**	**29.81**	**26.08**	**23.11**	17.10	15.89	20.26	**23.27**	**32.62**	**24.53**	**38.80**	16.10	**23.02**
			17	Total Compliments	456	380	404	414	347	295	404	386	320	298	409	124	440	**3023**
			17	Compliments per 1000 bed days	191.03	129.38	136.86	140.24	108.35	109.69	133.72	114.99	101.99	106.81	127.00	42.96	147.61	**108.93**
				Food - Real Time Patient Survey	66.07%	75.00%	69.75%	77.54%	77.50%	85.43%	86.67%	90.48%	92.40%	90.00%	90.60%	92.00%	96.60%	**89.08%**
			17	Friends and Family Net Promoter Score	84.73%	87.00%	84.50%	86.18%	84.8%	79.00%	87.0%	84.0%	80.0%	83.0%	88.0%	90.0%	86.0%	**80.00%**







Experience Commentary

COMPLAINTS

7 complaints (all formal) received in the month slightly down on last month's number of 8 which represents a reduction of 13% on last month.

Number of complaints responded to in agreed timescale in December is 3/4 or 75% which is slightly below the KPI of 80%. The 1 complaint that is overdue was as a result of a prolonged delay by a Consultant to provide feedback despite repeated escalation within the directorate.

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

Clinician approach x 2 ; Communication and administration x 2; Nursing care x 2; Access to services – delays to have spinal OPA

PALS:

PALS contacts down this month to 48 from 112 (a decrease of 57%) which is normal for the time of year. The only real area of concern raised this month in any volume (6) was queries regarding progress/confirmation of care and treatment plans for spinal.

Numbers of PALS received by Directorate:

Corporate	6
Small Joint	4
Large Joint	7
Oncology	7
Clinical Support	6
Paediatrics	3
Spinal	15
Theatres	1
Total	**48**

COMPLIMENTS:

Normal levels of reporting resumed this month which is pleasing to see.

Number of Compliments by Directorate:

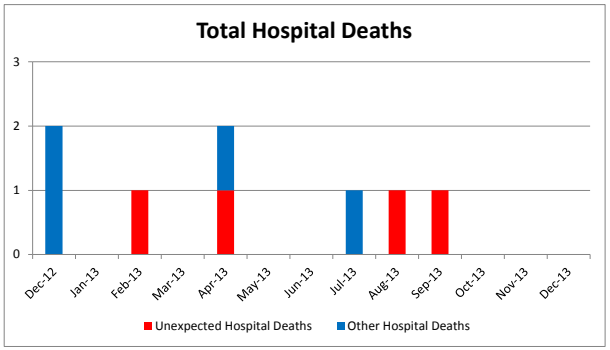
Clinical Support	8	Spinal	99
Small Joint	3	Theatres	71
Large Joint	157	Corporate	4

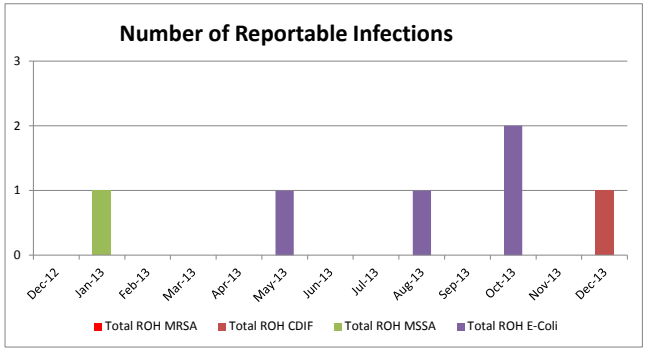
Quarterly Detailed Report
Effectiveness Indicators as at December 2013

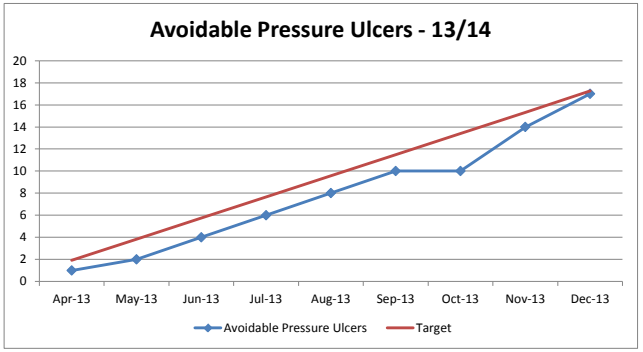
Headlines

- There were no deaths in month
- There was 1 case of CDIF
- There was 1 avoidable Grade 3/4 pressure ulcer

	Monitor	National	CQC Standard		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	13/14 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	2	0	1	0	2	0	0	1	1	1	0	0	0	5
			4,18	Hospital Deaths per 1000 bed days	0.84	0.00	0.34	0.00	0.62	0.00	0.00	0.30	0.32	0.36	0.00	0.00	0.00	0.18
			4,18	Unexpected Hospital Deaths	0	0	1	0	1	0	0	0	1	1	0	0	0	3
				Other Hospital Deaths	2	0	0	0	1	0	0	1	0	0	0	0	0	
			8	MRSA % Screened	149.7%	138.7%	135.5%	114.3%	129.56%	129.13%	140.59%	145.53%	127.51%	146.00%	132.00%	114.30%	100.10%	127.14%
	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	1	1
			8	Total ROH MSSA	0	1	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	0	0	0	1	0	0	1	0	2	0	0	4
			8	HCAIs not attributable to ROH	2	0	1	0	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	1	1	0	2	1	5
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	3	5	5	5	1	1	2	2	1	1	0	2	2	12
			4	Avoidable Pressure Ulcers per 1000 bed days	1.26	1.70	1.69	1.60	0.31	0.37	0.66	0.60	0.64	0.72	0.00	1.39	1.01	0.61







Effectiveness Commentary

There have been no deaths during December.

There was 1 Grade 3 (avoidable) pressure ulcer in December. This was considered avoidable because although the patient is very complex and has advanced dementia, the stepping up onto a specialist mattress was not undertaken as quickly as it could have been.

There was 1 case of CDIF within the Trust which was not avoidable

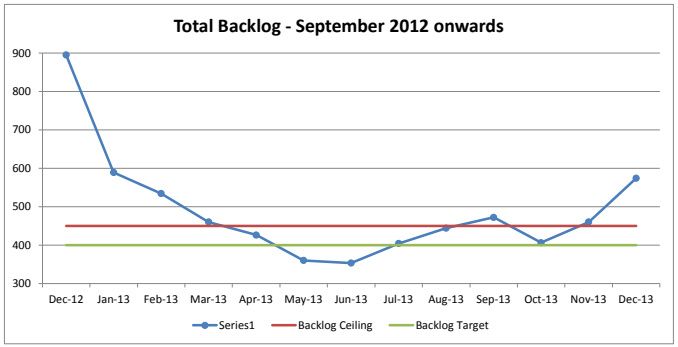
Further information is available in the Quality report

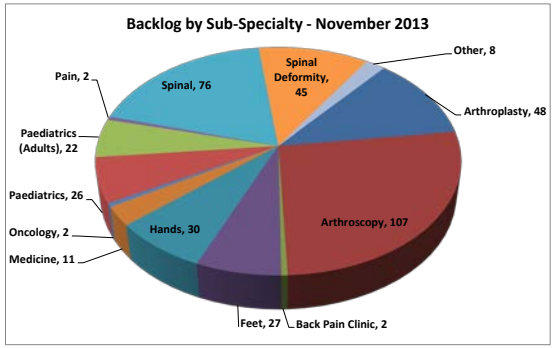
Quarterly Detailed Report
Treatment Targets as at December 2013

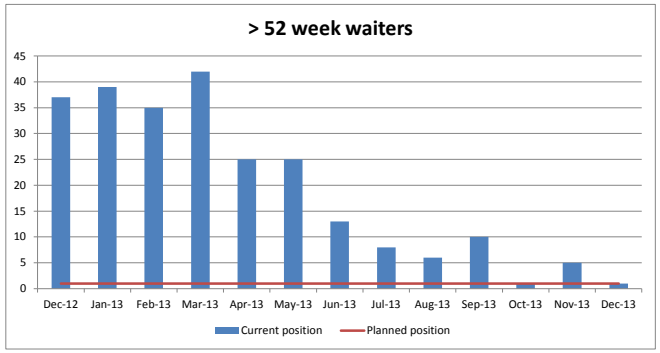
Headlines

- The Admitted Treatment Target has been failed for the past 2 months
- The 62 day cancer target was failed for the month however it is likely that the Q3 overall target will be achieved
- There was 1 cancelled op not readmitted within 28 days

	Monitor	National	CQC Standard		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	13/14 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	37	39	35	42	25	25	13	8	6	10	1	5	1	1
	M	N	4	Referral to treatment time - Non Admitted %	95.09%	95.03%	95.07%	95.18%	95.24%	95.08%	95.35%	95.29%	95.78%	95.42%	95.24%	95.13%	95.12%	95.30%
	M	N	4	Referral to treatment time - Admitted %	90.59%	90.42%	90.37%	90.00%	90.22%	90.39%	91.37%	92.05%	90.33%	90.19%	90.09%	88.12%	85.18%	89.82%
	M	N	4	Referral to treatment time - Incomplete Pathways %	90.52%	90.68%	91.09%	92.01%	92.77%	94.36%	94.77%	94.18%	93.71%	93.34%	94.01%	93.33%	92.12%	93.62%
			4	Non admitted Backlog - Pathways waiting >18 wks	438	221	199	187	155	121	110	131	159	163	160	167	296	296
			4	Admitted Backlog - Pathways waiting >18 wks	457	368	335	273	271	239	243	273	285	309	246	293	278	278
			4	Total Backlog - 18 week pathways waiting >18 wks	895	589	534	460	426	360	353	404	444	472	406	460	574	574
			4	Incomplete 14 -18 Week Waiters	717	610	629	535	388	411	504	477	630	654	565	640	711	711
	M	N	4	Cancer 2 week (all cancers)	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100%*	100.0%
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.0%	100.0%	100.0%	100.0%	93.33%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100%*	99.04%
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100%	100.0%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.0%	100.0%	100.0%	100.0%	90.00%	100.00%	66.67%	80.00%	100%*	83.30%	100.00%	85.70%	66.7%*	87.72%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	100.00%	99.98%	100.00%	100.00%	99.24%	100.00%	99.52%	99.20%	99.09%	99.70%	99.43%	99.36%	99.03%	99.37%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	1	0	0	1	2
			1,21	Data Quality on Ethnic Group - Inpatients	95.12%	95.20%	95.11%	91.99%	97.64%	95.29%	96.44%	94.86%	95.31%	98.35%	95.65%	95.66%	95.16%	96.00%







Treatment Targets Commentary

Referral to Treatment Time Targets. The Admitted Target has not been achieved in either November of December for the following reasons:-
- There was Increase in the number of patients on combined admitted and non-admitted patient pathways, from previous average of 6,400 in Q1 13/14 to 7,700 in August and September 2013
- We have seen an 11.5% increase in new OP attendances (an additional 1,441 first outpatients above plan at the end of December) and a corresponding 4.5% increase in elective activity this year compared to 2012/13 (mainly DC)
- The position was compounded by a drop in activity in August and September which corresponded with the highest number of patient pathways.
- High numbers of patients were treated in November – the highest since March 2012 a higher proportion of which were >18 weeks. This "wave effect" has continued in December.

62 Day Cancer Waits. We were accountable for 3 patients in total on a 62 day pathway. Of these 3 patients,1 was treated within 62 days, 1 was a complex patient involving 4 Trusts in the diagnostic pathway and resulted in 0.5 breach for ROH, 1 was patient who declined date and wished to wait until after holiday resulting in 0.5 breach for ROH. This means that out of 3 patients we had a total of 1 breach – giving 66.67% in December

Cancelled Operations not Readmitted Within 28 Days. This breach was identified due to the vigilance of a member of the cancelation project team who had been monitoring a patient before their surgery and when they discovered they had been cancelled due to a medical reason, they investigated further. During the investigation they identified that the surgeon had cancelled the patient believing them to be unfit based on a blood result that was subsequently discovered to be an old blood result. Therefore the patient had been fit to proceed and constituted a hospital cancelation. By the time the investigation had concluded it was not possible to schedule the patient a suitable patient in time.

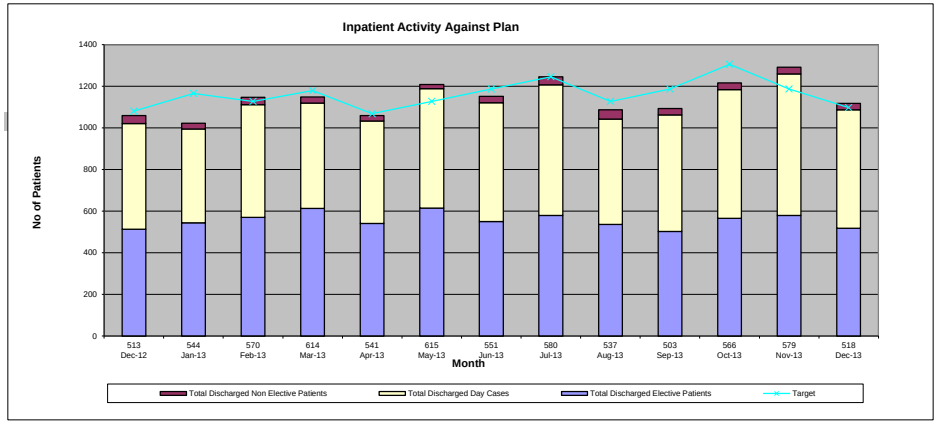
52 Week Waiters. There was one patient waiting more than 52 weeks at the end of December.

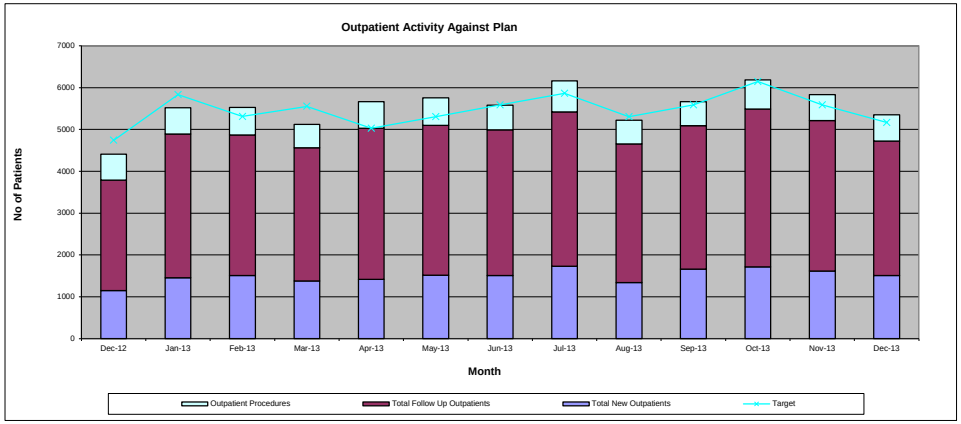
Quarterly Detailed Report
Activity Targets as at December 2013

Headlines

- Inpatient activity was below original plan but ahead of that expected as part of the rectification plan
- Day cases activity continues to over perform (13% in month)
- First outpatient attendances continue to over perform (15% in month)

	Monitor	National	CQC Standard		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	13/14 Full Year Position
Activity			4	Total Discharged Elective Patients	513	544	570	614	541	615	551	580	537	503	566	579	518	4990
			4	Total Discharged Non Elective Patients	39	27	35	29	25	20	30	38	44	30	33	32	31	283
			4	Total Discharged Day Cases	508	451	542	506	493	574	570	627	506	560	618	680	569	5197
			4	Total New Outpatients	1146	1455	1510	1381	1416	1513	1508	1728	1343	1659	1713	1619	1508	14007
			4	Total Follow Up Outpatients	2641	3435	3356	3179	3611	3583	3481	3691	3314	3428	3774	3595	3214	31691
			4	Outpatient Procedures	622	631	662	562	635	662	594	743	560	575	697	618	627	5711
			4	Elective as % Against Plan	94.4%	92.8%	100.5%	108.3%	99.43%	107.1%	91.1%	91.4%	93.5%	83.2%	85.1%	95.8%	92.6%	93.00%
			4	Non Elective as % Against Plan	106.3%	68.2%	91.4%	75.8%	72.4%	54.8%	78.1%	94.3%	120.6%	78.1%	78.1%	83.4%	87.3%	83.06%
			4	Day Cases as % Against Plan	101.5%	83.5%	103.8%	96.9%	100.7%	111.1%	104.8%	109.8%	97.9%	103.0%	103.3%	125.0%	113.1%	107.66%
			4	% New Outpatients Against Plan	94.3%	97.3%	111.0%	101.5%	111.1%	112.5%	106.5%	116.2%	99.8%	117.2%	110.0%	114.3%	115.1%	111.47%
			4	% Follow Up Outpatients Against Plan	91.0%	96.2%	103.3%	97.8%	114.2%	107.4%	99.1%	100.1%	99.3%	97.6%	97.7%	102.3%	98.9%	101.66%
			4	% Outpatient Procedures Against Plan	99.8%	82.3%	94.9%	80.6%	107.6%	106.3%	90.6%	108.0%	89.9%	87.7%	96.7%	94.3%	103.4%	98.18%





Activity Commentary

Inpatient activity was below original plan but ahead of that expected as part of the rectification plan and is in the context of 3 theatres being closed for a 3 month period in the month

Day cases activity continues to over perform (13% in month) which has been a consistent theme for 8 of the 9 months in this financial year.

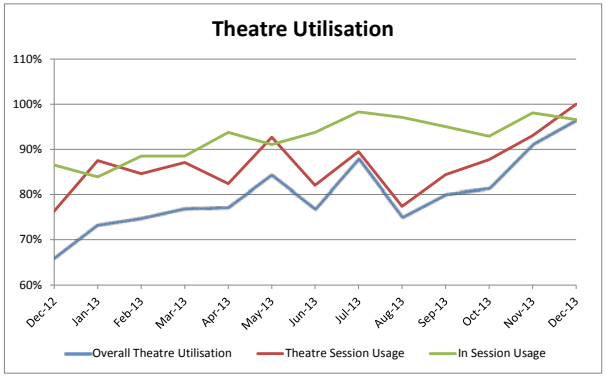
First outpatient attendances continue to over perform (15% in month) which suggests a strong order book

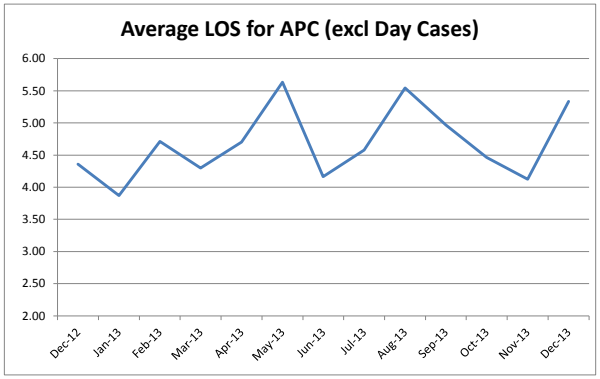
Quarterly Detailed Report
Efficiency Indicators as at December 2013

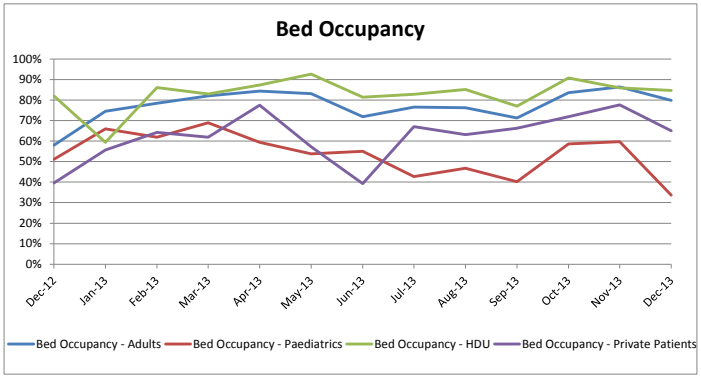
Headlines

- Theatre was significantly higher than the previuos month and December 2012 after accounting for planned theaatres shut downs
- There were 10 on the day hospital cancellations in the month
- Although reduced for the previous month with the exception of paediatrics ward occupancy levels were significantly higher than December 2012

	Monitor	National	CQC Standard		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	13/14 Full Year Position
Efficiency			4	Overall Theatre Utilisation	66.0%	73.4%	74.9%	77.0%	77.30%	84.41%	76.95%	87.98%	75.15%	80.19%	81.51%	91.23%	96.58%	81.68%
			4	Theatre Session Usage	76.30%	87.50%	84.60%	87.07%	82.45%	92.72%	82.09%	89.50%	77.38%	84.42%	87.73%	93.02%	100.00%	85.84%
			4	In Session Usage	86.5%	83.9%	88.5%	88.5%	93.76%	91.04%	93.73%	98.31%	97.11%	94.99%	92.92%	98.07%	96.58%	95.17%
			4	Unused Theatre Sessions	92	57	63	53	76	30	77	50	102	67	61	30	0	233
			4	Number of Cases per Theatre Session	3.45	2.46	3.13	3.11	2.82	3.01	3.08	2.79	2.95	2.91	2.67	3.06	2.93	2.91
			4	Total Cancelled Operations (On Day or Day Before)	95	108	78	52	91	72	63	88	58	62	82	120	84	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	5	4	2	4	5	5	11	14	4	2	11	10	66
			4	% Cancelled Operations by Hospital	0.59%	0.51%	0.37%	0.18%	0.40%	0.43%	0.46%	0.93%	1.36%	0.38%	0.17%	0.90%	0.95%	0.66%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.51	2.63	2.30	2.59	2.76	2.44	2.53	2.24	2.53	2.36	2.32	2.34	2.28	2.48
			4	Pain Review-To-New Ratio	3.83	3.65	3.70	2.99	3.53	4.65	2.90	4.02	4.24	1.89	3.59	2.70	3.38	3.69
			4	Outpatient DNAs	9.37%	10.51%	9.05%	10.52%	7.70%	8.79%	9.23%	8.70%	9.33%	8.49%	8.46%	8.51%	8.65%	8.63%
			4	Bed Occupancy - Adults	57.92%	74.44%	78.34%	81.96%	84.37%	83.16%	71.91%	76.53%	76.26%	71.19%	83.58%	86.36%	79.80%	79.20%
			4	Bed Occupancy - Paediatrics	51.18%	65.86%	61.90%	68.89%	59.44%	53.76%	55.00%	42.71%	46.77%	40.28%	58.60%	59.72%	33.67%	49.79%
			4	Bed Occupancy - HDU	81.99%	59.35%	86.06%	82.89%	87.36%	92.53%	81.44%	82.76%	85.15%	77.01%	90.67%	85.92%	84.62%	87.06%
			4	Bed Occupancy - Private Patients	39.63%	55.64%	64.29%	61.91%	77.47%	57.14%	39.29%	66.96%	63.13%	66.19%	71.89%	77.62%	64.94%	65.65%
			4	Admissions on the Day of Surgery	357	384	400	457	381	433	403	417	373	371	417	401	381	1634
			4	AVLOS for APC (excl day cases)	4.36	3.87	4.71	4.30	4.70	5.63	4.16	4.58	5.55	4.97	4.46	4.13	5.33	4.75







Efficiency Commentary

During the second half of December 3 theatres were closed for maintenance works. After adjusting for this utilisation was significantly higher than the previous month and December 2012 after accounting for planned theatres shut downs

With the exception of paediatrics (where occupancy levels were reduced to facilitate the temporary ward transfer) ward occupancy levels were significantly higher than December 2012. Both this and the theatres utilisation statistics are reflective of the ongoing increase in activity as part of the rectification plan.

There were 10 on the day hospital cancellations in the month primarily caused by theatres overruns and emergency admissions.

% Harm Free Care	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Pts Rec Harm Free Care	93	101	95	90	91	76	97	86	89			
Total Cohort	95	105	97	91	93	77	100	87	94			
YTD Total	97.89%	97.00%	97.31%	97.68%	97.71%	97.85%	97.72%	97.85%	97.50%	97.50%	97.50%	97.50%
Month Outturn	97.8947%	96.1905%	97.9381%	98.9011%	97.8495%	98.7013%	97.0000%	98.8506%	94.6809%	#DIV/0!	#DIV/0!	#DIV/0!

% Waiting Under 6 Weeks Diag	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Under 6 Weeks	917	1084	1036	741	976	1084	1142		1122			
Total Cohort	924	1084	1041	747	985	1087	1152		1133			
YTD Total	99.24%	99.65%	99.61%	99.53%	99.44%	99.49%	99.43%	99.43%	99.37%	99.37%	99.37%	99.37%
Month Outturn	99.2424%	100.0000%	99.5197%	99.1968%	99.0863%	99.7240%	99.1319%	#DIV/0!	99.0291%	#DIV/0!	#DIV/0!	#DIV/0!

DQ Inpat Ethnics	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Valid Code	1034	1152	1110	1178	1032	1078	1218	1235	1064			
Total Cohort	1059	1209	1151	1245	1084	1089	1276	1291	1118			
YTD Total	97.64%	96.38%	96.40%	95.93%	95.79%	96.30%	96.17%	96.10%	96.00%	96.00%	96.00%	96.00%
Month Outturn	97.6393%	95.2854%	96.4379%	94.6185%	95.2030%	98.9899%	95.4545%	95.6623%	95.1699%	#DIV/0!	#DIV/0!	#DIV/0!

MRSA Screening Rate	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Patients Screened	732	820	814	895	723	661	783	694	601			
Elec + Emerg	565	635	579	615	567	529	591	607	600			
YTD Total	129.56%	129.33%	133.00%	136.22%	134.55%	133.09%	133.01%	130.59%	127.14%	127.14%	127.14%	127.14%
Month Outturn	129.5575%	129.1339%	140.5872%	145.5285%	127.5132%	124.9527%	132.4873%	114.3328%	100.1667%	#DIV/0!	#DIV/0!	#DIV/0!

Cancer 2ww	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Seen in 2 weeks	29	28	26	52	24	25	36	29	29			
Total Cohort	29	28	26	52	24	25	36	29	29			
YTD Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Month Outturn	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	#DIV/0!	#DIV/0!	#DIV/0!
Quarterly			100.00%			100.00%			100.00%			

Cancer 31-Day Primary	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Treated in 31 days	14	10	12	16	7	9	8	14	13			
Total Cohort	15	10	12	16	7	9	8	14	13			
YTD Total	93.33%	96.00%	97.30%	98.11%	98.33%	98.55%	98.70%	98.90%	99.04%	99.04%	99.04%	99.04%
Month Outturn	93.3333%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	#DIV/0!	#DIV/0!	#DIV/0!
Quarterly			97.30%			100.00%			100.00%			

Cancer 31-Day Subsequent	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Treated in 31 days	19	8	10	20	7	10	5	7	10			
Total Cohort	19	8	10	20	7	10	5	7	10			
YTD Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Month Outturn	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	#DIV/0!	#DIV/0!	#DIV/0!
Quarterly			100.00%			100.00%			100.00%			

Cancer 62-Day	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Treated in 62 days	4.5	4	1	4	0.5	4	3	3	1			
Total Cohort	5	4	1.5	5	0.5	4.5	3	3.5	1.5			
YTD Total	90.00%	94.44%	90.48%	87.10%	87.50%	87.80%	89.36%	88.89%	87.72%	87.72%	87.72%	87.72%
Month Outturn	90.0000%	100.0000%	66.6667%	80.0000%	100.0000%	88.8889%	100.0000%	85.7143%	66.6667%	#DIV/0!	#DIV/0!	#DIV/0!
Quarterly			90.48%			85.00%			87.50%			

18-Week Nonadmitted	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Treated Under 18 Weeks	1100	1063	1005	1194	1067	1126	1321	1075	994			
Treated Over 18 Weeks	55	55	49	59	47	54	66	55	51			
YTD Total	95.24%	95.16%	95.22%	95.24%	95.35%	95.36%	95.34%	95.31%	95.30%	95.30%	95.30%	95.30%
Month Outturn	95.24%	95.08%	95.35%	95.29%	95.78%	95.42%	95.24%	95.13%	95.12%	#DIV/0!	#DIV/0!	#DIV/0!
Quarterly			95.22%			95.49%			95.33%			

18-Week Admitted	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Treated Under 18 Weeks	683	742	741	857	710	763	836	830	638			
Treated Over 18 Weeks	74	79	70	74	76	83	92	112	111			
YTD Total	90.22%	90.30%	90.67%	91.05%	90.92%	90.79%	90.68%	90.33%	89.82%	89.82%	89.82%	89.82%
Month Outturn	90.22%	90.38%	91.37%	92.05%	90.33%	90.19%	90.09%	88.11%	85.18%	#DIV/0!	#DIV/0!	#DIV/0!
Quarterly			90.67%			90.91%			89.42%			

18-Week Incomplete	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Treated Under 18 Weeks	5469	6028	6401	6542	6610	6614	6364	6434	6723			
Treated Over 18 Weeks	426	360	353	404	444	472	406	460	575			
YTD Total	92.77%	93.60%	94.02%	94.06%	93.99%	93.87%	93.89%	93.82%	93.62%	93.62%	93.62%	93.62%
Month Outturn	92.77%	94.36%	94.77%	94.18%	93.71%	93.34%	94.00%	93.33%	92.12%	#DIV/0!	#DIV/0!	#DIV/0!
Quarterly			94.02%			93.74%			93.43%			

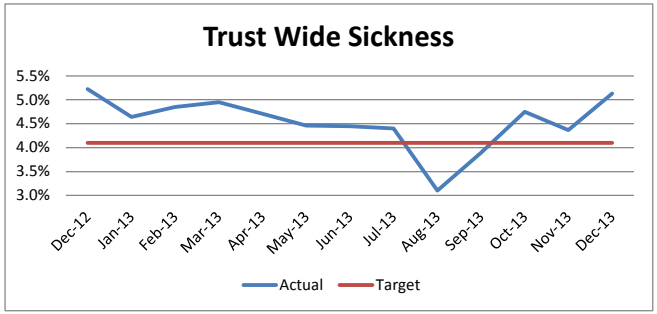
VTE Assessment	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Assessed	822	962	919	972	770	896	964	1014				
Total Cohort	875	1012	966	1036	865	943	1000	1051				
YTD Total	93.94%	94.54%	94.74%	94.50%	93.50%	93.75%	94.15%	94.46%	94.46%	94.46%	94.46%	94.46%
Month Outturn	93.94%	95.06%	95.13%	93.82%	89.02%	95.02%	96.40%	96.48%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

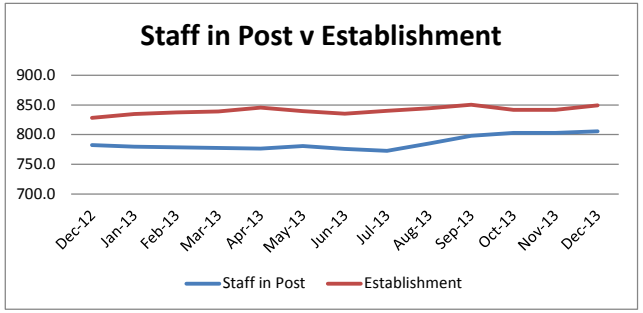
Monthly Report
Workforce Indicators as at December 13

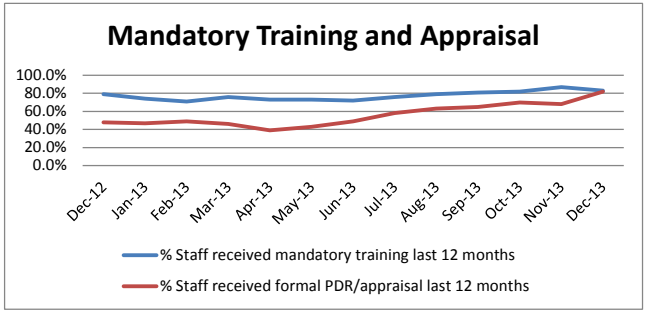
Headlines

- The WTE staff employed continues to rise and circa 40 WTE vacancies remain
- Sickness has increased, primarily due to an increase in long term absence
- Appraisal has improved significantly by 14% due to considerable efforts in the clinical directorates.

	Monitor	National	CQC Standard		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	13/14 Full Year Position
Workforce			13	Total WTE Employed	782.6	779.6	778.6	777.5	776.5	780.5	775.8	772.5	784.9	797.7	802.6	802.9	805.3	794.3
			13	Total WTE Employed as % of Establishment	94.5%	93.4%	93.0%	92.7%	91.8%	93.0%	92.9%	92.0%	92.9%	93.8%	95.3%	95.4%	94.8%	94.0%
			13	Staff Turnover (%)	10.4%	11.1%	12.6%	12.7%	11.6%	12.0%	12.6%	12.5%	12.5%	12.7%	12.8%	12.9%	13.1%	12.7%
			13	% of Sickness - Trust wide	5.2%	4.6%	4.9%	5.0%	4.7%	4.5%	4.5%	4.4%	3.1%	3.9%	4.8%	4.4%	5.1%	4.3%
			13	Agency % of Staff Cost	4.2%	5.6%	6.4%	8.7%	6.1%	8.0%	8.4%	6.1%	6.5%	6.4%	6.2%	5.6%	5.8%	6.1%
			13	Temporary staffing hours as a % of establishment														
			13	% Staff received mandatory training last 12 months	79%	74%	71%	76%	73%	73%	72%	76%	79%	81%	82%	87%	83%	81%
			13	% Staff received formal PDR/appraisal last 12 months	48%	47%	49%	46%	39%	43%	49%	58%	63%	65%	70%	68%	82%	68%
			13	% of required staff receiving safeguarding training					33%	30%	21%	51%	51%	54%	60%	58%	66%	57%
			13	Qualified Nurse / Bed ratio														
			13	Staff Net Promoter score					3.84									







Workforce Commentary

The WTE staff employed continues to rise and circa 40 WTE vacancies remain with the main areas being registered and unregistered practitioners in Theatres , Wards and Clinical support services (22.37) and 6WTE in domestics

Turnover continues to rise . Of the 10 leavers this month five were permanent staff leaving the Trust for undisclosed reasons or for employment elsewhere e in the NHS.

Sickness has increased, primarily due to an increase in long term absence (+200 days lost compared to November). Although there was an increase in the number of short term episodes, the total time lost did not increase significantly. further analysis of the long term absence will be given at EMT

Mandatory training has deteriorated slightly primarily in the Corporate,, Large Joints and Facilities areas. Those areas at less than 85% will be asked for their trajectory to achieve compliance by end March.

Appraisal has improved significantly by 14% due to considerable efforts in the clinical directorates. All have produced their trajectory to achieve 90% by March and all are on target to achieve this at the time of writing.

Quarterly Detailed Report
Financial Performance as at December 13

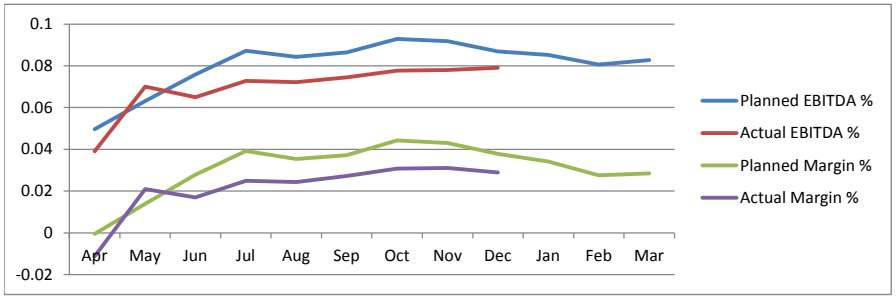
Headlines

- The Trust made a surplus of £81,000 compared to a planned deficit of £36,000
- The Trust has a year to date surplus of £1,599,000 against a plan of £2,125,000 which is a shortfall of £526,000.
- CIP achievement currently sits at £2,039,000 of which 95% is recurrent. This is £462,000 behind the target after Month 9.

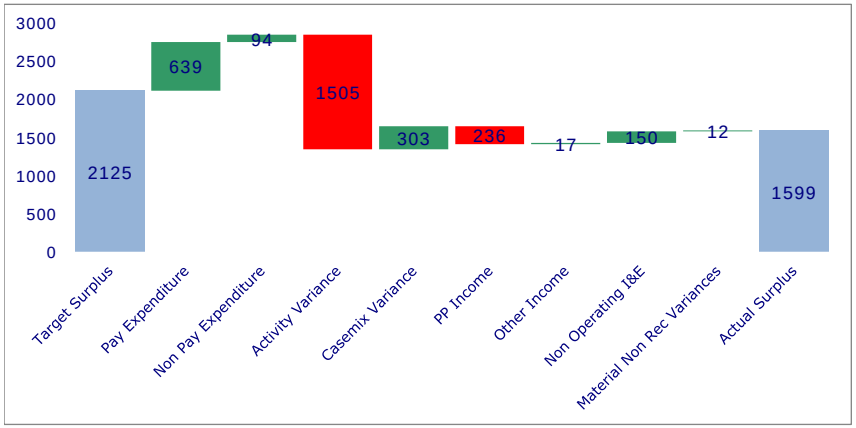
Trust Financial Metrics

	Year to Date		
	Actual	Plan	Risk
Capital Servicing Capacity	4.1	4.9	4
Liquidity Ratio	82.3	78.7	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 December the Trust made a **surplus of £81,000** compared to a planned **deficit of £36,000**. The Trust therefore has a year to date surplus of £1,599,000 against a plan of £2,125,000 which is a shortfall of £526,000. 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).

As part of Monitor's requirements the Trust will submit a full set of accounts based upon the Q3 position. To support this, stock takes and agreement of balances exercises with debtors and creditors have taken place. This additional level of check and balance ensures the robustness of the financial statements in the run up to year end.

Income

Compared to the original Trust activity plan December showed activity under performance similar to that experienced in November. However, compared to the activity rectification plan previously presented to the Board, we delivered in excess of the forecast activity for the month which is encouraging particularly in the context that 3 theatres were closed for 3 weeks during the period.

Although healthcare activity levels remained below plan in December the general income position has improved. This is due to finalised November healthcare income being in excess of the draft levels which are reported through the CPR monthly, the private patient income position improving and £73,000 Donated Asset income being received.

Pay

The total paybill is in line with the 12 month average and has reduced in December which is consistent with planned and actual activity levels during the month. The substantive paybill has reduced marginally after 2 months of increase. Agency spend in December is the lowest level experienced for the past 12 months but again this is consistent with reduced activity levels in the month and 3 theatres closed for a 3 week period.

Compared to the Monitor plan we continue to spend less on pay than predicted. 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 (£188,000 or 8% more than the average for the year). This was driven primarily by an adjustment for stock and an increase in bad debt provisions as part of the Q3 accounts finalisation process.

CIP

CIP achievement currently sits at £2,039,000 of which 95% is recurrent. This is £462,000 behind the target at Month 9.

Balance Sheet & Cash Flow

The Statement of Position is broadly in line with plan at month end. Cash balances remain healthy and are now in line with plan and the revised capital plan is on target. An estimated impairment of £141,00 has been included in the Q3 position.

Quarterly Detailed Report

Financial Efficiency Indicators as at December 13

Headlines

- The paybill has reduced from last month and is lowest for the last three months.
- Agency pay has reduced and is the lowest since December 2012
- Both the Trust surplus and CIP performance remain below planned levels

		Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Cost of Staffing	Total Paybill	£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	£3,279,000	£3,311,000	£3,274,000
	Substantive Pay	£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	£2,861,500	£2,919,000	£2,877,100
	Bank Pay	£222,000	£183,483	£226,000	£246,000	£203,441	£187,000	£197,000	£252,000	£230,000	£213,956	£208,000	£195,000	£201,000
	Overtime Pay	£5,000	£5,665	£4,000	£5,000	£9,915	£4,000	£4,000	£4,000	£5,000	£7,612	£5,500	£4,000	£4,900
	Agency Pay (excluding Medical Locums)	£75,000	£140,543	£123,000	£234,000	£139,565	£241,000	£191,000	£150,000	£144,000	£138,048	£177,000	£133,000	£109,000
	Medical Locum Pay	£54,000	£37,621	£80,000	£62,000	£54,484	£28,000	£81,000	£54,000	£67,000	£68,319	£52,000	£60,000	£82,000
	ADH Payments - Surgical	£25,000	£28,000	£45,000	£40,000	£26,000	£38,000	£20,000	£17,000	£26,000	£23,000	£22,000	£31,000	£22,000
	ADH Payments - Clinics	£7,000	£14,000	£20,000	£17,000	£11,000	£14,000	£7,000	£17,000	£9,000	£13,000	£15,000	£19,000	£17,000
	ADH Payments - Anaesthetics	£27,000	£35,000	£48,000	£84,000	£46,000	£47,000	£48,000	£63,000	£46,000	£53,000	£48,000	£53,000	£62,000
	ADH Payments - Spot Work & Strategy	£1,000	£1,000	£1,000	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Income & Efficiency	Trust Surplus	£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	£1,599,000
	Normalised Surplus	£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	£1,587,000
	Total Income	£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	£6,436,000
	CIP	£3,579,326	£3,630,122	£3,679,000	£3,820,000	-	£339,000	£561,000	£869,000	£1,125,000	£1,378,000	£1,537,000	£1,787,000	£2,039,000

Summary

The paybill has reduced from last month and is lowest for the last three months and Agency pay has reduced and is the lowest since December 2012.

The Trust therefore has a year to date surplus of £1,599,000 against a plan of £2,125,000 which is a shortfall of £526,000 .

CIP achievement currently sits at £2,039,000 of which 95% is recurrent. This is £462,000 behind the target after Month 9.

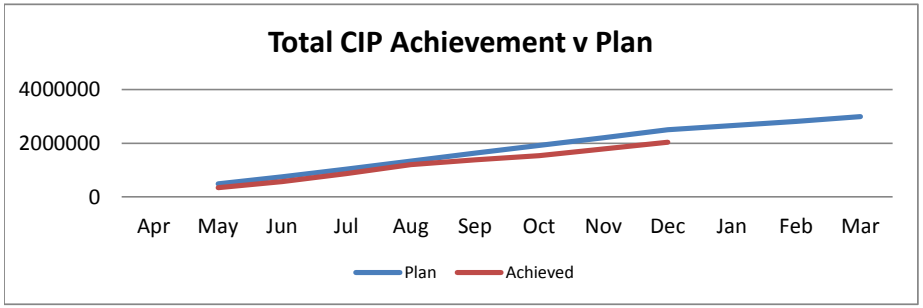
Monthly Report

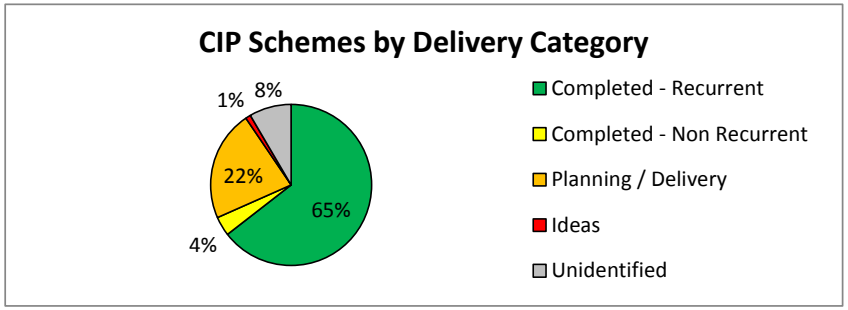
Cost Improvement Programme Indicators as at December 13

Headlines

- CIP achievement currently sits at £2,039,000 of which 95% is recurrent. This is £462,000 behind the target after Month 9.
- To date 69% of the required annual CIP value is completed and implemented. 9% is not identified or ideas at this stage
- No medium or 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	862	13	21	212	1,017	85%	155
Corporate Areas	774	677	47	10	40	704	96%	27
Income	1,100	500	600	0	0	780	64%	280
Total	**2,982**	**2,039**	**660**	**31**	**252**	**2,501**	**82%**	**462**



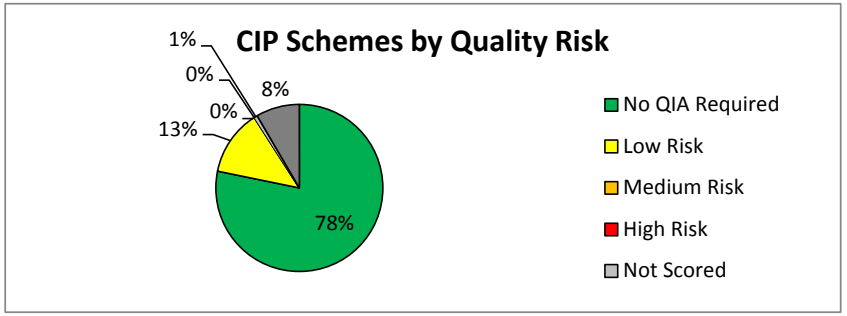


Significant Exceptions

Theatres & Anaesthetics. To date only 52% of the £473k target has been implemented. 45% 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



Quarterly Detailed Report
Statement of Position as at December 13

Headlines

The Trust finished Q3 with a Statement of Position £0.4m behind plan which reflects the current underperformance against the planned surplus for the year to date.

The cash balance is now back in line with plan seeing a recovery of c£2.6m within the quarter.

The Trust finished Q3 with a Statement of Position £0.4m behind plan which reflects the current underperformance against the planned surplus for the year to date.

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 the end of Q1.

Based on the original plan capital expenditure still appears to be £2m behind. The capital report later in the pack shows performance against the revised plan and this is now showing the Trust as being on target.

A stocktake took place within Theatres during December and all adjustments have been reflected in the closing figure for Q3. Theatres stock accounts for 87% of the overall stock figure. Stock is higher than planned due to the planned increase in activity and departments procuring stock to meet the needs of the activity recovery plan for Q4.

Although the creditors balance is lower than plan, this has reduced to a 9% variance in Q3 as opposed to 13% in Q2. Further improvements are expected in Q4 as revised payment procedures are fully embedded.

The cash balance is now back in line with plan seeing a recovery of c£2.6m within the quarter. This has been achieved by improved credit control processes and revised payment procedures.

The £541,000 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 17 days
Creditor days: Creditor days currently stands at 30 days

Debtors > 90 days: Total debts over 90 days is £533k or 11.79% of the total debtor balance. A bad debt provision for high risk areas is included in the I&E position.

Creditors > 90 days: Total creditors over 90 days is £718k at a percentage of 7.68% of the total creditor balance. The majority of this balance relates to one supplier where the contract is yet to be finalised and so the Trust is holding payment.

During Q3 the Trust received £91,000 from the Emery Efficiency Fund in the form of Public Dividend Capital to support the replacement roof capital programme.

STATEMENT OF POSITION	Actual £000	Plan £000
FIXED ASSETS:		
Intangible assets	153	18
Tangible assets	41,134	43,392
Investments	0	0
TOTAL FIXED ASSETS	**41,287**	**43,410**
CURRENT ASSETS:		
Stocks and work in progress	3,373	2,751
Debtors	4,875	4,651
Investments	0	0
Cash at bank and in hand	20,410	20,664
TOTAL CURRENT ASSETS	**28,658**	**28,066**
CREDITORS:		
Creditors falling due within one year	(9,706)	(10,655)
NET CURRENT ASSETS/(LIABILITIES)	**18,952**	**17,411**
TOTAL ASSETS LESS CURRENT LIABILITIES	**60,239**	**60,821**
CREDITORS:		
Creditors falling due after more than one year	(541)	(693)
PROVISIONS FOR LIABILITIES AND CHARGES	(265)	(259)
TOTAL ASSETS EMPLOYED	**59,433**	**59,869**
FINANCED BY		
TAXPAYER'S EQUITY		
Public dividend capital	38,995	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	17,726	18,252
TOTAL TAXPAYERS' EQUITY	**59,433**	**59,869**

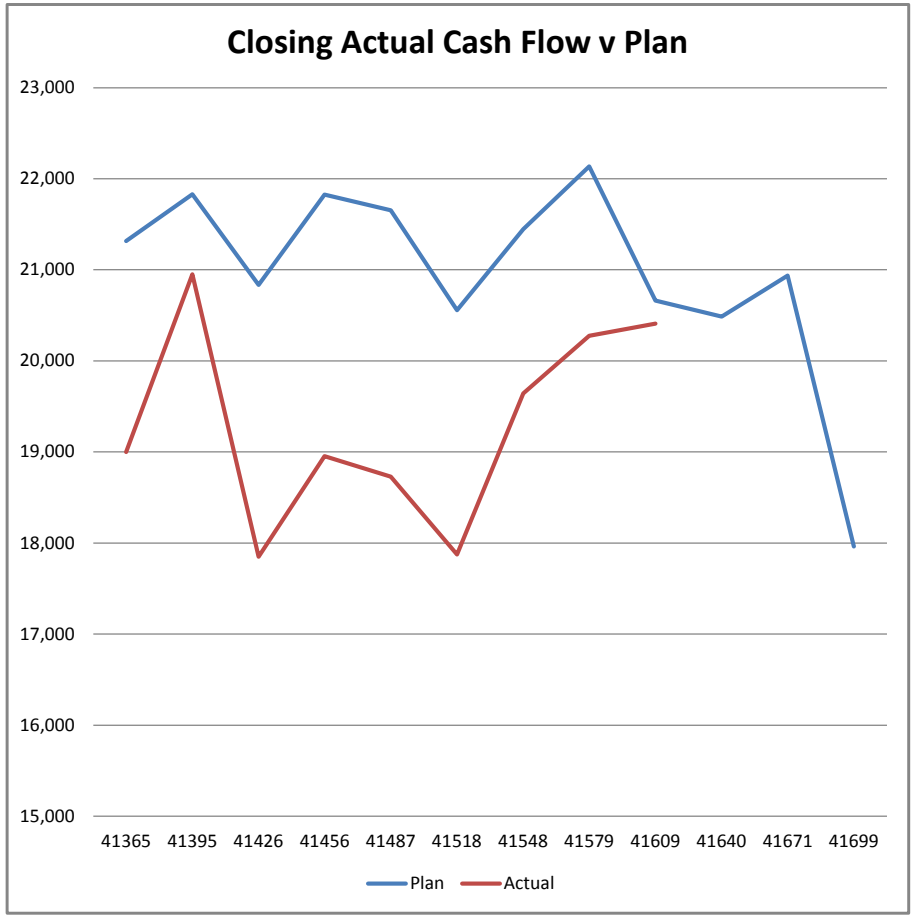
Quarterly Detailed Report
Financial Cash Flow as at December 13

Headlines

The Trust closed Q3 with a much improved cash balance of £20.4m which is £0.3m behind plan. More detailed analysis of the variances is provided in the balance sheet report

CASHFLOW STATEMENT
As at 31st December 2013

	Actual £'000	Plan £'000	Variance £'000
Earnings Before Interest Taxation & Depreciation	4,379	4,879	(500)
Movement in Working Capital			
(Increase) / Decrease in Stock	(532)	90	(622)
(Increase) / Decrease in Debtors	(1,892)	(1,134)	(758)
Increase / (Decrease) in Creditors	(345)	681	(1,026)
Increase / (Decrease) in Provisions and Liabilities	(146)	(76)	(70)
Total Movement in Working Capital	**(2,915)**	**(439)**	**(2,476)**
Cash flow from Operations			
Capital Payments	(2,110)	(4,261)	2,151
PDC Reserve Increase	91	0	91
Cash flow before Financing	**(2,019)**	**(4,261)**	**2,242**
Financing			
Interest Received	60	16	44
Interest Paid	0	0	0
Capital element of finance lease rental payments	0	0	0
Public Dividend Capital Received	91	0	91
Public Dividend Capital Repaid	(634)	(979)	345
Dividend Paid	0	0	0
Loans Received	0	0	0
Loans Paid	0	0	0
Grants Received	0	0	0
Grants Paid	0	0	0
Total Financing	**(483)**	**(963)**	**480**
Net Cash Inflow / (Outflow)	(1,038)	(784)	(254)
Opening Cash Balance	21,448	21,448	0
Closing Cash Balance	**20,410**	**20,664**	**(254)**

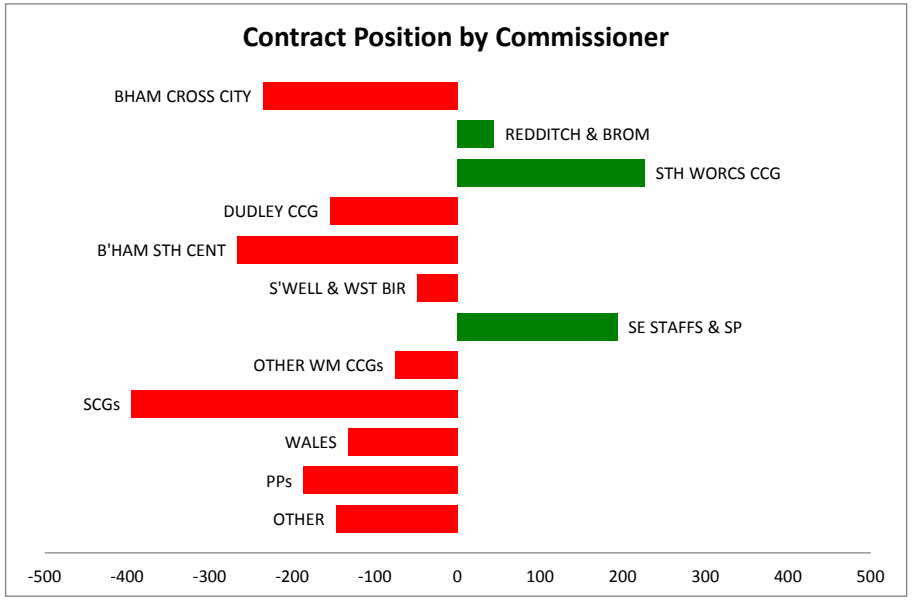


Quarterly Detailed Report
Income and Expenditure Statement as at December 13

Headlines

- The Trust's surplus is £526,000 behind plan at quarter 3
- EBITDA margin is 0.7% behind plan at Quarter 3.
- 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	18,968	19,041	(73)	54,852	56,093	(1,241)	74,621
Pay Costs	(9,863)	(10,173)	310	(29,460)	(29,988)	528	(40,204)
Drug Costs	(98)	(70)	(28)	(859)	(829)	(30)	(1,537)
Other Costs	(7,276)	(7,120)	(156)	(20,154)	(20,397)	243	(26,709)
EBITDA	**1,731**	**1,678**	**53**	**4,379**	**4,879**	**(500)**	**6,171**
Depreciation	(602)	(601)	(1)	(1,623)	(1,791)	168	(2,740)
Net interest	(4)	5	(9)	42	16	26	21
Other	(504)	(335)	(169)	(1,199)	(979)	(220)	(1,323)
	621	**747**	**(126)**	**1,599**	**2,125**	**(526)**	**2,129**
Exceptional Items							
Net surplus / (Deficit)	**621**	**747**	**(126)**	**1,599**	**2,125**	**(526)**	**2,129**
EBITDA %	9.13%	8.81%		7.98%	8.70%		8.27%
CIP	661	881	(220)	2,039	2,501	(462)	2,993



Finance Commentary

The Trust surplus was behind plan in Q3 by £126k compared to £201k in Q2. Overall Q3 the surplus is £526k behind plan after the first 9 months of the year.

The Trust is under recovering total income by £1.2m as at Q3, which is driven predominantly by under recovery in NHS healthcare income of £1.3m (which includes CIP growth assumptions) and private patients of £0.2m.

The biggest area of contract underperformance in the year to date (which excludes CIP growth assumptions) has been against contracts with Specialist Commissioning Groups, equating to nearly £395k to the end of Q3.

Performance against our local contracts is variable, with underperformances against Birmingham Cross City, Dudley, Birmingham Central offset by over performance in South Worcester and South East Staffordshire. Overall the local contract's income is under performing against the plan by £242,000.

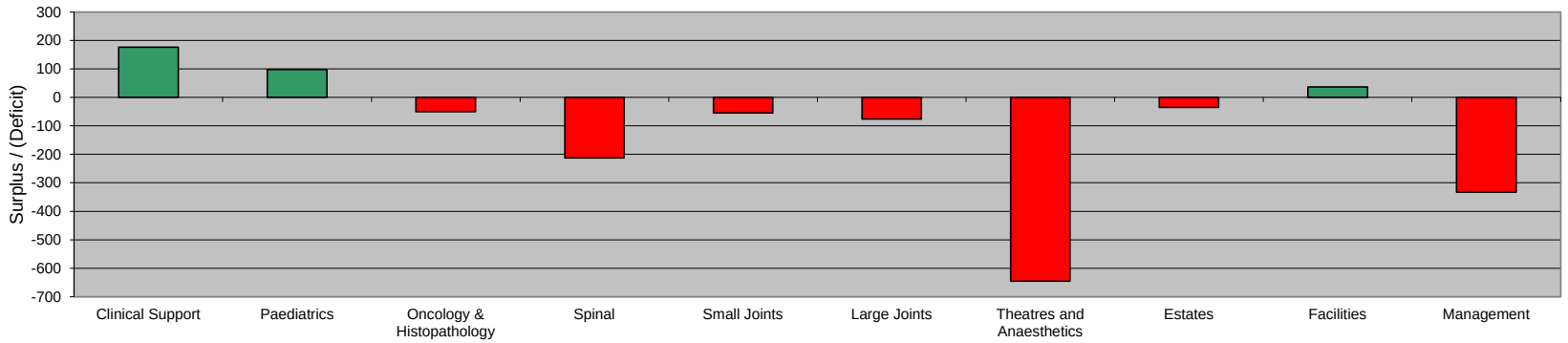
Compared to the plan we are spending less on pay and non pay than predicated. When the plan was set we were anticipating activity over performance to meet the £1.1m income CIP target. This and the associated costs are yet to materialise which shows as a positive pay and non pay variance. We did however in Q3 see an adjustment for stock, an increase in bad debt provisions and the transfer of project management costs for the IM&T Programme from capital which led to a higher level of non pay spend than planned.

Quarterly Detailed Report
Finance Performance by Directorate as at December 13

Headlines

- 7 of the 10 Directorates within the Trust are overspent at the end of Quarter 3.
- Theatres and Management have significant overspends, please see details below.

Performance against budget



Theatres & Anaesthetics - £645,000 overspent
Pay- Theatres are overspent by £240,000 at month 9 on staffing as a result of year to date agency cost (£523,000 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 £275,000 overspent on non pay medical supplies, equipment & consumables.
CIP - £170,000 of the overspend is caused by unmet CIP although this has improved in the past month.

Management - £333,000 overspent
Pay is overspent by £339,000 mainly on locums on Trust funded junior doctors.
Non pay is underspent which partially offsets pay and CIP overspends.
CIP - £97,000 of the overspend is caused by unmet CIP.

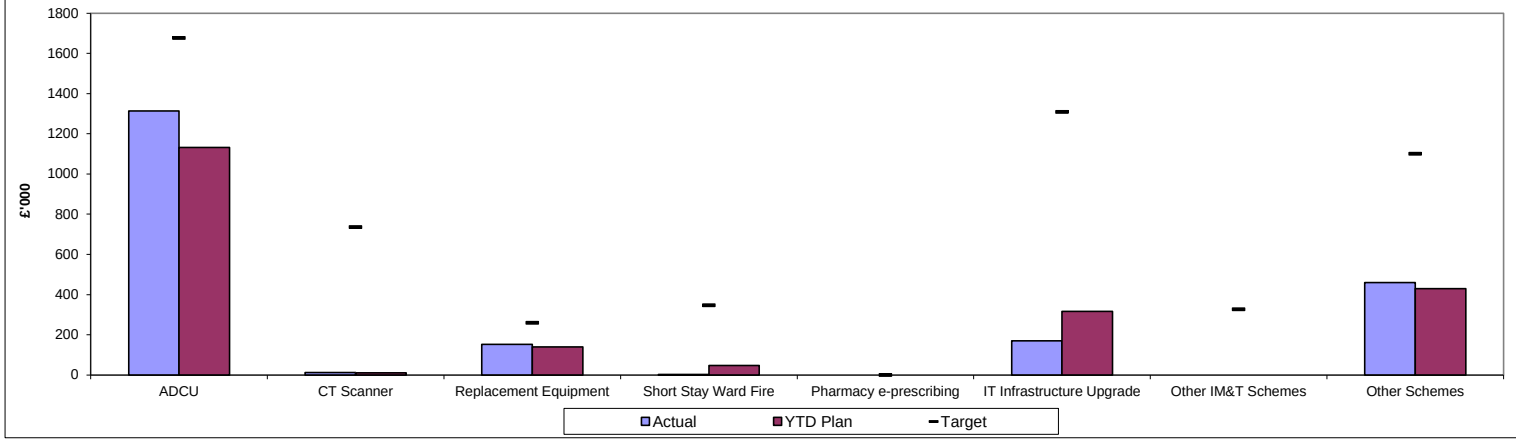
Spinal - £212,000 overspent.
Non pay is overspent by £197,000 which mainly relates to the treatment of patients in the private sector ,BCH and EEG /radiology contracts with external providers.

Quarterly Detailed Report
Capital Programme Update as at December 2013

Headlines

The capital plan is £36,000 behind plan at Q3 based on the revised capital plan submitted to Monitor.

Scheme Analysis



Capital Commentary

At the end of December the capital plan was in line with plan.

ADCU
The new ADCU facility opened in July 2013 however work continues to finalise this. The project is on track and work is expected to be completed in January 2014. It is anticipated that this project will come in on the planned budget of £1.7m for 2013/14.

CT Scanner
There has been minimal expenditure on this project to date. The majority of the spend is planned in the last quarter of 2013/14. S Milward has confirm that the project is on track and will be completed in line with plan.

Replacement Equipment
£152k has been spent to date of the £260k budget. The main spend has been in Theatres in relation to an Allen Frame and theatre lights. Requests for funds in this area will need to be monitored closely from now on to ensure that the budget is not exceeded and the equipment replacement strategy is met.

Short Stay Ward Fire
Work has been delayed due to bed shortages. Awaiting a Board decision on how to proceed with this project.

Pharmacy e-prescribing
This project has now be moved to 2014/15.

IM&T
Spending against this scheme is minimal until the IM&T Strategy is finalised. The tendering process has now taken place and it is anticipated that a supplier will be selected by the end of January with full delivery of the project planned for completion by 31 March 2014.

Quarterly Detailed Report
Business Intelligence as at December 13

Headlines

- Opportunities to utilise capacity for additional activity due to other Providers failing to meet waiting time standards have not been as successful as hoped
- CQUIN performance in Q3 - all targets expected to be achieved in Q3 with exception of Dementia
- Commencing Contract Negotiations with Commissioners 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 3

The following tables illustrate the change in activity between 2012/13 and 2013/14 reported
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 the most recent Quarter

Table 1 - Comparison of Elective Admissions

	Quarter 3			
Admission Type	**12/13**	**13/14**	**Variance**	**%**
Elective Admissions	1,657	1,645	-12	-.724%
Day Case	1,538	1,867	+329	+21.391%
Grand Total	**3,195**	**3,512**	**+317**	**+9.922%**

Table 2 - Comparison of GP Referrals

	Q3			
GP Referrals	**2012-13**	**2013-14**	**Variance**	**%**
No of GP Referrals	4,530	4,283	-247	-5.453%

Table 3 - Comparison of Outpatient Attendances

	Quarter 3			
Outpatient Type	**12/13**	**13/14**	**Variance**	**%**
New	4,610	5,057	+447	+9.696%
Follow-Up	11,762	12,417	+655	+5.569%
Grand Total	**16,372**	**17,474**	**+1,102**	**+6.731%**

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**	**Q3**	**Grand Total**
1	LORDSWOOD HOUSE GROUP MEDICAL PRACTICE	126	130	158	165	135	714
2	M M P SOUTH BIRMINGHAM	83	97	99	119	86	484
3	NORTHFIELD HEALTH CENTRE F	91	70	98	80	76	415
4	HOLLYMOOR MEDICAL CENTRE	72	73	93	85	86	409
5	HALL GREEN HEALTH	91	82	76	86	62	397
6	WYCHALL LANE SURGERY	88	65	91	85	58	387
7	LEACH HEATH MEDICAL CENTRE	79	51	81	73	89	373
8	KINGSFIELD MEDICAL CENTRE	66	74	75	63	43	321
9	JIGGINS LANE SURGERY	61	73	62	67	56	319
10	MILLENNIUM MEDICAL CENTRE	55	63	63	69	62	312

Business Opportunities

Waiting List Initiatives for Local Trusts and Welsh Providers
The Trust has undertaken a waiting list initiative to treat long-waiting patients from WHAT; however the numbers have been far less than was originally indicated by the referring Trust. The Trust was also expecting SWBH to transfer patients in order to relieve their orthopaedic waiting time pressures, however these referrals have not been forthcoming. In addition Powys Local Heath Board were to transfer patients to the ROH but yet again these have not materialised, despite continued dialogue between the Trust and the Health Board.

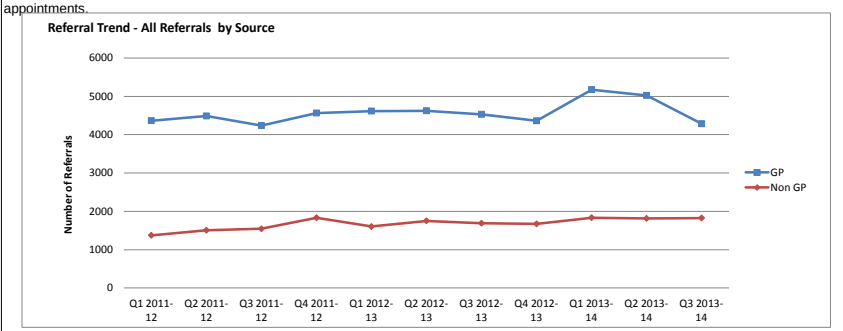
Commissioning Issues
Although the Trust failed the VTE Risk Assessment CQUIN in Q1 and Q2, the 90% assessment target has been met in October and November of Q3. The Trust needs to achieve the target for the remaining month of December to ensure the target is met for the Quarterly CQUIN payment. The Trust has achieved the Dementia CQUIN target for 2 consecutive months and must now be achieved in January in order to secure the CQUIN funding. Commissioners have proposed that the withholding of CQUIN payments related to failure to achieve the "zero" Grade 3 and 4 Pressure Ulcers target will be linked to repeat occurrences on the same Ward and patient in order to make this less punitive, given the "zero" target.
The Trust has made excellent progress in reducing the number of patients waiting over 52 weeks and as a consequence the financial penalties imposed by Commissioners have been minimal in Q3.

The Trust Team will be meeting with Worcestershire CCG in February 2014 regarding the commissioning arrangements for Electro-Acupuncture treatments. The CCG have stated they will not continue to fund this treatment; the Trust has pushed for clinical dialogue between the respective clinical representatives to review the CCG Public Health findings following their clinical effectiveness review of this treatment.
As reported elsewhere in the CPR, the Trust is under-performing against its contracted activity income targets for the Q1-3 period. Contracts with CCGs are 1% below the financial plan and Contracts with Specialised Commissioners are 5% below plan for the period. The Trust has implemented rectification plans to improve this position.

2014-15 Commissioners Intentions
The 2014-15 NHS Standard Contract has been published. The key changes relate to the mandated financial penalties for breaches to Quality KPIs, for example, penalties for waiting time breaches will be levied on a per patient basis.
The Trust has commenced contractual negotiation discussions with CCG Commissioners. The Trust must ensure that Commissioners set contract plans at sufficient levels to sustain 18 week waiting times and at levels that reflect the expected forecast out-turn in line with the Trusts rectification plans.
There are some specific service line contractual priorities, such as; further reductions in Spinal Deformity waiting times, maximising Therapy capacity to reduce waiting times for treatment, maintenance of new services introduced in 2013-14.
The Trust is awaiting publication of the CCGs 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 the most recent Quarter is likely to increase due to the time lag between receipt of referral and booking appointments.



Clinical Programme- Highlight Report

Programme Name:	Clinical Programme
Senior Responsible Owner:	Amanda Markall
Reporting Period:	December 2013

Overall Programme Progress & Status

Current RAG Rating	**Amber**	**Previous RAG Rating**	**Amber**

Commentary on Overall Position

The Clinical Programme Board was set up to enable the delivery of projects in a more formal and standardised way (this is consistent with the Estates, CIP and IMT Programme Boards) and consists of all executives and the project leads for each project.

The key activities are to:

- Hold the Project Leads to account
- Track delivery of key milestones, ensure benefits are realised, risks mitigated & interdependencies managed including workforce and quality
- Escalate issues as appropriate
- Provide assurance to the Executive Management Team and the Trust Board on the delivery of the Programme

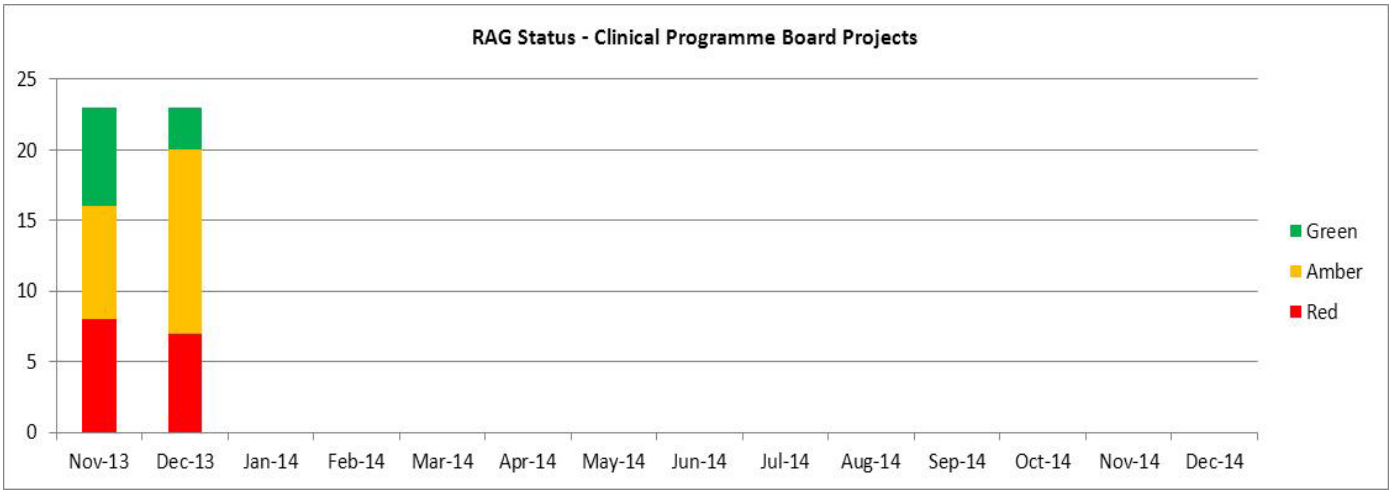
The Clinical Programme Board has met for 3 consecutive months and formal structure and governance arrangements have been agreed and implemented for the reporting of all projects and the overall Programme.

There are six primary projects and 17 supplementary projects, each with a project lead. The projects have varying degrees of maturity and have therefore been asked to undertake a project health check.

In the past 2 months, since the formal reporting of projects has been undertaken, we have pleasingly seen a reduction in Red rated projects. More disappointingly however we have seen a reduction in green rated projects. Key points for each Primary Project are included in Appendix 1. The key issue for all projects at this moment is the diversion of management resources from within the Trust towards increasing activity levels and 18 week waiting time issues.

Key Performance Indicators

- Programme wide KPI's - to be agreed by Programme Board



Red Risks	Recommended Action(s)	Owner
Benefits do not get realised or maximised or sustained in the long term	• Granular & quantified benefits to be identified by project • Regular monitoring and robust management of realisation during implementation • Post implementation review prior to handover	AM
Effective engagement & communication with stakeholders does not take place leading to delay or failure of programme or projects.	• Agree comms strategy and plan for the programme • Implement Programme wide and Project specific Comms & Engagement plans	AM
The Trust does not have the capacity & capability to implement the programme	• Fill gaps especially Project Managers & Clinical Lead • Training / support needs to be established and mitigated • Phasing of projects to maximise delivery probability	AM

Key Next Steps

- Develop programme wide KPI's
- Develop a more robust arrangement in the space between project and programme management
- All projects leads to complete a project health check and develop and implement action plans where appropriate

Recommendations

- To note progress, issues and risks

Amanda Markall
Director of Operations
January 2014

Appendix 1 Work Stream Progress

Primary Projects

Work Stream	RAG Status		Key Points
	Current	Previous	
Cancellation of Surgery	Amber	Green	• Pre admission plan created • Scope changed from Avoidable Hospital Cancellations to All On The Day Cancellations and Day Before Cancellations
Enhanced Recovery	Red	Amber	• Anaesthetic & post-op protocol outstanding. To be discussed at Jan 14 audit • First up training is not going as fast as anticipated • Audit data is being collected
Nursing WF Review	Amber	Green	• Data collection completed with the exception of one ward, analysis has commenced, and we are currently behind schedule for the analysis phase.
6/7 Day Working	Green	Green	• Engagement of staff has commenced to obtain feedback
CQUINs	Amber	Amber	• Commissioners confirmed achievement of Q2 CQUIN with exception of VTE • Dementia assessment not yet achieved 90% target for 3 consecutive months • CCGs proposing financial penalties linked to ward location & patient type
Medical WF Review	Red	Red	• Contact has been made with the representative from Russell's Hall Hospital- meeting will take place in February. • Project documentation to be established

Supplementary Projects

Green	Amber	Red
Out Patient Pathway	Direct Booking	Pre-Operative Pathway
Medical Records Management	Digital Dictation	WHH Model of Care
ESR	Standardisation & Copying of Letters to Patients	Electronic WL Management
Electronic Document Transfer	Capacity Management	Increase in Market Share
	Maximising Procurement	Marketing
	Paediatric Refurbishment	Patient Involvement and Experience

Date of MEETING: 29TH January 2014 **ENCLOSURE NUMBER:**

SUMMARY OF REPORT TO 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 Report, encompassing patient safety, experience and effectiveness.**

SUMMARY

This new style paper will provide Trust Board with an update on patient quality, safety and experience activity during December 2013.
Patient quality, safety and experience must remain a high priority for the organisation and it is anticipated this report will assist the Trust Board understanding and assurance of key quality issues.
It is anticipated that this report will develop in the coming months to reflect all aspects of safety, experience and effectiveness and is being led in partnership by the Medical Director and Director of Nursing & Governance.

The Trust Board is asked to note the additional inclusion of:

- CQUIN Schemes
- CQC standards
- Friends and Family Test (Net promoter)
- Litigation
- Safety Thermometer
- Matron KPI
- PROMs

RECOMMENDATIONS

The Trust 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

PATIENT SAFETY

1.1 Serious Incidents requiring investigation (SIRI)

There have been 3 SIRIs reported in December; compared to 5 reported during the previous month.

Ref	Incident date	Date raised to Commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final Report due
12139	30/12/13	30/12/13	Grade 3 pressure ulcer	Moderate	Large Joints	Investigation underway	05/03/2014
12004	28/11/13	29/11/13	Confidentiality leak	Minor	Spinal	Investigation underway	19/02/2014
11959	21/11/12	22/11/12	Grade 3 pressure ulcer	Minor	Theatres & Anaesthetics	Investigation underway	12/02/2014

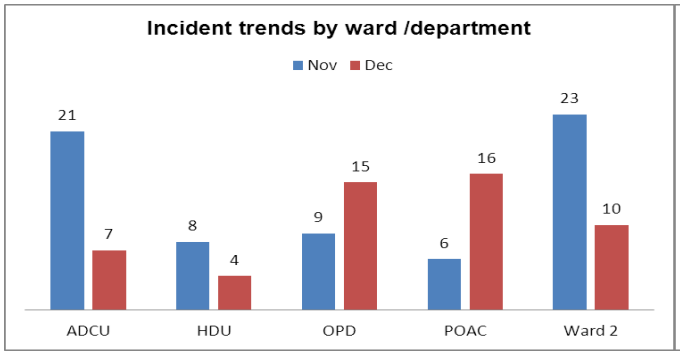
1.2 Deaths

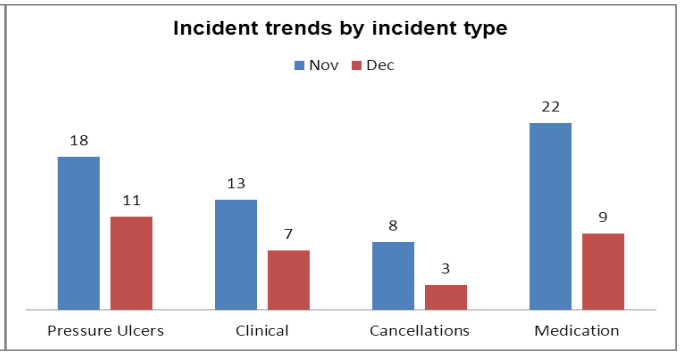
There have been no deaths during December.

1.3 Incident trends

There has been a slight decrease in incidents reported across the Trust with 130 incidents reported during December, compared to 181 incidents reported during November 2013.

Notable trends by ward/department and by incident category are outlined below. Next month the report will include a summary of all areas reporting incidents and a comparator against incident reporting nationally.

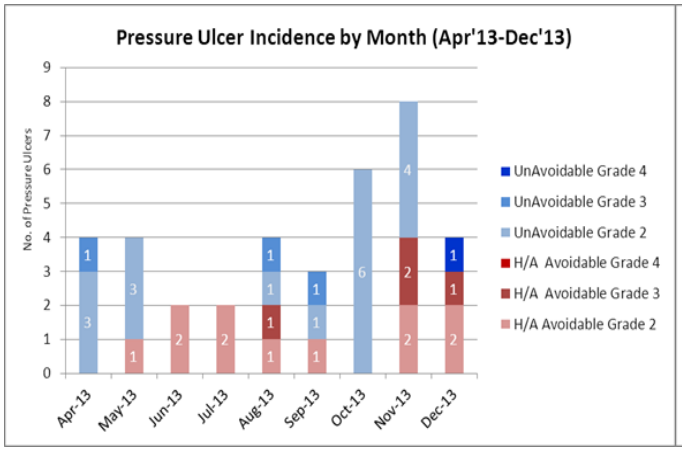


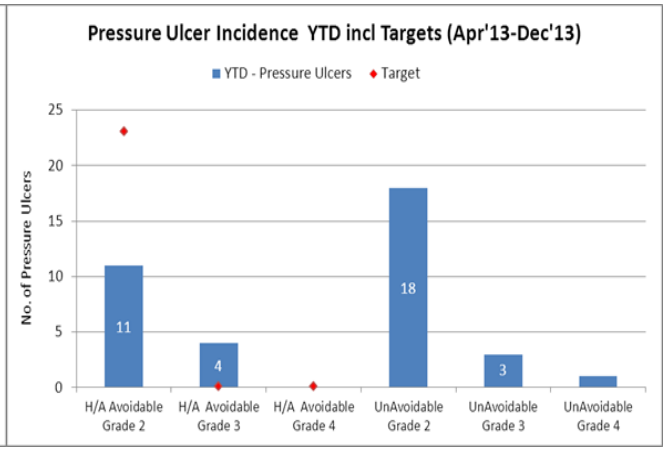


1.4 Pressure Ulcers

There were 4 hospital acquired pressure ulcers during December and these include:

- Grade 4 (unavoidable) a terminal care patient admitted with a grade 2 pressure ulcer which despite all care and complete and accurate documentation deteriorated to a Grade 4. (ward 3).
- Grade 3 (avoidable) the patient had complex healthcare including advanced dementia, the stepping up onto a specialist mattress was not undertaken as quickly as appropriate (Ward 2). A second grade 3 ulcer developed.
- Grade 2 (avoidable) documentation was not complete or robust.(ward 12)



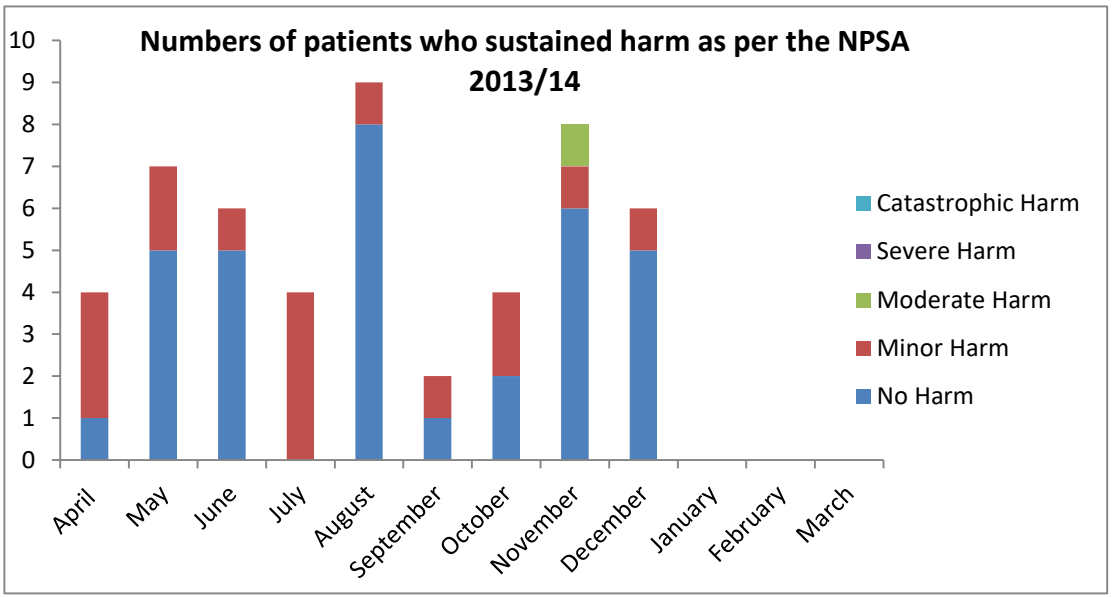


1.5 Falls

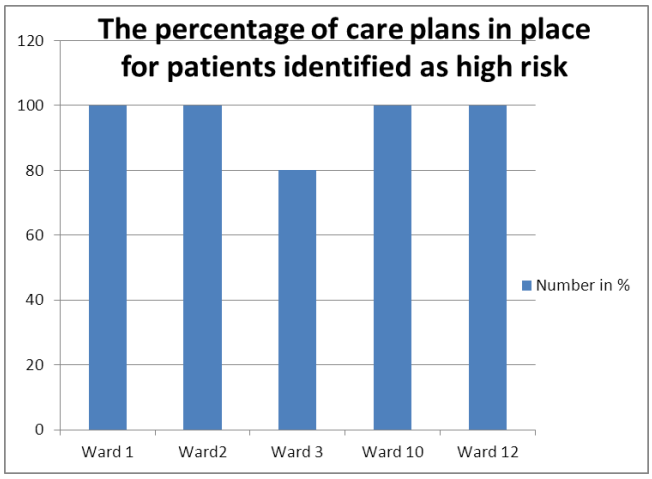
In December there were no avoidable patient falls. 14 incident forms were received for the month and categorised as (adult) falls, slips or trips with 6 of the 14 identified as reportable and 8 non reportable.

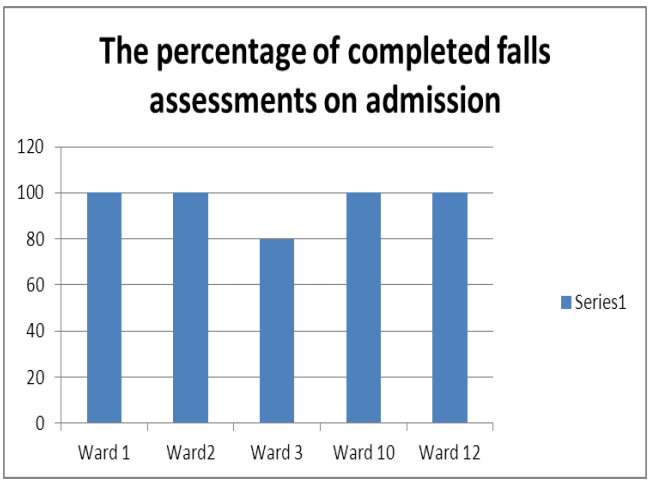
December Falls incident analysis			
Location of Falls	**Number of falls per area**	**Non Reportable incidents**	**Incident Number**
Ward 1	4	Patient voluntarily sat himself on floor	12131
Ward 2	2	Slip not fall Trip not fall	12076 12112
Ward 3	4	Faint not fall - Visitor not patient Collapse	12045 12067
Ward 10	0		
Ward 12	2	Slip not fall	12111
X-ray	1	Controlled sit to fall	12065
ADCU	1	Faint not fall	12062

Inpatient falls since April 2013 average 5.5 per months with the highest number of reported falls occurring on ward 3 (ytd n.19) and the lowest on ward 10 (ytd n.1).



Falls Assessments





The two quality indicators are:-
91% of Falls' assessments to be completed within 6 hours of admission
91% of high risk patients have a care plan in place
The above tables are based on wards auditing their own documentation.

An Inpatient fall (November 13) resulting in moderate harm to the patient underwent an RCA investigation. The key points were noted as:-

- Poor documentation by SHO – unable to identify how long after fall patient was reviewed.
- Patient unable to follow physiotherapy instruction due to language barrier.
- No neurological observations completed as per policy.
- Reduced number of staff visible/caring for patients at the time of the incident. Low staff to patient ratio.

With recommendations/Actions as:

- Ensure patients understanding, utilising interpreter service if required.
- Reiterate policy amongst ward staff regarding neurological observations following an unwitnessed fall – refresher training organised by ward manager.
- Physiotherapy teams to ensure patients understand instruction at point of contact.
- Discussion with junior medical staff to reiterate required documentation standards

1.6 CQUIN Schemes

The trust has achieved all monthly compliance targets for 2013/2014 CQUINS.
Improvement in compliance is noted within the Dementia CQUIN with achievement of the 90% target in months November and December. This must be maintained for January 2014 to achieve the three consecutive month target for the year.
Continued improvement is noted in relation to the VTE CQUIN with over 95% compliance noted in December. Sustaining the methodology within ADCU is essential to maintain this standard.
A further avoidable Grade 3 Pressure Sore in December is a breach of the agreed zero target, this will affect the quarter 4 contractual agreement within the contract.
New CQUIN schemes for 2014/2015 are currently being reviewed and negotiated with our partner Commissioners. The Director of Finance and Director of Nursing are reviewing the risk register related to CQUIN schemes, currently this reflects the financial risk of non-achievement and not the clinical risk. It is planned to have this in place for the new schemes.

1.7 CQC standards

During the December 2013 CQC workshop Outcome 4 – Care and Welfare of People who use services- improved from 'red' to 'amber'. A further 8 outcome areas were self-assessed as 'amber', 6 CQC Outcome areas are yellow and 1 outcome is green. It was acknowledged that a number of these Outcomes had remained Amber for some time and Outcome leads were asked to agree trajectories for improvement from Amber to Green with the Deputy Director of Nursing.

2 PATIENT EXPERIENCE

2.1 Compliments, Complaints and PALS

Compliments

Directorate	Compliments December 2013
Clinical Support	8
Small Joint	3
Large Joint	157
Oncology	33
Paediatrics	65
Spinal	99
Theatres	71
Corporate	4
Total	**440**

Complaints

7 formal complaints were received in the month of December, a decrease of 13% on last month. The complaints response time is 75% (3 of the 4) which is below the KPI of 80%. The outstanding complaint is due to a prolonged delay providing feedback from a Consultant, this was escalated within the directorate.

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

- Clinician approach x 2
- Communication and administration x 2
- Nursing care x 2
- Access to services – delays to have spinal OPA

PALS

PALS contacts down this month to 48 from 112 (a decrease of 57%) which is an expected pattern for the time of year. One area of concern raised the most (6) were queries regarding progress/confirmation of care and treatment plans for spinal.

PALS received by Directorate:

Corporate	6
Small Joint	4
Large Joint	7
Oncology	7
Clinical Support	6
Paediatrics	3
Spinal	15
Theatres	1
Total	**48**

2.2 Friends and Family Test (net promoter score)

The Friends and Family Test net promoter score for December was 86 against the national target of 80 and an average return rate of 50%. Nationally the net promoter score is 79 based on a response rate of 29%. Next month the report will include a comparator to other specialist orthopaedic organisations.

General trends for December:

What we are getting right:- Level of care is very high,Teamwork on wards, Medical Care

What we can do better - Communication remains the main issue. This includes information about what is going to happen, plans for discharge, explanations to patients. Manner in which information or instruction is conveyed – staff appearing unhelpful to each other as well as to patients; some perception of rudeness. Explanations of ward routines e.g. lights out times, drug round times, meal times

2.3 Litigation

5 new potential clinical negligence cases were submitted to the Trust during December 2013 and a summary is outlined below:

Ref	Details	Directorate
T433	Delay in diagnosis and treatment of cauda equina. Numerous potential defendants including UHB, HoEFT, GP, etc.	Spinal
T432	Morphine administration. Also SIRI and complaint.	Spinal/HDU
T340	"Operation on fractured back 2012" Patient has made a previous claim relating to treatment in 2009/10 - allegations denied and case closed March 2013	Spinal
T431	Leg length discrepancy	Large Joints
T430	No details	Spinal

2.4 Single Sex Compliance

There were no single sex compliance breaches in December.

2.5 Patient Reported Outcome Measures (PROMs)

The Trust has met the 90% target compliance rate completed questionnaires for both hip and knee replacement surgery. The figures are based upon the actual theatre activity according to ORMIS and are checked against the patient details in PAS. The PROMS questionnaire compliance data for December 2013 is detailed below:

	Indicator	December 2013
4A N13ii	PROMs: Hip replacement - % patients completing questionnaires.	90.5%
4A N13iv	PROMs: Knee Replacement- % patients completing questionnaires.	97%

3. EFFECTIVENESS OF CARE

3.1 Safety Thermometer

The Trust achieved harm free care for 94.68% of patients in December. Quarter 3 compliance was 96.8% harm free patient care across the quality domains of pressure ulceration, urinary tract infection, VTE and Falls. The sample size of this point prevalence audit averages 120 inpatients a month.

3.2 Matron KPI

On review the following key findings are noted;

- HDU - In all areas of the KPI's have improved this month, with an overall rating that has now moved from red to amber. This largely due to the impact of the matron working closely with the team.
- Ward 1 – In all aspects of the KPI's there is an overall rating that is sustained as amber. The Directorate and Senior Ward Team are working through an action plan to achieve green across more indicators.
- Ward 2 and SSW - the KPI's remain at an overall performance rating of amber. Both areas have focused work being undertaken by the Senior Ward team and Matron.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 29 January 2014 **ENCLOSURE NUMBER: 8**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Jo Chambers, Chief Executive**
AUTHOR(S)	**Jo Chambers**
TITLE	**Governance Declaration – Quarter 3 2013/14**

SUMMARY

To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 3 2013/14 to Monitor. This declaration is the first prepared in line with the requirements of 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 90% Admitted Referral to Treatment Time Target

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report To	Trust Board
Report Of	Jo Chambers, Chief Executive
Report Presented By	Jo Chambers, Chief Executive
Purpose of the Report	To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 3 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 Risk Assessment Framework. The Q3 submission is due on the 31st January 2014..
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 October to 31st December 2013 is contained in the Trust Corporate Performance Report. 2. <u>Service Performance Targets</u> The table of Monitor requirements and evidence is Appendix One of this report. The Trust has been unable to sustain the delivery of all waiting time targets having breached the 90% Admitted Referral to Waiting Time Target in November and December 2013. All other targets have been met. The reasons for non-achievement of the target is due to a 20% increase in patients on treatment pathways, related to an 11.5% increase in new out patient attendances with a corresponding 4.5% increase in elective activity but without full increase in capacity within 18 weeks. A rectification plan is now in place however it is expected that the target will continue to be breached in Quarter 4 whilst the number of patients over 18 weeks are treated. 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 took up post on December 2nd 2013.. • A substantive Director of Nursing and Governance was appointed in

December 2013.

- There have been no governor elections during the period.
- 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.
- The Integrated Governance Committee has changed its terms of reference and name part way through the quarter to become the Clinical Governance Committee. It 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 CGC 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.
    .
- The Audit Committee met once during the period in respect to this declaration and can offer the following assurance:
    - Having updates on the work of the external audit and internal audit the Board is assured that work remains on plan and there are no material issues or problems to report;
    - Ongoing work to improve the clarity of reporting on the Board Assurance Framework was received by the committee, who were happy that the new format of the report would make the understanding of the Trust's key risks far clearer.
    - The appointment process for a new Internal Audit & Counter Fraud contract starting in April 2014 was approved, and the Board can therefore be assured that robust Internal Audit
    - The Trust Board received assurances from Clinical Governance and the Audit Committee that the key risks have been identified.

4. The Board received and approved the Audit Committee's Annual Report and formal work plan at its September meeting and this was being followed.

APPENDIX ONE

The Trust provides financial information reflected in the CPR as assurance.

The Trust provides performance and quality information as set out in CPR and Patient Safety Report as assurance.

In quarter 3 there have been no CQC inspections or comments.

In quarter 3 no elections took place. Changes to the Board include 2 substantive executive appointments – to the Director of Nursing Post and to the Chief Executive Post.

The Trust can confirm that there are no exception reports to be provided in quarter 3 with regard to:

- Continuity of services
- Financial Governance
- Governance

But that there will be an exception report on failure to meet 18 week target for admitted patients.

Targets and indicators with thresholds for 2013/14

	Inicator	Threshold (A)	Weighting (B)	Source of evidence	Commentary
Access	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted **(C)**	90%	1.0	CPR	Not achieved.
	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted **(C)**	95%	1.0	CPR	Achieved
	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway **(C)**	92%	1.0	CPR	Achieved
	All cancers: 62-day wait for first treatment **(E)** from: urgent GP referral for suspected cancer NHS Cancer Screening Service referral	85% 90%	1.0	CPR	Achieved
	All cancers: 31-day wait for second or subsequent treatment **(F)**, comprising: surgery anti-cancer drug treatments radiotherapy	94% 98% 94%	1.0	CPR	Achieved
	All cancers: 31-day wait from diagnosis to first treatment **(G)**	96%	1.0	CPR	Achieved
Outcomes	Clostridium (C.) difficile – meeting the C. difficile objective **(M)**	DM* ROH target is 2	1.0	CPR	Achieved

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of EMT: 19th January 2014 **ENCLOSURE NUMBER:**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Anne Cholmondeley** **Director of Workforce and OD**
SUBJECT:	**Quarter Three Workforce Report**

SUMMARY

This is the regular report to Trust Board on workforce issues. The report provides an update on KPIs and also provides an initial summary of the results from the Staff Survey undertaken in late 2013.

RISKS

Although improved, mandatory training and appraisal levels remain below the contractual target set by Commissioners. The risk of intervention or financial sanction remains.

The poor staff survey results concerning the reporting of errors or near misses and staff not feeling safe to raise a concern could be an indicator of a culture which is not open. This will be an area of focus during 2014.

RECOMMENDATIONS

The Trust Board is asked to discuss and note the workforce report, in particular the staff survey results.

Quarter Three Workforce Report 2013-14

1. Key Performance Indicators

The number of staff employed by the Trust continues to increase with a net gain during the quarter of 8 WTE, despite an overall increase in staff turnover of 0.4%. The survey of staff who left was undertaken however the number of returns were low and were predominantly from individuals who had retired after a long and positive career with the Trust. There were therefor no insights from this piece of work.

Sickness absence has increased during the quarter due to increased long term absence and to a lesser extent, winter health conditions (cough/cold/flu and gastro-intestinal illnesses). The moving annual average however continues to fall and remains circa 0.5% below levels in April 2013. Information from Health Education West Midlands indicates that the Trust's overall levels of absence remain 0.9% higher than other acute specialist organisations, with absence relating to stress/anxiety/depression circa 12% higher. Managing stress will therefore be a key feature of the Health and Well Being Action plan which is in development following work with NHS Employers and the Royal College of Physicians.

Mandatory training has risen by 2% in quarter but remains below our internal target. All directorates will need to submit trajectories to achieve 90% compliance by March 2014. Levels of appraisal have risen by 17% due to considerable focus by the clinical directorates. All areas have set their own trajectory for achievement of 90% by the end of March and are on target to achieve this.

2. Pay Negotiations

Constructive negotiations continue with the local and regional full time officers concerning implementation of revised arrangements for incremental progression for those staff employed on Agenda for Change terms. It is expected that formal agreement will be reached by the end of January to link pay progression in 2014/15 with attendance at mandatory training, appraisal and the absence of performance and misconduct concerns. For supervisors, managers and leaders, individual pay progression will be linked to achievement of Trust targets relating to appraisal and mandatory training within their areas of responsibility, as well as for them as individuals. Negotiations will then continue to reach agreement about implementation of pay progression linked to skills, knowledge and delivery from April 2015.

3. Electronic Staff Record (ESR) – Implementation of Self-Service Functionality

The project to roll out both employee and manager self-service functionality for the HR and payroll information system, ESR is underway. The current focus of the project is testing IT functionality and pay process re-design prior to commencement of formal pilots. It is envisaged that the functionality will be rolled out over a 12 month period. The objectives of the project are to increase ownership by staff and managers of workforce information,

streamlining of some pay actions by conversion to electronic processes and enable real-time availability of staff information.

4. **Recruitment Process Improvement**

During the quarter work has been undertaken to explore how best to facilitate further improvement in recruitment times. Information has been provided to a potential third party company already on NHS Procurement frameworks to explore the feasibility of outsourcing. In addition conversations are progressing with UNIPART concerning potential for some joint working. A formal proposal is awaited from UNIPART.

5. **Staff Awards**

Over 130 nominations were received for this year's awards from all areas of the Trust. The awards ceremony will take place on Friday 31st January, facilitated by Sandy Barton. A number of those staff who have made nominations will be filmed and these will be shown at the ceremony.

6. **Staff Survey Results.**

The initial results from the staff survey undertaken between October and December 2013 have been received.

For the second year running, positive responses have been received in relation to personal development and training received within the Trust (various questions improving from +5% to +25% over three years). Staff are seeing the increased focus from senior management on involving them in decision making (+8%) and acting on feedback received (+4%). We also continue to see an increase in favourable responses in relation to the Trust being a good place to work (+4%) and receive treatment (+2%). Staff opinion on the care of patients/service users being the top organisational priority has increased by 2% in year and 3% over 3 years.

The areas for improvement correlate strongly to the output of the work undertaken by MSB in particular:

a. Your Job

The percentage of staff feeling able to make improvements in their area of work decreased by 8% and the level of satisfaction with the freedom staff have to choose a method of working decreased by 9%.

b. Your Managers

Six percent fewer staff said their immediate line manager asks for their opinion before making decisions that affect their work and perception of communication between senior managers and staff remains flat at 38%

c. Your health and well-being

Staff reported greater pressure to attend for work, either from their manager (+3%) and colleagues (+2%).

d. Safety at Work

The overall trend for reporting incidents is a cause for concern. The percentage of staff reporting an incident reduced by 2% in year with an overall decrease of 6% over three years. However within this there is an improvement in staff taking personal responsibility with an increase of 17% over 3 years of staff reporting incidents themselves rather than leaving others to report on their behalf.

More staff perceive the organisation blames or punishes people for errors or near misses (+7% in year and +9% over three years). Fewer staff feel safe to raise a concern (-4% on last year and -5% over three years) and fewer staff have confidence the organisation will address their concerns (-7% on last year and -8% over three years). A culture of strong reporting of concerns, errors and near misses is important in driving service improvement and staff engagement. This therefore will need to be a key priority for action.

The percentage of staff personally experiencing discrimination from their manager or other colleagues remains flat at 8%.

Once the full survey results are received with the benchmark data a full report will be provided to the Trust Board, together with the OD Strategy and Plan for addressing the key issues.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD ON
WEDNESDAY 29TH JANUARY 2014,
9.45am – 1.00pm IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
1	**Apologies for Absence** Chairman	Frances Kirkham	To Note	
2	**Introductions & welcome** Chairman		To Note	
3	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
4	**Minutes of Public Board Meeting held on the Wednesday 18th December 2013** Chairman		For Approval	Enc. 1
5	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
6	**Chairman's Report**		For Assurance	Verbal
7	**Chief Executive's Report** Chief Executive Officer		For Assurance	Enc. 3
8	**Medical Directors Report** Medical Director		For Assurance	Enc. 4
	Performance Management / Assurance Reports			
9	**Corporate Performance Report** Director of Finance		For Discussion	Enc. 5
10	**Programme Board Update** Director of Operations		To Note	Enc. 6
11	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 7
12	**Quarterly Governance Declaration** Chief Executive		For Assurance	Enc. 8 – to follow
13	**Quarter 3 Workforce Report** Director of Workforce and OD		For Discussion	Enc. 9
14	**Any Other Business**			
	Date of Next Meeting: Wednesday 26th February 2014 8.30am – 1.00pm followed by work shop			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD ON
WEDNESDAY 26TH MARCH 2014,
8.30AM – 12.00 NOON IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
03/14/34	**Apologies for Absence** Chairman	Andrew Pearson	To Note	
03/14/35	**Introductions & welcome** Chairman		To Note	
03/14/36	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
03/14/37	**Minutes of Public Board Meeting held on the February 26th 2014** Chairman		For Approval	Enc. 1
03/14/38	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
03/14/39	**Chairman's Report** Chairman		For Assurance	Verbal
03/14/40	**Chief Executive's Report** Chief Executive Officer		For Assurance	Enc. 3
03/14/41	**Medical Staff Committee Report** Deputy Medical Director			Enc. 4 – to follow
	Performance Management / Assurance Reports			
03/14/42	**Annual Plan 2014-16** Company Secretary			Enc. 5
03/14/43	**Budget Approval 2014-15** Director of Finance			Enc. 6
03/14/44	**Corporate Performance Report (inc CIP & RTT Rectification Plan)** Director of Finance			Enc. 7
03/14/45	**Patient Quality Report** Director of Nursing & Governance			Enc. 8
03/14/46	**Board Assurance Framework** Director of Nursing & Governance			Enc. 9

03/14/47	**Trust Annual Equality Report 2014** Director of Workforce and OD			Enc. 10
	Strategy			
03/14/48	**Trust Response to Francis Enquiry** Director of Nursing & Governance			Enc.11
	Board Committee Reports			
03/14/49	**Audit Committee Report** **Clinical Governance Committee** **Remuneration Committee** **Charitable Funds Committee**			Enc. 12 – to follow Nil Nil Verbal
03/14/50	**Any Other Business**			
	To be followed by a work shop			
	Date of Next Meeting: Wednesday 30th April 2014 8.30am – 1.00pm followed by work shop			

Enclosure 1

Minutes of the Trust Board Meeting
held in public on Wednesday 26th February 2014 in the Boardroom

Present:
Trust Board
Mr Tim Pile, (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Mr Andrew Meehan, Non-Executive Director
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director

In attendance:
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development

Agenda No.	Agenda Item	ACTION
02/14/17	**Apologies and welcomes** There were no apologies.	
002/14/19	**Declarations of Interest**	
	No other Declarations of Interest than those registered previously.	
02/14/20	**Minutes of the Trust Board meeting held on 29th January 2014**	
	The minutes were approved as a correct record.	
02/14/21	**Action Points** The action notes were updated (see separate sheet).	
02/14/22	**Chairman's Report** TP deferred to the CEO.	
02/14/23	**Chief Executive's Update** **1.Care Quality Commission (CQC): Hospital Inspection Programme** The Care Quality Commission (CQC) had written to advise the Trust that it would receive an inspection between April and June 2014; the inspection will be undertaken using the new CQC model. The inspection team would comprise over 20 people and	

	be headed by a senior NHS clinician or executive, working alongside senior CQC inspectors. They would be on site for 2 days. Mr Pile asked the Board to acknowledge that this visit would be during what is already an extremely busy phase for the trust and adds yet more pressure. Mrs Shoker advised that her team had been discussing with colleagues elsewhere the nature of these inspections in order to prepare the organisation as fully as possible. Ms Cholmondeley advised that the trust would offer support to staff following the visit as had been seen to be good practice elsewhere.	
	2. Development Strategy The Executive Team and the Board had commenced its programme of activities in support of the strategy refresh the Board agreed to undertake in recognition of the changing external context and leadership changes within the Trust. The submissions to Monitor would occur in two phases: Phase 1 – 4 April 2014 – for review by Monitor April to May 2014 Phase 2 – 30 June 2014 – for review July to September 2014 The Board noted the following actions: • Main CCG partners have been invited to nominate a lead clinician and manager to work with the Trust to ensure alignment of forecasts and plans. • The lead manager with the specialised services commissioning team has been approached to work with the Trust. • A number of internal reference groups are being established to enable a cross-section of staff within the trust to engage in the process of review and development, the first meeting of the consultant clinical reference group is due to take place on 28 February. • An inclusive and participatory event with all key stakeholders is being planned for late April to further test and develop the emerging plans. • The capital programme is being reviewed with a view to ensuring that the profile and phasing of investments will support and enable operational plans to be delivered in the first two years and create a platform for strategic transformation over the longer term. • Short-term enabling investment is being considered and outline plan developed to utilise reserves to expedite	

	transformational capabilities. • A commercial partner has been commissioned to provide advice and 'critical friend' external challenge to the Trust during the development of the plans.	
	3.West Midlands Provider Chief Executives' Meeting Mrs Chambers gave a report on the meeting which covered 1.The National Trust Development Authority - current performance and planning challenges within the NHS Trust sector. There continues to be pressure on Accident and Emergency services and. concerns were also expressed regarding the Referral to Treatment (RTT) times for patients because waiting lists nationally are beginning to build up. Trusts were signposted to the National Audit Office report on this subject which includes recommendations considered to be helpful to all. **This would be discussed at Audit Committee**.: • A new accountability framework is expected to require to some form of external validation of RTT processes every three years and internal audit every year. • Access policies should be reviewed every year and published. • Annual Governance statements should include reference to assurance for RTT. It was likely that Monitor would introduce a requirement for external validation of RTT for foundation trusts; a review of access policies annually and inclusion of a reference to RTT in the annual governance statement and the Trust will consider these recommendations as part of its ongoing work to improve its RTT management procedures 2. Chief Executives noted the challenge of developing whole health economy plans in parallel with emerging commissioning strategies and meeting the rising demand for services within a tight financial settlement. The tariff uplift includes some allowance to implement the recommendations contained within the Robert Francis report on Stafford Hospital, however, the costs of doing so will be variable across different organisations causing some concern. Mrs Chambers advised that the business plans coming forward indicated that the trust would be delivering several initiatives of relevance to Francis. 3. The new Director of the West Midlands Academic Health Sciences Network (AHSN), Chris Parker, had presented an update on the establishment of this new entity**. It was agreed**	**TS/AP/ Ed**

	that Mr Southwood, Mr Pearson and Mr Davis meet with David Adams to revitalise the Trust's academic strategy. 4. Sir David Nicholson, the out-going Chief Executive of NHS England, had also presented the new NHS England strategy, which will form the framework within which Clinical Commissioning Groups and Specialised Services commissioners will be developing their strategic plans. The strategy comprises six new models of care designed to address the unprecedented scale of change required to meet the challenge faced by the NHS and are considered to be the characteristics of a sustainable system. The tariff and other levers and incentives would be used to deliver the changes required. In relation to the Trust's strategy development the areas of greatest significant would be the strategic direction for elective care and specialised services, which will be considered by the Board in its work to refresh its strategy.	**Davis**
	4.Specialist Orthopaedic Alliance A meeting of the Specialist Orthopaedic Alliance (SOA) had taken place on 7 March, bringing together Chief Executives, Medical Directors and Finance Directors. (The Royal Orthopaedic Hospital is one of 5 founding members of the alliance, which now has 14 members). Key topics discussed and presented on included • National Joint Registry update. • The 'Getting it Right First Time' project (benchmark data will be available from April for ROH – focusing on joint replacement) • Specialised Services Commissioning consultation. Key considerations in the designation process will be: o Research and teaching capabilities – centres of excellence o Volumes of activity – minimum thresholds o Core requirements – standards The consultation process will define a 5 year strategy for specialised services. Mr Southwood felt that the SOA should be further encouraged to undertake work which seeks to identify and advance best	

	practice. Ms Mountford asked if the SOA was being listened to by those in political corridors of power and was advised that it was, and that this was supported by its membership having some very strong voices with great professional credibility. **The Board noted the Chief Executive's report.**	
02/14/24	**<u>Medical Director's Report</u>** Mr Pearson presented the Medical Director's Report which summarised meetings attended. Mr Pearson advised the Board that the staff investigation had now called in external support. Steps had been taken to ensure that no harm come to patients as the investigation continued. Staff appointed to roles in ADCU and theatres were very enthusiastic and it was anticipated that this would have a very positive impact. Revalidation processes at ROH were going well and the trust was generally ahead of its peers. Mr Southwood asked that Mr Pearson consider preparing a more issues based report rather than listing meetings attended. FK asked for a more detailed report on clinical directors**. It was agreed that Mr Pearson and Mrs Markall in corporate more information into the report for the next meeting.** **The Board noted the update**	**AP/AM**
02/14/25	**<u>Corporate Performance Report & Programme Board Update</u>** Mr Athey and Mrs Markall presented the activity and financial updates. Performance in January 2014 was 27% higher than in the previous January. Inpatient performance continued to be below plan and much below rectification plan, whereas day case activity was much higher than planned and above the trajectory of the rectification plan. There was financial impact as a result of this in excess of £436K down compared to the rectification plan. Figures to date for February were presented and an under-achievement of 80 cases was possible (this may be bettered as validation takes place). Mr Southwood asked about the predictability of the service. The rectification plan had predicted that the trust could turn things round yet this had not been delivered. Was the plan predictable for failure or not, given what we knew. Mrs Markall commented	

	that more patients had come through the system but the change in case mix had not been anticipated yet had persisted all year. Mr Southwood commented that the surgeons would know what they were going to do in terms of procedures. AM felt that the absence of robust and timely data made planning a challenge. Mr Pile commented that forecasting was clearly a challenge and asked if it were possible to tag patients earlier in the pathway to indicate the profile more accurately. AM advised that at present this would necessitate major manual effort. AP confirmed that an IT system would help. Mrs Kirkham asked if the rectification path should be revised given the work to date. Mr Athey and Mrs Markall indicated that they would share a revised forecast within the presentation. Mr Pile felt that the strategic issues around how the market now works must be assessed. NEDs expressed concern at continuing to live with uncertainty in the absence of a good IT solution. Mr Pearson felt that the plan had been based on very positive assumptions but that this degree of optimism was unfounded in reality. Mr Southwood felt that the key bit of information which was missing was the identification and quantification of high tariff patients. Mrs Kirkham felt that the Board needed some timescales on when the information might be sufficiently robust to support adequate planning. TP suggested that work-arounds would be needed for many months to come. Mrs Chambers advised that the team had been asked to consider in detail the work planned for the next six weeks. TP agreed but felt that a greater depth of data was needed to underpin better forecasting. AP suggested that a coder in the rapid assessment clinic could make a difference. HS advised the Board that the teams of staff working really hard to support this programme needed to be encouraged to maintain their morale despite a year end position that may not seem positive. Mr Athey reminded the Board of how the rectification plan was developed to bring the Trust back to its planned financial	

	surplus. The change in case mix is forecast to leave the Trust £1.3m down on its planned healthcare income at the end of the year. This equates to a shortfall on contribution of £0.4m and is the main driver for a forecast shortfall against the Trusts financial surplus target at year end. It is anticipated that the Trust will finish with a surplus before impairments of £2.0m against a plan e of £2.4 early indications from our external valuer are that the trust should expect a significant impairment in it 2013-14 accounts as s result of the valuation of the ADCU building, Mr Athey highlighted that this is purely an accounting adjustment and is excluded from Monitors risk ratings. Contracts for next year were based on the new mix of activity. Mr Pile asked how this might affect ratings and was advised the trust would still stay ranked as a four. Deloittes had also benchmarked their clients and ROH came in third for financial strength. Mr Athey also commented that the trust's performance needed to be compared to that of trusts as a whole. Mr Pile congratulated the team on its achievements on delivery of initiatives and growth in patient numbers despite the marginal failure to achieve a financial target. He asked that this be relayed to staff in a balanced but very positive way. Mrs Markall explained the management processes in place and updated on the annual leave, study leave and professional leave position. CDs had been reminded of the processes and need for compliance and a review was being undertaken which would underpin the development of a new policy which will maintain patient safety but also affirm that patient waits are a key quality indicator. She also highlighted additional centralised management responsibility for 18 week RTT coupled with dedicated analytical support. Mr Athey confirmed that Monitor ratings would be 4 and green. Mrs Markall confirmed that the trust had no patients waiting over 52 weeks. The 18 week target had been failed for the third month (as predicted) this was due to increased numbers of outpatient's attendances. This would be rectified from the new financial year. All other targets had been achieved with the exception of the imaging 6 week target where demand for scans exceeded supply locally and with partners. Ms Cholmondeley advised that the release of staff for mandatory training had dipped due to the demands on them to	

	maintain activity. Appraisals completion had also dipped though there may be some tolerance for administrative errors. The staff survey scores on appraisals were reassuringly strong. Mr Pile suggested that staff turnover could be a very useful indicator as we moved forward. Mrs Chambers felt that some staff turnover was good and brought new ideas to the Trust, but that we should aim to understand the reasons for turnover. Ms Mountford suggested that there should be some trend analysis to consider, for example, the connection between appraisal/PDR and staff turnover. Mr Pearson advised that there had been a case of CDiff in a patient who had had this before and had multiple anti-biotic treatments. Mrs Shoker noted that although bank and agency was higher this was in part due to opening ward 7. Nursing staff felt this was appropriate. Ms Mountford asked whether there should be concerned at an apparent rise in pressure ulcers and was advised that this was cumulative figure. Mrs Markall referred to the patient survey which indicated that food satisfaction levels had risen from 65% to 90% plus. We had been approached by a national organisation to help work on improvement in hospital food using our experience. There was a follow-up television programme and this should be publicised to staff.	
02/14/26	**<u>Clinical Programme Board and Estate Board Update</u>** Mrs Markall highlighted the work on Ward 12 and the closure of Ward 7 from April. Mr Pearson advised that he was talking to surgeons and anaesthetists on Friday about the agreed approach to enhanced recovery. He felt that this would improve next month. Medical workforce issues remained of concern. Mr Pearson noted that there had been an expression of interest from someone, but they had withdrawn, possibly because it will be so challenging. Ms Cholmondeley advised that they were looking for medical workforce specialists to support Mr Pearson. **The Board noted the report**	
02/14/27	**<u>Patient Quality Report</u>** Mrs Shoker introduced the Patient Quality Report and	

	highlighted the following: • The report is still work in progress and will be further improved • Incidents had been discussed with senior nurses and it was felt this rise was predominantly about better reporting • There had been no pressure ulcers on ward 3 for 8 months and are disappointed at having had an incident • Leadership challenges in HDU continued to be tackled • Patient harm meetings take place once a month • WHO compliance – 100% in January. • CQUIN targets are being met and the challenge of meeting the dementia target had always been recognised as significant but the trust had met it for three successive months. Consideration is being given to wider dementia screening. VTE CQUIN was on track for quarter four. • Patient experience showed PALs as very high but only half were concerns with clinical care as opposed to queries for health. JC asked how the target had been set and HS was unaware of how this had been done in the past. If senior sisters (a funding proposal) are visible, then PALs and complaints should drop • Friends and Family results remain one of the top in the country. The response rate has dropped slightly but patient services team are working with ward staff to get the rates up again. A bid has gone in for a technology solution which would allow some real-time feedback. • PROMs – further detail will be available in March. • Safety thermometer performance was good. • Spinal directorate and Ward 1 had been subject to some scrutiny over patient quality matters and the changes in leadership is having clear and positive impact. • Mrs Chambers asked for assurance that the falls meetings (reported as poorly attended by some areas where falls were high) were being seen as important. HS responded that the falls awareness was begun in pre-op and that wards would have the right skill mix to support patients. **The Board noted the Patient Quality Report**	
02/14/28	**<u>Trust Annual Equality Report 2014</u>** Ms Cholmondeley introduced the report and highlighted the Trust's public sector equality duty. There had been improvements in data capture and staff awareness of issues, but recording of information about patients needed improvements as did assessment of service change	

	impact on people with protected characteristics. There may be issues around promotion and discrimination among some communities. There is a gender pay gap and very few of the trust's 16 -25 year olds participate in learning. FK felt that the gender pay gap should be reviewed and AC advised that this would be looked at over the next 6 months. Mr Pile asked for reassurance that the pay gap was based on role rather than anything else. Mrs Chambers felt that Agenda for Change meant that there was assurance that this should not be other than role based. More detail would be sought over time. Ms Mountford asked if there were any barriers to progress, or pace of progress. Ms Cholmondeley felt that it would have been better to be further ahead, especially with patients but that capacity was a limiting factor. Ms Mountford commented that there were so few women in consultant roles and Mr Pearson suggested he wanted to tackle this issue, especially given that the majority of graduate medics were female. ROH should endeavour to make its brand attractive to women. Mrs Kirkham felt that the culture of an organisation should be welcoming to women. Ms Mountford asked that consideration be given to when things might be done within a plan and to consider whether discrimination really does take place during recruitment and promotion interview processes. Mrs Markall felt we should be concerned about Trust staff being representative of the local population whereas it is not representative of Birmingham. Mr Pile felt that if the trust were to determine to draw patients from a wider area, its staff would need to better reflect that population profile. Mrs Chambers felt that there were opportunities to market the Trust as welcoming to a wide group of patients in order to encourage greater participation from more diverse groups than currently make up our patient population. It was suggested that a final re-draft be undertaken to ensure that all ideas were taken on board and that the language used	

	reflected the key areas of concern. **The Board noted the report and asked that re-drafting be undertaken prior to formal release of a revised paper which would be approved at a future board meeting.**	**AC**
02/14/29	**<u>Audit Committee Report</u>** No meeting held.	
02/14/30	**<u>Remuneration Committee</u>** No meeting had taken place. Mr Pile asked that Saxton Bampfylde prepare a brief report for the Board on Chair Recruitment.	
02/14/31	**<u>Clinical Governance Committee Report</u>** Mr Southwood circulated the report on the work of his committee which highlighted: • NHSLA – changes are expected in April 2014 and preparation is underway to mitigate this – it may be a useful topic for a TBALD • BAF – the committee remains unclear about its remit but feels that staff engagement needs scrutiny other than at EMT • Committees concerned with evaluation are still silo working and asked that these might come together and be better resourced • PROMs reported that there had been decisions about influencing better PROMS – physiotherapy and follow-up of patients. • How to support staff who are whistle-blowing so that they were not ostracised. AC confirmed that the policy needs refreshing in light of the Francis Report. The committee had felt that there should be pro-active support for the person. This should apply to less formal raising of concerns as well. HS commented that this links to duty of candour and how comfortable staff feel about raising concerns even about their own practice. Next year there will be a staff survey on patient safety culture. TS talked about a move from fair blame to fair accountability. • The dementia CQUIN for 2014/15 will pose a risk if the trust is to make appropriate assessments. **The Board noted the report**	
02/14/32	**<u>Charitable Funds Committees</u>** No meeting held.	

02/14/33	**<u>Any Other Business</u>** Mrs chambers advised the Board that the Staff Awards event (Bollywood) had been a great success. Mr Pile endorsed this and welcomed the fact that all the executives had attended. Mr Pile asked what process was in place to capture feedback from NEDs about visits to parts of the trust**. It was agreed that we put a new item on the agenda and ask NEDs to feed into this.** Mr Pile had visited ADCU and found it very impressive. Mr Pile had been to a volunteer event and felt their role to be very important **and that a strategy should be discussed at a future meeting.**	**JS/JC** **JS**
<u>Date and Time of Next Trust Board Meeting</u> March 26th 2014 at 8.30am 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

Enclosure 2

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 26th February 2014

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
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
07/13/1447	Proposal for Option Appraisal Commercial Tissue Requests Process to be fully explained to theatre staff.	ED	Sep 2013		Outstanding. AP to contact ED and update in January 2014. Suggest AP puts in his report
01/14/07	Corporate Performance Report & Programme Board Update EM asked that the compliance with annual leave policy be reviewed to identify the extent of breaching		April 2014		
02/14/23 Chief Executive's Update (26.02.14)	The new Director of the West Midlands Academic Health Sciences Network (AHSN), Chris Parker, had presented an update on the establishment of this new entity**. It was agreed that TS, AP and Ed Davis meet with David Adams to revitalise the Trust's academic strategy.**	TS / AP/ Ed Davis	April 2014		
02/14/24 (26.02.14)	TS asked that AP consider preparing a more issues based	AP / AM	April 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
Medical Directors Report	report rather than listing meetings attended. FK asked for a more detailed report on clinical directors**. It was agreed that AP and AM prepare something**				
02/14/28 Trust Annual Equality Report 2014 (26.02.14)	The Board noted the report and asked that re-drafting be undertaken prior to formal release of a revised paper which would be approved at a future board meeting.	AC	March 2014		Re-draft on March Board agenda

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26 March 2014 **ENCLOSURE NUMBER: 3**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Chief Executive's Report**

SUMMARY

To update the Board on national and local issues.

IMPLICATIONS

To ensure Board members are aware of the context and policy framework in which the Trust is operating, to support and inform the development of strategy and Board oversight of performance.

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

Report to: Trust Board

Report of: Chief Executive

Purpose of the Report: To update the Board on national and local issues.

Recommendation: The Board is asked to note the contents of the report and discuss items as appropriate.

This report provides Board members with an overview of key issues in relation to the Trust.

1 Strategy Development – Update

The early work to support a review of Trust strategy has now been shared with senior managers, clinical directors, staff members and the Council of Governors to test and develop ideas based on analysis of external influences, market analysis of services and forecasts of demand. The key themes to emerge from the work to date include:

- Delivering excellent patient experiences and best clinical outcomes
    - Caring about the whole patient journey
    - Achieving best clinical outcomes for routine care, and
    - Doing complex, specialist activity that no-one else can do
- At the forefront of research, innovation and education
    - As a specialist organisation we will lead the way with new discoveries and provide excellent educational opportunities
    - We will strengthen our collaboration with research and industry partners to accelerate the introduction of new technologies
- A valued partner
    - We recognise the increasing importance of collaborating with others within a complex local health system
    - We will work with our partners to ensure that patients get the specialist care they need as a centre of excellence in orthopaedic care
- A great place to work
    - We train, develop and empower our staff to ensure that patients receive the best possible care because our staff feel a great sense of pride in their work and feel valued

These themes enable the Trust to build on its tradition of delivering high-quality and innovative care, whilst at the same time putting patients' experiences at the centre of how we work. We will continue to set new standards as the specialist centre of excellence for orthopaedic care as well as offering services that support musculoskeletal well-being in the most appropriate setting for patients.

We recognise that there are a number of areas which require investment to enable the Trust to start to deliver this next phase of its development and proposals will be

developed to enable improvements to be made over the next couple of years in support of the strategy.

Key areas for investment include:

- IM&T, especially clinical and patient management systems
- Increase diagnostic capacity
- Improve communication systems including the Trust's website
- Service transformation capability
- Leadership development to support the change management process
- Enabling works for new theatres

These actions will enable improved patient waiting times and flow, improved booking for patients, improved communication between ROH clinicians, patients and their GPs and new ways of working to provide more holistic care to patients.

At the Board workshop there will be further consideration of the emerging themes.

To support the Trust in further testing and developing the emerging themes a number of stakeholder engagement activities are underway as described in the next section.

2 Strategy Development – Stakeholder Engagement

As part of the work underway to develop the Trust's strategy a number of stakeholder engagement opportunities are being introduced and planned. A consultant clinical reference group has been initiated and other internal groups are being formed to seek the active involvement of staff in the development of ideas and proposals for the future.

Additionally, a large scale stakeholder strategy day is being planned for 25 April 2014, which will involve a wide variety of internal and external stakeholders. Invitations are being sent to members of staff, commissioners, partners and other stakeholders with the intention of seeking a wide range of insights to help develop and test emerging thinking.

Board members and the Council of Governors will also be in attendance at the event and will have the opportunity to work collaboratively with others as strategic proposals take shape.

3 Executive Management Team – March 2014

Key points to note from this month's Executive Management Team meeting, held on 19 March, are:

- A review of the EMT Risk Register items and Board Assurance Framework developments. Further work will continue to clarify the reporting process and follow through of actions.

- Quality, performance and financial reports, including the 2014/15 budget setting paper in which proposals for the revenue and capital budgets were unanimously supported for recommendation to the Board.
- A business case was supported which will bring additional MRI capacity on-site. The on-site mobile scanner will reduce the number of scans done at multiple settings off-site and also enable the backlog of waits to be reduced. Further work will be undertaken regarding the use of external reporting compared to using additional internal reporting capacity. There is a capital cost of £40k to house the scanner and an additional revenue cost of £95k for which there will be improved convenience, capacity and patient benefit through reduced waiting time.
- The annual information governance year-end report was also received and action plan noted. Further work is required to ensure compliance with training requirements.
- The latest strategy development work was discussed and it was noted that there will be a large scale stakeholder engagement event on 25 April to coincide with the usual Trust Business and Learning Day; a significant number of staff will be involved in the strategy workshop together with a variety of external stakeholders.
- A number of new policies or policy amendments were approved and will now be cascaded through the organisation.
- A small increase in car parking charges was agreed.
- A presentation was received on the high-level staff survey results for 2013.

4 Monitor's Quarterly Analysis

Monitor, the regulator for foundation trusts, conducts a quarterly monitoring analysis based on Board's governance declaration. This exercise has been completed for quarter 3 and the Trust's ratings are:

- Continuity of services risk rating - 4
- Governance risk rating - Green

It was noted that the Trust has been assigned a Green governance risk rating but has failed to meet the Referral to Treatment Time (RTT), 18 weeks (admitted patients) target.

The commentary on the key risks facing the Trust noted the actions the Trust is taking to improve the 18 week RTT position, the appointment of the new Chief Executive on 1 December 2013 and the on-going process to recruit a new Chairman and non-executive directors, and the response to the staff engagement diagnostic work.

5 Foundation Trust Network

The Trust is a member of the Foundation Trust Network and there are various networking systems available to support foundation trusts and aspirant FTs appreciate the national context in which we are operating, together with opportunities

to hear how various organisations are meeting some of the common challenges that we face.

Key points to note from the topics discussed in March were:

- The overall strategic position remains a challenge nationally
    - Slow public deficit reduction
    - The biggest and longest financial squeeze in NHS history
    - £25bn cuts anticipated in the next parliament – the £20bn 'gap' was based on a presumption that the NHS would be ringfenced from further cuts, but that may not be a sustainable position throughout the period of recovery
    - Concern that the 2015/16 'financial cliff edge' will occur in 2014/15 with more trusts reporting deficits in 2013/14
    - Additional service pressures arising from the transfer of resources in the Better Care Fund and responding to the Francis recommendations
    - Lack of system strategies to address rising demand
    - Increasingly difficult to balance financial and quality, so finances are deteriorating across the provider sector
- Tariff and financial outlook
    - 2014/15 tariff worse than expected -1.5% for acute trusts compared to -1.1% in 2013/14
    - Differential tariff for non-acute trusts being challenged
    - Specialised services budget under significant pressure – unidentified QIPP targets of 8% - 10% being set
    - Longer-term exploration of multi-year tariffs and CCG allocations
    - 2014/15 contracting is behind in many places
    - Monitor 'affordability challenge' running significantly higher than usual level of savings and assumes 'flat cash'.
    - A real challenge ahead regarding timescales to move to new models of care and the ability to deliver service changes and reconfigurations to deliver savings
    - New system responsibilities still in the process of clarification
    - Capacity for longer-term changes impacted by immediacy of 'make do and mend' to deliver daily operational requirements
    - Some Boards will face a difficult 'Declaration of Sustainability' decision as part of strategic plan submissions.
- Commissioning
    - The first clinical commissioning group (CCG) mergers are taking place, indicating the likelihood of further reform to ensure CCGs effectiveness
    - Specialist commissioning consultation indicates a likely reduction from 290 to between 15 – 30 centres in future
- Regulation
    - Care Quality Commission (CQC) inspections are gathering speed. The ROH is scheduled for a new style inspection in June 2014
    - Special measures are being triggered by CQC inspections but it is unclear how trusts get out of special measures
    - There is an apparent growth of interventionism and performance management, which has doubled since last year (Monitor)

Further work continues nationally on a number of key projects including:

- Urgent and emergency care pathway
- Consultant contract negotiations
- 7 day services – moving beyond acute services and costing proposals
- Rose review of NHS leadership
- Dalton review of 'hospital chains'
- European Working Time Directive
- Review of staff engagement and ownership models
- Land sales and the Department for Communities and Local Government
- Board diversity

Additionally, David Bennett, Monitor's CEO, gave a presentation and participated in an interactive session on key issues for foundation trusts. There were three challenges identified for all organisations:

- Driving operational changes to meet NHS targets as well as addressing the quality agenda
- Getting longer-term consensus regarding new models of care and implementing them
- Finding and supporting the leadership to make the necessary changes

Monitor is increasingly interested in organisational capability to manage change. Monitor's primary duty is to promote and protect the interests of patients.

The strategic planning process will help to identify problems and support discussions about the challenges the NHS is facing going forward. Not all health economies have good commissioning plans in place yet and therefore trusts must sign off based on 'best efforts', recognising the uncertainty in the system. The first 2 years of the plans should be more concrete but longer-term there will be more iterations as the scale of the challenge becomes clearer.

6 Conclusion

This paper provides a high level overview of the range of significant activities going on at a national and local level, which will impact on how the Trust moves forward and develops its own strategic response.

7 Recommendation

The Board is asked to note the contents of this report and discuss as appropriate.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Annual Plan 2014-2016

THE centre for orthopaedic excellence

Annual Plan 2014-2016

Contents

Annual Plan 2014-2016

1 Executive Summary

The Royal Orthopaedic Hospital NHS Foundation Trust has prepared this two year plan in the context of its five year strategy. The first two years are dedicated to building a strong foundation for the future by investing in enabling transformational initiatives including clinical leadership development and change management capabilities. The trust, as a recognised specialist provider operating in close proximity to a very large acute facility, recognises the need to identify itself as a niche provider in the changing NHS landscape. We see ourselves as a provider achieving better outcomes than others and as having the capacity and capability to undertake complex and specialist work not done elsewhere. This requires us to concentrate on basic modernisation in support of an enhanced patient journey – ***rectifying hitherto slow–paced and under-resourced investment in technology*** and ***building robust partnerships that underpin service development*** rather than trying to achieve everything independently ourselves. Within the longer term this will allow the trust to establish itself as a self-evident leader in orthopaedic care, looking beyond surgical intervention towards ***health promotion and preventative activity*** and also ensuring that the trust is both ***innovative and an early adopter of best practice innovations*** in its field.

The 2 year plan therefore moves the trust away from generating surpluses for later re-investment, into the here and now of investing when the need arises. The Board identified capital investment in IT as a clear priority in 2012/13 and began a procurement process to provide the infrastructure necessary to support modern information systems. This plan accelerates investment still further by beginning the procurement of holistic IT services and clinical systems which will increase quality and provide much more robust assurance than has been possible with the multiplicity of systems currently in use. Much of this work will be done in partnership and allow us to learn from others who are more advanced.

In addition we intend to invest in an area of growing clinical pressure – imaging. Not only do ***we intend replacing our current MRI scanner, we intend adding a second***. This will enable us to repatriate work currently undertaken on our behalf elsewhere and reduce waiting times for our patients. We recognise it may also stimulate still more demand, but it may also offer an extra facility in the local health economy which already experiences demand pressures in this area.

These investments have necessitated a review of risk since our previous capital plan would have been to develop new theatre capacity in light of the need to mitigate the risk of theatre plant failure and potential loss of utilisation of three theatres. The trust has assessed this risk and identified an alternative mitigation that facilitates the

erection of temporary theatre space coupled with planned changes to working practice.

In terms of elective activity commissioned by our CCGs, the trust has secured a ***6% growth in contract value (against 2013/14 baseline) for the first year of this plan***. Activity profiles take account of the changes in ***case mix which follows the international trend away from inpatient stays, towards day case.*** At the same time we have taken account of growth in the elderly population of up to 2% per annum.

Specialist activity has maintained its year on year position and the trust has benefited from a small contract to deliver a sarcoma pathway from an additional CCG, thus meeting the needs of patients and enhancing our reputation and geographical coverage for specialist work.

Changes in working practice to accommodate enhanced weekend cover, ***operating over 6 days a week and additional physiotherapy to enhance outcomes*** have also been factored into these plans.

The trust has been cautious about generating additional income by significant growth in patient activity as its track record cannot justify this. Once the refocusing and efficiency gains of the next two years is underway, there will be evidence on which to base our marketing as a centre of undisputed excellence where patient and GP choice will be automatically directed towards our provision because its better outcomes will provide clear differentiation in the market place. The trust intends taking a radical approach to the development of its patient benefit by considering opportunities for service change beyond the incremental – for example a ***radical reduction in waiting time***. This will be evolved in line with the infrastructure changes identified within the IT and informatics strategies. The trust will (in consultations with partners) also ***consider major expansion of its broader musculo-skeletal services*** using its partnership with Bournville Village Trust to pilot an innovative approach.

New developments in the first two years will include ***baseline work to completely overhaul the trusts' learning, research and innovation capability*** and this will be done in line with the Academic Health Science Network and partner universities as well as the deanery. This will allow much greater focus on the training of doctors and our own staff and will encourage high calibre staff to join and stay with the organisation. The facility will take a multi-disciplinary approach and will encourage the involvement of local GPs and other clinical staff who may benefit from courses offered. It is anticipated that this will require capital and charitable investment.

The trust's quality agenda remains a top priority and this has been signalled by a refresh of the role of the Board's own Clinical Governance Committee and the infrastructure beneath. The trust will receive a CQC inspection in June 2014 and believes that its existing good practice, coupled with the additional interventions as a

result of much internal work on the Francis recommendations, will maintain its strong reputation for quality. A ***nursing skill mix review*** is underway and this will further ensure that the quality and quantity of staff remains right for the new patient profile. ***Leadership development will be prioritised*** at many levels and this will be tailored to the needs of the individual and their contribution to the annual and the five year strategic plan, with staff being absolutely clear about their roles. The ***engagement of the medical workforce continues to evolve***. It is likely that, in the early stages of this plan, the trust will undertake some internal restructuring to better align clinical teams and resources to the needs of the strategy.

In support of improved performance, the trust will ***move emphasis from 'targets' to 'standards of patient care'***. We believe this fits better with the ethos of the Francis report and speaks more directly to our staff. If the trust is seen to be getting it right for patients rather than trying to meet externally set targets, we feel it more likely that we will secure buy-in from the whole organisation. This also signals the benefits of adopting best practice and helps mitigate risk in situations where a huge variety of different approaches are taken to the same issue. At the same time, the trust will endeavour to retain the flexibility needed to meet the demands of individual patients rather than simply pushing them through a treatment process.

Financial information and activity summary

The table below shows the summary I&E plan for 2014/15 – 2015/16:

	2013/14 Forecast Outturn (£m)	**2014/15 Plan (£m)**	**2015/16 Plan (£m)**
Clinical Revenue	69.1	70.6	72.9
Other Operating Revenue	5.0	4.4	4.4
Total Operating Revenue	**74.1**	**75.0**	**77.3**
Pay	40.7	42.1	43.0
Clinical Supplies	20.5	21.0	21.2
Non Clinical Supplies	4.1	4.3	4.9
Other expenses	3.3	3.2	3.3
Total Operating Expense	**68.6**	**70.7**	**72.4**
EBITDA	**5.5**	**4.3**	**4.9**
Non-Operating Revenue & Expenses	3.5	3.8	4.4
Surplus before Impairments	**2.0**	**0.5**	**0.5**

The activity plan for 2014-15 and 2015-16, taking into account all the factors mentioned above, is shown below.

	13/14 F/cast Outturn	14/15 Activity Plan	Growth %
Day Cases	7,293	7,578	3.9%
Electives	6,726	6,988	3.9%
Non Electives	390	392	0.5%
TOTAL	**14,409**	**14,958**	**3.8%**

	14/15 Activity Plan	15/16 Activity Plan	Growth %
Day Cases	7,578	7,881	4%
Electives	6,988	7,268	4%
Non Electives	392	392	0%
TOTAL	**14,958**	**15,541**	**3.9%**

2 Operational Plan

2.1. The short term challenge

2.1.1 During the early phases of this plan, the trust faces some key internal challenges:

- The need to return to consistent delivery of the 18 week RTT targets despite changing case mix and increased demand
- The need to maintain high standards of data integrity and administration during transition to better IT systems and processes
- The need to maintain financial performance such that the planned outturn is delivered despite increased levels of committed spend set in initial budgets
- The need to develop, in parallel, the five year vision with the full engagement of staff
- The need to build from scratch, many of the partnership relationships that will be essential going forward and to maintain within those relationships a position of independence and strength when many will be much larger and more powerful than ourselves
- The need to develop business plans that take account of emerging best practice and to pilot new approaches without unnecessary disruption
- The need to recognise the need for change and find ways of making it less painful but more beneficial
- The need to evidence our competence within the organisation by delivering on promises
- The need to engage key people, identify champions and to welcome, accommodate and acknowledge staff who only wish to follow rather than lead, but nonetheless play a key role.
- The need to develop standards of practice throughout the organisation that are focused on patient benefit
- The need to take tough decisions on the range of clinical services offered and to ensure these fit within the context of the health economy.

2.1.2 The external environmental challenges include:

- Uncertainty over designation as a specialist centre
- Uncertainty over the national hub proposals for commissioning
- Not being one of the key commissioner priorities
- The potential impact of the Better Care Fund on resource available for investment

The trust aims to achieve a Continuity of Service Rating of 4 in the short term and for the period of the plan. However, there will be a number of short term financial challenges to ensure we meet this target;

- Increasing activity, whilst ensuring RTT times are met. The trust recognises that this will incur additional spend, and will therefore need to ensure that these costs are closely monitored, in particular, by managing the use of ADHs, bank and agency staff.
- In light of the increasing challenge in finding cost improvement efficiencies, the trust recognises the short term challenge of ensuring CIP plans are robustly developed, in order that they are deliverable, whilst also maintaining or improving quality of care.
- The trust is going through a period of significant investment in order to improve both clinical and non-clinical efficiency and improve patient care. In particular the trust is focussing on the development of IMT infrastructure and increasing internal imaging capacity. It will be important to track this spend closely, and monitor any financial or operational risks arising as a result of the developments.

2.2 Quality plans

- Implementing Francis Report Recommendations.

The organisation (through workshops with board, governors, staff and stakeholders) has identified the areas requiring focus and development..
Examples of underpinning work in 2014-2016 include :- supervisory practice for the senior sisters creating ward clinical environments that are conducive to healing and an excellent patient experience and, developing greater awareness of the duty of candour leading to an organisational wide culture of openness and transparency, ensuring complaints and incidents are reviewed at local level and lessons shared and disseminated widely. This links to our approach towards standard setting and adherence.

- Patient Safety Culture

A staff survey will be completed in year one to explore staff members' understanding and perception of the organisational culture of patient safety. This important initiative will inform the Board, allowing the appropriate and relevant steps to be taken to aid staff members in ensuring patient safety in an organisation that is supportive and welcoming of incident reporting or the escalation of concerns through other routes, such as whistle blowing.

- Maintaining the standards of existing quality measures

Maintaining and promoting standards will be a priority for year one and two as part of our setting of strong foundations. In year one the CDiff target of zero cases will be a challenge, however we welcome the national guidance for identifying avoidable/unavoidable cases. ROH has been undertaking root cause analysis of CDiff for some time as standard good practice, we shall share our experiences with colleagues regionally and nationally in the coming year. Pressure damage prevention has been a significantly successful quality improvement programme in recent years and we anticipate that in 2014-16 there will be a slower rate of reduction in the number of reported ulcers. This indicates that ROH is fast approaching the lowest level of achievable and avoidable damage and this will continue to be evidenced through robust and transparent root cause analysis.

Previous quality schemes, not specifically CQUINs, have been incorporated into the contract for 2014/15 and we anticipate achievement of these business as usual standards for our patients benefit.

- IT investment supporting enhanced quality

Quality standards, as measured by CQUIN schemes and local CCG contractual requirements, are currently heavily reliant on staff members to deliver processes and paper based recording systems. By nature this is cumbersome and poses certain risks to safety. The IMT strategy will bring technological solutions to the quality agenda – for example the introduction of e-prescribing will help eradicate avoidable drug errors; recording of Friends and Family data (including free text comments) will be via hand-held devices allowing for real-time review and action; clinical information on individual patients will be shared through data warehousing affording less opportunity for data error and patient harm; real time reporting is anticipated for pressure damage and patient falls.

The ability to review quality initiatives promptly will enable the wider organisation to share practice at increased speed, helping to prevent further harm/potential harm to other patients.

- Externalisation

The historical organisational record of excellent delivery against quality standards will be shared to a greater extent with the aim of educating our external stakeholders of the standards to be expected when referring their patients or commissioning services. This aligns to the two year strategy of a strong foundation from which to develop new services from years three to five. It is recognised that this highly relevant patient related knowledge has not been celebrated or shared sufficiently across the local health economy and will be vital in positioning the ROH in the West Midlands conurbation.

- Special needs of the elderly patient

The specific reference within the year one activity plan to the growing elderly population will be recognised through the detailed consideration and resulting actions taken from the Francis report recommendations for elderly care. This will include a review of the provision of physician care and continued development of safeguarding and dementia screening activity.

- New CQUIN scheme

Following sample patient pathways enables learning and awareness of the whole patient journey across our existing organisation. This will provide valuable details and inform the organisation of areas of strength and further development. Whilst the scheme has a prescribed number of patient journeys we anticipate undertaking further reviews in years one and two.

- 6C’s

The Compassion in Practice document (6C's) will be used to focus on behaviours appropriate to great care. At the same time we will be looking for new opportunities, for example to receive formalised feedback on our community based service, which will give us quality standards for expanding this type of work.

- Board Awareness

The review of the internal governance structure and processes undertaken in 2013/14 will be further embedded in year one. Following the announced CQC visit in June 2014 an action plan held at board level will oversee the implementation of any recommendations made. It is anticipated that the new inspection regime may identify aspects of our organisation's quality of care and the patient experience which have hitherto been less well scrutinised. The board welcomes the new inspection regime and the enhanced involvement in inspection by CCGs and will try to work in partnership so as to make the most positive response to any necessary changes.

- Board Assurance

The Board Assurance Framework and corporate risk register were also reviewed in 2013/14 and will be enhanced though actively working in the new manner through year one of the new strategy. This is highly relevant to ensure quality of care is supported throughout the next two years as the organisation sets its foundation for years three to five.

- Challenges.

- The introduction of IT based solutions across the nursing workforce has risks associated with implementation. This is an area that has previously been neglected across the organisation and so the wider nursing workforce are less familiar with the practical use of IT within patient care. These risks will be managed through sensitive and pragmatic support of the nursing teams.
- Maintaining the historical achievements in quality standards will be a challenge as the portfolio of contractual and CQUIN schemes increases and the short term risks of running existing paper based processes.
- Supporting staff to educate and empower on behalf of quality of care needs time and attention, but will be ameliorated by the introduction of a fourth matron post, implementation of supervisory time and the introduction of a supernumerary bleep holder role.
- Developing the nursing workforce in areas such as 6C's and Care Makers given the relative age profile and stability of the workforce in some areas and consequent lack of exposure to practices which are often well embedded in larger multi-speciality hospitals..
- Proposed structure changes will affect matron portfolios upon the introduction of fourth matron post and handovers and balance will require careful attention.

3 Operational requirements and capacity

Context & Challenges

3.1.1 Increased referrals → need to treat additional patients

Overall in 13/14 our referral rates increased, year on year, by more than 20% following a previous trend in reducing referrals over a couple of years. The growth has been seen predominantly for procedures such as injections and surgery on hands and feet. As an elective centre we believe that we can offer certainty to patients, in that limited exposure to emergency patients significantly reduces the risk that patients will be cancelled due to unplanned admissions and that exposure to infection can be controlled more closely.. Key challenges include:

- Understanding our referral pattern and identifying how to proactively manage any changes in demand and capacity along the whole patient pathway – OP/Imaging/Theatre/Bed.
- The established 16% increase in demand for MRI will be addressed in the short / medium term with a mobile unit that will be situated on the ROH site from Q2 14/15
- Actively promoting the Trust as the centre for orthopaedic excellence both amongst GP community, other referring centres and commissioners and most importantly amongst the public.
- Increasing working at weekends to make Saturdays a normal part of the working week – this commenced in 13/14 with theatres now working a minimum 2 weekends per month. Increased hours of operating in pharmacy, imaging and for therapies at weekends also implemented in 13/14 and this will extend further to include standardised OP Clinics at weekends and further therapy support in 14/15

3.1.2 Case mix changes → need to treat a different mix of patients

The trust saw a switch in case mix in 13/14 from elective to day case procedures with a 12% increase in Day Case procedures but a 6% reduction in elective work. This reduction in length of stay (LOS) and switch to day case is reflective of a changing health delivery model. ROH will therefore:

- Model the impact of the case mix change and increase ADCU (admissions and day-case unit) capacity accordingly (working later into the evening)
- Examine the type of surgery that currently goes through main theatres and look to re-provide this in other settings – either in ADCU/Injection Suite or in outpatients (OPD) for small joint procedures in particular.

3.1.3 RTT failure → need to smooth flow, reduce waits & improve performance management

In 13/14 we saw a 20% increase in outpatient referrals. As a result of this increase in demand, the trust failed to meet the RTT target for Admitted Care in Q3 and Q4. Work with the Intensive Support Team, internal audit of the RTT process along with National Audit Office recommendations in January 2014 have encouraged the trust to consider different ways of managing the waiting list. We will undertake full patient and process mapping in 14/15 along with continuation of capacity and demand exercises in key specialties and in diagnostic services. We are also examining our current policies with regard to leave arrangements for consultants as good discipline in this area, coupled with effective job plan reviews will allow us to better manage efficiency and build a base for delivering much reduced waiting times in the life of the overall strategic plan. This will complement work on 6 day working and flexible working patterns.

We will refocus management of waiting lists under 1 team and provide a more centralised approach, whilst still giving surgeons the discretion to choose which patients they will operate on according to clinical need. To secure maximum efficiency in process while maintaining the highest quality outcome for patients we will:

- Examine all aspects of the patient process from referral to discharge and implement Lean methodology.
- Work with CCG partners to provide a single point of access for referrals into the Trust either via choose and book or directly to the appointments office to reduce initial delays
- Get demand and capacity right in our key stretched specialties (spinal / spinal deformity and paediatrics), recruiting to additional consultant posts if required following robust cross team job planning.
- Undertake training needs analysis and ensure that our staff are trained and supported to deliver to an agreed standard which is supported by standard operating procedures and Policies.
- Complete the job planning exercise for all consultants commenced in 13/14 and to be finalised in Q2 of 14/15. This exercise will ultimately help us to provide a more flexible service for patients
- Examination of current Annual Leave/ Study Leave/ Professional Leave policies to ensure that they not only ensure patient safety but also that patients wait as short a time as possible for their surgery

3.2 Response to the challenges

3.2.1 Ensuring Appropriate Capacity and Improving Patient Flow

In 13/14 a programme of work commenced under a Clinical Programme Board (CPB). The CPB takes a project management approach working with key clinicians and managers in the organisation to address some of our most difficult issues, including:

3.2.2 Cancellation of surgery

At commencement of the project >5% of patients were being cancelled on the day of their surgery, some for unavoidable reasons such as illness but others for avoidable reasons such as running out of theatre time. Following detailed analysis and changing and improving processes, after 4 months this has reduced to 2% with an aim to reduce this further to 1% by the end of Q1 and sustain this position

3.2.3 Enhanced Recovery

Our targeted length of stay for hip and knee replacements is 2.5 and 3.5 days respectively due to consistently admitting patients on the day of their surgery and using the Royal Orthopaedic Community (ROCs) team to support patients in early discharge. However we aim to reduce this further and introduce a standardised approach to anaesthetics along with increased physiotherapy for patients including ensuring that patients are mobilised within 6 hours of their surgery. This “First Up” program will be delivered by nursing teams who will undergo a training programme commencing in Q4 of 2013/14and running throughout Q1 of 2014/15.

3.2.4 6/7 Day Working

Standardised theatre sessions now take place on at least 2 Saturdays per month however in 14/15 and by working in partnership with the Trust Consultative Committee, we aim to amend current and new staff terms and conditions to provide a more flexible workforce that can assist in delivery of services over a 6/7 day period as a standard. Clinical Standards will be developed in conjunction with medical colleagues to ensure that all patients are seen before and after their surgery.

3.2.5 Pre-operative and outpatient pathway

Since September 2013, no routine elective patient is admitted to ROH without being pre-assessed and clerked before the day of their admission. An anaesthetic clinic has been introduced alongside a rapid assessment Pre Operative Assessment Clinic (POAC) which ensures patients are assessed

and optimised before surgery. Additional improvements are required to continue to smooth out the processes that our patients go through. Wait times on the day of clinic for imaging are sometimes elongated due to demand and capacity restrictions in imaging. In 14/15. further imaging equipment is being replaced with faster technology that will allow 2-3 patients to be imaged in the time it currently takes to image 1 patient and our ability to image whole spines will triple, thus reducing waits and improving patients' experiences.

3.2.6 Direct Booking

The ability for patients to have certainty of the date of their surgery is really important to them and to us. The Direct Booking service was introduced in 13/14 with 70% of our consultants now using this to book their patients on the day the decision is made for their surgery in the Outpatient Clinic) In 14/15 we will roll out this service further and aim to increase this to 90%

3.2.7 Electronic Document Transfer (EDT) :

In October 2013 we launched the EDT pilot ensuring that GPs received an electronic discharge letter regarding their patient on the day that they were discharged home. Previously this was sent in the post and the information included was hand written and in an inconsistent format. By working in conjunction with our CCGs colleagues and our staff by April 14 we will have rolled out EDT for all correspondence going to GPs in our local commissioning area – Birmingham Cross City – for both discharge letters and outpatient letters. We will continue to work with commissioners across a wider Birmingham / West Midlands area to roll this out further in 2014.

3.2.8 Admissions and Day Case Unit (ADCU)

This new facility opened in Sept 2013 and is supported by new ways of working and managing patients. Following feedback from patients we now stagger their admission to prevent them waiting excess time in hospital on the day of their surgery with the aim that no patient waits longer than 3 hours from the time they arrive to the time they go to theatre. We will continue to embed this in 14/15

3.2.9 Improving our Estate

- Improvements to the Children's Ward include additional side wards, a play room (in part funded from the Project Playroom fundraising campaign) increased privacy and dignity and better facilities overall for patients, their families and staff. Opening in July 2014
- An option appraisal for the relocation of our pathology service (which is currently off site) will be undertaken

- The business case for additional MRI capacity and potential partnerships with others to provide cohesive scanning within an imaging suite
- Completion of the final phase in medical records relocation
- Demolition of part of the old estate and provision of a pad to allow mitigation in case of increased/alternative theatre capacity being needed
- Feasibility plans for the redevelopment of the Research and Teaching centre to develop a modern multi-disciplinary learning hub for medical school students, post-graduates and trust staff.

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4 Finance and operations

4.1 Efficiency

Transformational Cost Improvement Plans (CIPs) – underway or needed for the strategic plan

As highlighted in previous years, the Trust continues to believe that as a small, single-specialty hospital, there is a need for cost improvement plans to balance the requirement to deliver the cash releasing expenditure savings needed to ensure we run as an efficient and effective hospital against the requirement to grow our turnover to cover the increasing overheads as a result of the continued desire to improve the quality of our patient care and experience and to fund the capital investment needed to ensure a sustainable service.

As such, the Trust is planning to deliver £1m of additional contribution through activity growth in each of the 2 years of the operational plan. In addition to this, £2.0m (2.7%) of expenditure savings will be generated in 2014/15, with a further £2.5m (3.4%) of expenditure savings planned for 2015/16.

Schemes to the value of 96% of the required target have been identified for 2014/15, with delivery of the schemes managed through the CIP Programme Board. The Board will also ensure that Quality Impact Assessments are developed, scrutinised and approved.

The majority of the expenditure schemes identified for 2014/15 are traditional in nature, with a significant emphasis on the opportunity for increased efficiency across the Trust. Projects are already underway to look at reducing cancellations in theatres, improving theatre utilisation through greater upfront planning and challenge of theatre lists and reducing reliance on outsourcing of clinical work to other providers.

The longer term focus for CIPs is firmly on transformational projects; a range of which have begun or are in the planning stage for delivery in the back end of 2014/15 and on into 2015/16. These include reviewing innovative ways to provide step-down rehabilitation services currently provided through the use of community hospital beds, targeting the review and management of surgical site infections to reduce infection rates, thereby reducing the cost of treating such infections, and expanding our successful Bone Infection Unit into a more commercial offering. This model is currently being provided in pilot form to a local NHS Trust.

The Trust is also reviewing a range of options aimed at radically reducing our spend on orthopaedic implants. Following a major piece of work in 2011/12, savings totalling £1m were generated through the reduction of our implant prices, however these costs continue to make up over 10% of our total cost base. We need to consider innovative approaches to making further savings in this area, and are currently working alongside other Trusts within the Specialist Orthopaedic Alliance to

scope out a pilot project with the Department of Health and NHS Supply Chain to target ways to take costs out of the supply chain that will benefit both Trusts and suppliers. In addition to this work, we have also met with our high volume implant suppliers to discuss other options for greater partnership working which will form part of a full option appraisal paper aimed at setting out a 5 year procurement plan for orthopaedic implants. We have set ourselves a target of achieving £1m (approximately 15%) savings over this 5 year period.

In addition to the schemes outlined above, the Trust have also set out a range of service transformation schemes that, whilst not directly linked to CIP delivery, will clearly have a long term impact on the efficiency and effectiveness of the hospital.

4.2 Service Transformation themes:

1. Investment in technology – hardware to accommodate contemporary programmes such as e-prescribing and electronic patient records. PAS replacement. Data warehousing. Health informatics upgrades. Outcomes data platform.
2. Building robust partnerships that underpin service development. Working in tandem with GPs, community providers and rehabilitation teams as well as agreeing major plans for paediatric orthopaedic provision with Birmingham Children's Hospital.
3. Health promotion and preventative activity will be developed to ensure increasingly appropriate referrals from GPs.
4. Ensuring that the trust is both innovative and an early adopter of best practice innovations in its field by looking outwards to the activity of other orthopaedic practitioners and actively considering the benefits of changing practice.
5. Replacing our current MRI scanner and adding a second in anticipation of incipient growth in demand and potential offer to the LHE.
6. Taking account of, and understanding the changes in case mix which follow the international trend away from inpatient stays, towards day case.
7. Operating over 6 days a week in order to build in efficiencies through changed contracts and ensuring effective weekend cover
8. Offering additional physiotherapy to targeted patients to enhance outcomes
9. Working towards a radical reduction in waiting time in order to deliver best service to patients and inherent efficiency.
10. The trust will (in consultations with partners) also consider major expansion of its broader musculo-skeletal services in recognition that patients seek support from GPs at an early stage but may not seek surgical intervention appropriately. The trust will aim to oversee the whole pathway from pain through surgery to aftercare.
11. In order to develop a learning organisation the trust will undertake baseline work to completely overhaul the trusts' learning, research and innovation capability

12. A nursing skill mix review is scheduled for the early period of this plan and this will further ensure that quality and quantity of staff remains right for the new patient profile. Other disciplines may be subject to a similar review as the plan evolves and the balance of skill mix changes in line with whole pathway needs.
13. Leadership development will be prioritised at many levels and this will be tailored to the needs of the-is annual and the five year strategic plan, with staff being absolutely clear about their roles. The engagement of the medical workforce continues to evolve
14. The trust will move emphasis from ‘targets’ (perceived as externally imposed) to ‘standards of patient care’. This will increase standardisation of best practice but still allow variation and development of better practice within a controlled and more efficient and effective environment.

5 Financial Plan

5.1 Introduction and Strategic Context

As previously outlined in this plan, the Trust is embarking on a clear operational plan for 2014-16, with key themes linked to sharpening our internal processes and standards, and starting to build relationships and partnerships across the wider health and social care sector.

In order to fully resource these plans, the Board have agreed to take advantage of the Trust's strong balance sheet and liquidity built up from several years of above average surpluses. £1m has been set aside in 2014/15, £0.5m of which can be invested recurrently, to ensure that we are able to make major, sustainable change to key areas such as our IM&T capabilities and leadership development. The £0.5m non recurrent enabling budget will also remain in 2015/16, as it is recognised that a longer term approach will be needed to fully release the benefits from these key enablers.

In addition to this investment on revenue funds, our 5 year capital plan has also been reviewed to ensure that capital resources are invested appropriately to support our key operational and strategic aims with significant investments in years 1 & 2 on IM&T and radiology equipment.

The table below shows the summary I&E plan for 2014/15 and 2015/16:

	2013/14 Forecast Outturn (£m)	**2014/15 Plan (£m)**	**2015/16 Plan (£m)**
Clinical Revenue	69.1	70.6	72.9
Other Operating Revenue	5.0	4.4	4.4
Total Operating Revenue	**74.1**	**75.0**	**77.3**
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Other expenses	3.3	3.2	3.3
Total Operating Expense	**68.6**	**70.7**	**72.4**
EBITDA	**5.5**	**4.3**	**4.9**
Non-Operating Revenue & Expenses	3.5	3.8	4.4
Surplus before Impairments	**2.0**	**0.5**	**0.5**

5.2 Healthcare Income & Activity

5.2.1 2014/15 Contract Negotiations

Contract negotiations with Birmingham Cross City CCG, acting as host commissioner for the 22 West Midlands CCGs, and with the NHS England Area Team with regards to Specialist Commissioning, have now concluded and contracts have been agreed.

Financial discussions with Birmingham Cross City CCG focused on the growth in referrals experienced during 2013-14 and how this would impact on 2014/15 activity levels. The CCG agreed that, in order for the ROH to return our waiting list back to April 2013 levels and enable us to achieve our 18 week waiting time targets in a sustainable manner, 6% growth in day case and inpatient activity would be required and this was built into the majority of individual CCG contracts. In addition to this, CCGs also agreed to fund a 12.5% growth in outpatient physiotherapy and orthotics plans to address the rising waiting times in these areas. Negotiations with our Specialist Commissioners ensured that our 2014/15 activity plan was maintained at 2013/14 contract levels.

Contract agreement is still outstanding with the Welsh Health Boards with regards to both specialist and Primary Malignant Bone Tumour (PMBTS) contracts. Wales has instigated demand management schemes in the last 12 months aimed at ensuring that all Welsh patients are treated in Wales wherever possible. This has caused our specialist contract to underperform by over £100,000 in 2013/14, and this trend in activity repatriation is built into our financial plans moving forward.

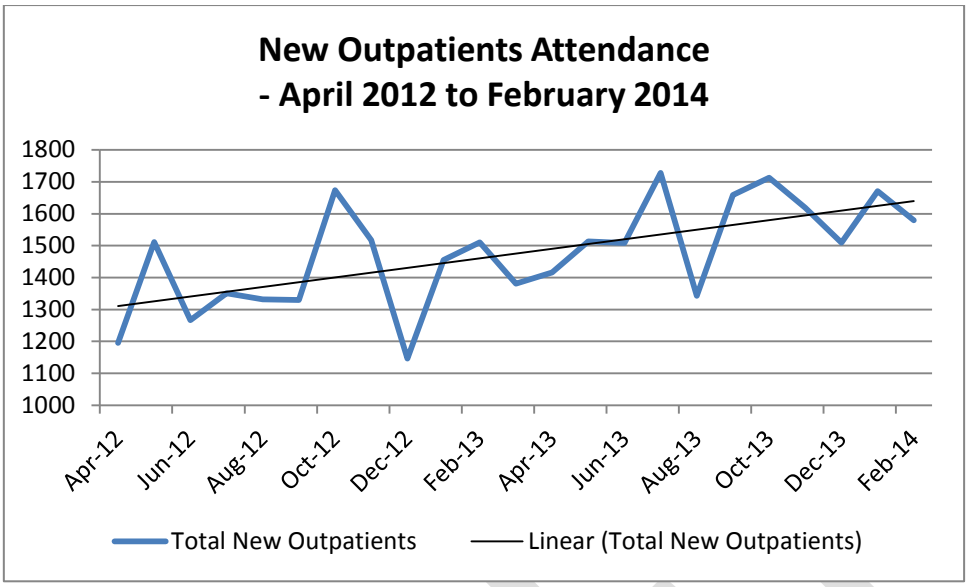
All 2014/15 contracts are based upon a tariff deflator of -1.5% which consists of inflation and cost pressure funding of 2.5% less 4% efficiency requirement. The financial planning for 2015/16 assumes a tariff deflator of -1.8%

5.2.2 Additional planned growth

As a small single-speciality Trust, we recognise there is a need to find an appropriate balance between internal efficiency and cost savings and the need to grow to ensure the cost structure required to develop as a high quality institution can be supported.

The Trust expects income to grow by £3m in 2014/15, after the impact of the tariff deflator. £1.9m of this growth is contracted by CCGs, and is designated to deliver appropriate waiting times for our patients. Further demographic growth is not included in contracts, however there is clear evidence of the increasing national demand for orthopaedic surgery. The Trust feels it is realistic to plan for a continuation of the growth seen in 2013/14 (see the graph below), and have

therefore included 2% activity growth in its plans for 2014/15 and 2015/16 to address this.



In addition to this demographic growth in general orthopaedics, there are specific pressure points that the Trust is working up plans to address over the coming 12 months that will impact upon activity levels in 2015/16. A new adult spinal surgeon will be appointed during 2014 to support the growing demand for spinal services, and will be picking up a full workload by the start of 2015/16.

In addition to this, there is a constant demand for additional paediatric work across the Birmingham area and the Trust are currently working up plans for how support can be offered in this area over the next 2 years. The ROH is particularly interested in how young adults can be supported in their move from paediatric to adult services, and our market analysis has identified a clear gap in services for this cohort of patients. Further work is ongoing to consider how this service can be developed, which we expect to result in service growth during 2015/16. Our modelling suggests this specific growth is expected to account for a further 2% growth in activity and income during 2015/16.

5.2.3 Activity Plan

The activity plan for 2014/15 and 2015/16, taking into account all the factors mentioned above, is shown below.

	13/14 F/cast Outturn	14/15 Activity Plan	Growth %
Day Cases	7,293	7,578	3.9%
Electives	6,726	6,988	3.9%
Non Electives	390	392	0.5%
TOTAL	**14,409**	**14,958**	**3.8%**

	14/15 Activity Plan	15/16 Activity Plan	Growth %
Day Cases	7,578	7,881	4%
Electives	6,988	7,268	4%
Non Electives	392	392	0%
TOTAL	**14,958**	**15,541**	**3.9%**

5.3 Expenditure Budgets

5.3.1 Cost Pressures

A number of key cost pressures have been built into the financial plans for 2014/15 and 2015/16 as highlighted below:

- Pay awards and incremental drift (14/15 - £437k & 15/16 - £424k) – Pay inflation has been costed in line with the government's announcement on 13th March.
- Interim Junior Doctor Pay (14/15 - £500k & 15-16 £500k) – Whilst the Trust's medical staffing review is being undertaken, there will be a continued reliance on locum junior doctors to support the safe provision of on-site and on-call medical services. This reliance will reduce in Year 2, but it is anticipated that these costs will be required to address the substantive cost of a new medical model.
- MRI Outsourcing (14/15 - £400k & 15/16 - £300k) – The Trust is currently outsourcing significant MRI work to the private sector due to the excess of demand over capacity. An additional MRI scanner is planned to be completed towards the end of 2015/16, so it is anticipated that these costs will continue until this point.
- CNST contribution (14/15 - £300k & 15/16 - £279k) – Trauma & Orthopaedics continues to see a significant year on year increase in the insurance claims, the impact of which is built into our long term financial planning.
- Increased cost of community rehab (£14/15 - £135k & 15/16 - £80k) – The cost of community rehabilitation care provided by Birmingham Community Health Trust has increased to match the income received for rehabilitation care. This cost increase is phased over a 2 year period.
- Other local cost pressures (14/15 - £850k & 15/16 - £515k) – A range of smaller cost pressures specific to each Directorate has also been funded as part of the local budget setting process.

5.4 Operational Business Developments

The Trust's financial plan for 2014/15 includes the provision of £400,000 to fund operational business developments aimed at improving patient care and experience. A similar budget has been set aside for such developments in 2015/16.

For 2014/15, this includes addressing the recommendations of the Francis report. As part of the Trust's detailed business planning process, all Directorates were asked to submit expressions of interest in bids that would improve patient care and service delivery. These bids were shortlisted by a group of clinical representatives, and are now being developed into business cases for consideration by the Executive Management Team in April. Shortlisted bids include:

- Supervisory Senior Sisters
- Additional Matron role
- Surgical Site Infection surveillance
- IM&T development
- Organisational Development interventions

5.5 Strategic Business Developments

In addition to the operational business development reserve mentioned above, the Trust has utilised some of our cash balances built up through the delivery of our surplus targets over a number of years to put aside a £1m development fund, of which £500,000 is recurrent. This will facilitate the delivery of key enablers required to support the service transformation themes outlined earlier in this plan.

5.6 Capital Plan

The Trust's previous capital plan has been reviewed in light of the key elements of our 2 year operational plan, and a number of initiatives originally planned in the period 2016/17 to 2018/19 have been brought forward.

Over the next 2 years, the Trust anticipates spending £8m on IT and Informatics systems and enablers to revolutionise the working environment for our staff and provide a safer and more streamlined service to our patients. This will include the roll-out of a new IT infrastructure across the Trust, provision of an electronic prescribing and pharmacy system, and improved informatics support in the shape of a data warehouse and trust-wide outcomes system.

In addition to this, £6m is being set aside to address radiology capacity and replace aging imaging equipment to tackle a key bottleneck in our existing services. A new MRI scanner will be added on site to address the £400,000 per year cost of outsourcing scans currently being incurred and to provide the long term resilience to support growth over the 5 year period of our strategic plan. In addition to this and

following on from the replacement of our CT scanner in 2013/14, a range of imaging equipment will be updated to provide a modern and efficient radiology service to our patients.

A summary of the 2 year plan is shown below:

	2014/15	**2015/16**
	£000s	£000s
IM&T	3,563	4,806
Radiology	1,480	4,420
Estate	1,761	470
Other Equipment	497	506
Total	**7,301**	**10,202**

An assessment of the likely capital charge implications is included in the financial plan.

5.7 Liquidity

The Trust has historically held a very high cash balance, with liquidity ratings significantly exceeding the levels required to score the lowest risk rating within the Continuity of Services risk rating.

However, the Board have made the decision that investment in key enabling areas such as IT infrastructure and imaging are an important requirement to ensure services for our patients remain fit for purpose into the future. As a result, this will impact on the cash balances of the Trust, as should below.

	2013/14 FOT £m	Capital spend	Other cash movements**	2014/15 Plan £m	Capital spend	Other cash movements**	2015/16 Plan £m
Cash	18.8	(8.6)*	2.8	13.0	(10.2)	3.3	6.1

*Note the difference between the £7.3m capital plan balance previously seen by the Board and the value here represents £1.3m of infrastructure spend for 2013/14, where goods are planned to be received on 31/3/14, but as a result of the timing of the year end the cash is unlikely to come out of Trust bank balances until 2014/15.

**Other cash movements represent areas such as the Trust's profit and working capital movements, which would have an impact on the cash balance.

5.8 Risk Ratings

Historic healthy surpluses and cash balances have previously resulted in the Trust having significant headroom against the capital servicing capacity and liquidity ratios.

The table below shows that the Trust is aiming to continue to achieve a COSSR rating of at least 4 for the period of this plan and therefore continue to maintain a strong financial position within a difficult local and health sector financial environment.

Due to the significant strategic investments being made over the coming period in areas such as IT infrastructure and imaging capacity, cash and surplus balances will be necessarily lower, resulting in lower headroom over the ratings.

	2013/14		**2014/15**		**2015/16**	
	Forecast	**Rating**	**Forecast**	**Rating**	**Forecast**	**Rating**
Capital Servicing Capacity	3.8	4.00	2.7	4.00	2.8	4.00
Liquidity Ratio	76.7	4.00	44.5	4.00	8.6	4.00
Overall Rating		4.00		4.00		4.00

In light of the lower headroom, the Trust has performed some sensitivity analysis to show how much cash and profit would need to decline in order for a rating of 4 to not be achieved (assuming all other variables remain constant).

The ratings and sensitivities are based on outline balance sheet figures at present, and will be further clarified over the coming week. As such, the exact sensitivities may change slightly and should be considered as indicative.

Profit

	2014/15 £m		**2015/16 £m**	
	Sensitivity to achieve rating of 4	**Sensitivity to achieve rating of 3**	**Sensitivity to achieve rating of 4**	**Sensitivity to achieve rating of 3**
Profit forecast	0.5	0.5	0.5	0.5
Sensitised profit/(loss)	0.24	(1.05)	0.03	(1.36)
Difference	(0.26)	(1.55)	(0.47)	(1.86)

Cash

	2014/15 £m		**2015/16 £m**	
	Sensitivity to achieve rating of 4	**Sensitivity to achieve rating of 3**	**Sensitivity to achieve rating of 4**	**Sensitivity to achieve rating of 3**
Cash forecast	13.0	13.0	6.1	6.1
Sensitised cash	4.4	3.0	4.4	3.0
Difference	(8.6)	(10.0)	(1.7)	(3.1)

The Board has noted that if one of the ratings fell to a 3, but the other remained a 4, then the Trust would remain at a rating of 4 overall.

Risk Management and Mitigation

An active risk register is reviewed regularly at the most appropriate level of the organisation including Trust Board, Executive Management Team and Directorate. The Audit Committee oversees the process of risk management and is assured that risks are regularly reviewed and mitigating actions taken.

In the circumstances that the Trust needed to mitigate the impact of an unexpected overspend in cash or profit terms, it has considered a number of potential options.

Firstly, as previously discussed, the Trust is currently holding reserves for operational and strategic business developments. In the circumstances where unforeseen costs or poor performance were identified, these reserves could be used to mitigate the risk to the Trust's finances.

In particular, the Trust has a capital plan in place for the next five years, but this plan could be reduced, staggered, or delayed to future years in these exceptional circumstances.

In addition, the Trust has also considered its ability to reduce spending in other ways, for example implementing measures such as vacancy controls and headcount reduction. Also reductions in discretionary spend such as training could be implemented.

The Trust estimates that it could raise an additional £2m using these methods should the circumstances arise where cost pressures of this magnitude were faced.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26 March 2014 **ENCLOSURE NUMBER: 6**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Paul Athey, Director of Finance
SUBJECT:	2014-15 Budget Paper

SUMMARY

The purpose of this report is to;
- outline the key issues involved in the development of the 2014-15 budget; and
- gain Board approval for the 2014-15 budget.

RISKS

Meeting the 2014-15 budget will require engagement and focus from the Board and clinical leads.

RECOMMENDATIONS

The Trust Board is asked to:

- Approve the 2014-15 revenue plan
- Approve the 5 year capital plan
- Support the planned mitigations if a downside scenario occurs

2014-15 Budget Paper – Trust Board

1. Introduction and Strategic Context

2013/14 was a challenging year for ROH finances, with a range of factors resulting in a forecast surplus before impairments of £2m, £400,000 less than plan. These factors included:

- Unachieved CIPs, both expenditure savings and income growth
- Case-mix changes impacting on income and profitability
- Significant cost pressures (Junior Doctors, MRI outsourcing, premium rate staffing)

The Trust is currently in the midst of a significant piece of strategic development work aimed at providing a clear direction of travel for the organisation over the next 5 years. The first stage of this work is the production of a 2 year operational plan, with key themes emerging around sharpening our internal processes and standards, and starting to build relationships and partnerships across the wider health and social care sector.

As a Board, we have taken the decision to support this plan by reducing our planned surplus in 2014/15, allowing major investment in the key enablers needed to ensure our success. £1m has been set aside in 2014/15, £0.5m of which can be invested recurrently, to ensure that we are able to make major, sustainable change to key areas such as our IM&T capabilities and leadership development.

In addition to this investment on revenue funds, our 5 year capital plan has also been reviewed to ensure that capital resources are invested appropriately to support our key operational and strategic aims with significant investments in years 1 & 2 on IM&T and radiology equipment.

The table below shows the summary I&E plan for 2014/15:

	2014/15 Plan (£m)	**2013/14 Forecast Outturn (£m)**
Clinical Revenue	70.6	69.1
Other Operating Revenue	4.4	5.0
Total Operating Revenue	**75.0**	**74.1**
Pay	42.1	40.7
Clinical Supplies	21.0	20.5
Non Clinical Supplies	4.3	4.1
Other expenses	3.2	3.3
Total Operating Expense	**70.7**	**68.6**
EBITDA	**4.3**	**5.5**
Non-Operating Revenue & Expenses	3.8	3.5
Surplus before Impairments	**0.5**	**2.0**

2. Healthcare Income & Activity

a. Contract Negotiations

Contract negotiations with Birmingham Cross City CCG, acting as host commissioner for the 22 West Midlands CCGs, and with the NHS England Area Team with regards to Specialist Commissioning, have largely concluded. Price/Activity matrices have been agreed with both parties, and we are confident of formally signing contracts during March.

Financial discussions with Birmingham Cross City CCG focused on the growth in referrals experienced during 2013-14 and how this would impact on 2014-15 activity levels. The CCG agreed that, in order for the ROH to return our waiting list back to April 2013 levels and enable us to achieve our 18 week waiting time targets in a sustainable manner, 6% growth in day case and inpatient activity would be required and this was built into the majority of individual CCG contracts. In addition to this, CCGs also agreed to fund a 12.5% growth in outpatient physiotherapy and orthotics plans to address the rising waiting times in these areas. Negotiations with our Specialist Commissioners ensured that our 2014-15 activity plan was maintained at 2013-14 contract levels.

Contract agreement is still outstanding with the Welsh Health Boards with regards to both specialist and Primary Malignant Bone Tumour (PMBTS) contracts. Wales has instigated demand management schemes in the last 12 months aimed at ensuring that all Welsh patients are treated in Wales wherever possible. This has caused our specialist contract to underperform by over £100,000 in 2013-14, and this lost income is built into our financial plans moving forward. The Welsh Health Boards are also looking to move our PMBTS contract from a block to a cost and volume contract, which could also result in a significant reduction in its value.

All contracts are based upon a tariff deflator of -1.5% which consists of inflation and cost pressure funding of 2.5% less 4% efficiency requirement.

b. Growth Requirements

In order to deliver our CIP target for 2014-15, £1m of contribution from income growth is required to support savings being delivered from expenditure schemes. In order to deliver this contribution, £3m of additional income needs to be generated, as it is anticipated that £2m of costs will be incurred to deliver this growth. £1.9m of this growth has already been built into our contract baselines; however we will need to plan for over-performance of £1.1m to deliver our growth targets.

c. Activity Plan

The activity plan for 2014-15, taking into account all the factors mentioned above, is shown below.

	14/15 Activity Plan	13/14 Forecast Outturn	Growth %
Day Cases	7,578	7,293	3.9%
Electives	6,988	6,726	3.9%
Non Electives	392	390	0.5%
TOTAL	**14,958**	**14,409**	**3.8%**

	14/15 Activity Plan	13/14 M8-12 (FYE)	Growth %
Day Cases	7,578	8,028	-5.6%
Electives	6,988	6,799	2.8%
Non Electives	392	408	-3.9%
TOTAL	**14,958**	**15,235**	**-1.8%**

3. Directorate Budgets

The operating budget forms the basis of the first year of the two year plan to be submitted to the regulator Monitor in April 2014.

The process for budget setting is split into the following key areas:

- Base-line budget setting – budget holders are engaged to discuss their current budgets, predicted activity, cost pressures and opportunities for efficiency. Once completed budget managers are then asked sign off budgets;
- Income - Contractual negotiation with commissioners takes place to determine levels of income (as discussed above);
- Efficiency and cost improvement targets and plans agreed
- Cost pressure and development funding confirmed
- Executive team recommendation of the base budget.

Appendix 1 gives details of the budgets proposed and more detail on the key expenditure areas is below.

a. Cost Pressures

As in previous years Directorates were asked to consider what cost pressures they would face in 2014/15. The cost pressures were considered by the Director of Finance and Director of Operations, with further queries being raised where appropriate. These bids were then split into 3 categories;

- Funded (£1,117k) – the funds have been delegated into the budget positions;
- Not funded (£599k) – the Directorates are required to mitigate these pressures and/or fund these cost pressures through their existing budget;

- More information required (£549k) – these costs have been reserved and will be released based on either further information received from the Directorates.

A breakdown of the cost pressures received and assessed, by Directorate, has been included in Appendix 2.

b. Operational Business Developments

In order to allow Directorates to become more involved in the business planning process, in December Directorates were asked to present their individual business plans to the Executive Directors, and key representatives of the other Directorates. As part of this process, the Directorates were asked to identify their aspirations and options for growth over the next 5 years.

Subsequent to those presentations, Directorates were then asked to think about those plans and to develop business cases for funding for consideration by the Business Planning Group. These bids took the form of a 1-2 page pitch document, to ease the initial burden on Directorates of writing full business cases. In total, £1.8m of bids were received for development funding.

The Business Planning Group scored the bids received, and have asked the top ranked £1m to develop detailed business cases for further consideration prior to EMT approval.

When scoring the bids received, the Business Planning Group were mindful of the c.0.3% of tariff uplift (corresponding to c£220k) in relation to the Francis report, and how this funding should be spent on addressing the recommendations of the report where possible.

A summary of the bids awaiting further consideration has been included in Appendix 3. Total funding of £400k (including tariff uplift for Francis implications) is available.

c. Strategic Business Developments

In addition to the operational business development reserve mentioned above, the Trust has also put aside a £1m development fund of which £500,000 is recurrent. This will facilitate the delivery of the Trust objectives should any short-notice development needs be identified and will fund some of the IT and leadership developments discussed at Trust Board.

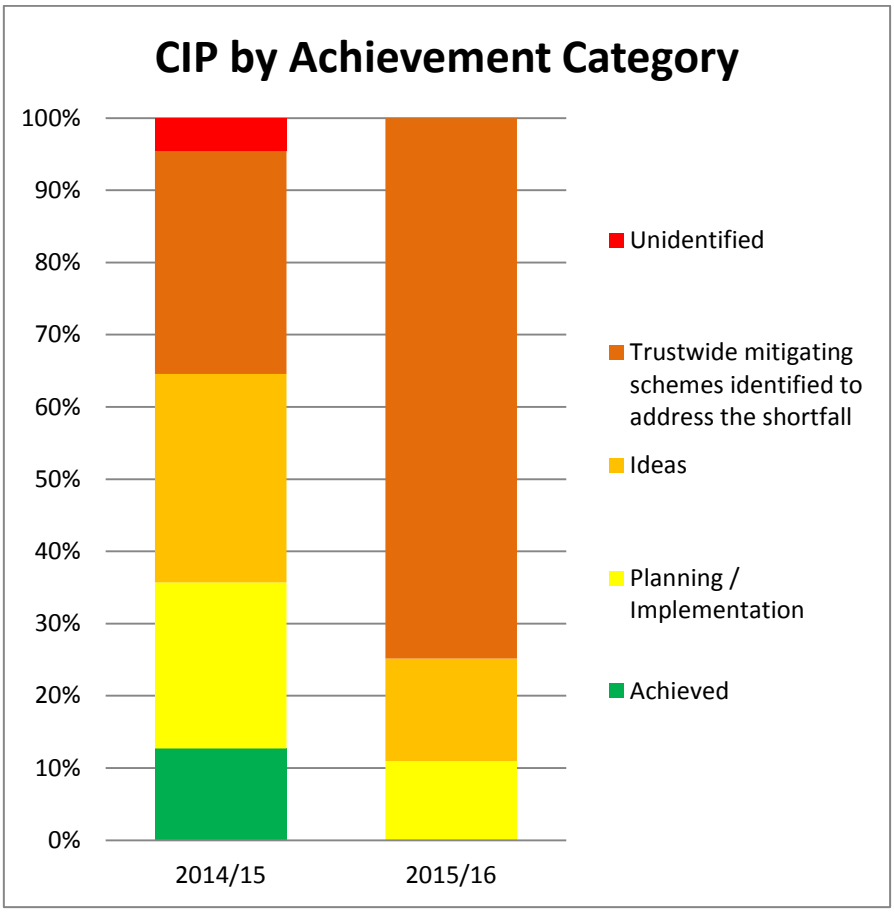
d. CIP Plans

2013/14 has seen the introduction of a Cost Improvement Programme Board, which meets on a monthly basis to performance manage progress of the Directorates against their CIP targets, share best practice and plan for future years.

The Trust requires a reduction in its cost base of £2.0m or 2.7% in 2014/15. This represents the level of cash that must be released from budgets, and reduced from actual spend. This level of efficiency gain requires the focus of the Executive Team and Clinical Directors.

Initial plans were submitted by each Directorate as part of the Business Planning process. At the March CIP Board the Director of Finance and Director of Operations used the meeting to discuss CIP plans with the individual Directorate Managers to assess the feasibility of the schemes, and identify where there were gaps.

Individual Directorate progress against target is included in Appendix 4 and has been summarised in the graph below.



As shown above, a significant proportion of the CIP targets sit in the mitigating schemes category. This element of the CIP was previously unidentified after the discussions with the individual Directorates at CIP Programme Board. These schemes are more transformational in nature, and as such they will involve significant input from the Directorates. These schemes will be worked up in conjunction with Directorates over the coming weeks, but are intended to support rather than replace shortfalls in existing Directorate plans.

Such schemes include reducing cancellations and DNAs, in addition to early IM&T efficiencies expected, and have been detailed in full in Appendix 5.

The CIP Programme Board will continue to performance manage the delivery of the target and will raise concerns through EMT to the Board if appropriate. The Board will also ensure that Quality Impact Assessments are developed, scrutinised and approved.

4. Capital Plan

Over the next 2 years, the Trust anticipates spending £8m on IT and Informatics systems and enablers to revolutionise the working environment for our staff and provide a safer and more streamlined service to our patients. In addition to this, £6m is being set aside to address radiology capacity and replace aging imaging equipment to tackle a key bottleneck in our existing services.

As summary is shown below and full detail are in Appendix 6.

	2014/15	2015/16	2016/17	2017/18	2018/19
	£000s	£000s	£000s	£000s	£000s
IM&T	3,563	4,806	3,900	900	900
Radiology	1,480	4,420	960	200	2,200
Estate	1,761	470	270	845	4,070
Other Equipment	497	506	486	466	466
Total	**7,301**	**10,202**	**5,616**	**2,411**	**7,636**

An assessment of the likely capital charge implications is included in the financial plan.

5. Downside Risks and Mitigations

Based upon historical delivery and the position of current plans significant financial risk exists within the plan. The major risks are shown in the table below.

Risk	Mitigations	Residual Risk £'000
Underperformance in activity or delivery of activity plan at additional costs to planned levels	• Directorate phased activity plans • Business plans to deliver growth • Relevant Clinical Programme Board Projects • Ongoing Performance Management	1,000
Non achievement of expenditure CIP	• Development of Directorate Plans • CIP Programme Board	500
Contract penalties for non-delivery of CQUIN, waiting times & other KPIs	• CQUIN Clinical Programme Board Project • 18 Week Improvement Plan • Ongoing Performance Management	500
	Total Residual Risk	**2,000**

The risks are not dissimilar to the challenges faced during 2013/14 but, given that the Trust is only planning for a £0.5m surplus and that there is therefore less flexibility in the overall plan, it is vital that these risks are minimised through strong planning and performance management.

If a downside scenario occurred in order to deliver, at worst, a breakeven financial position the following additional mitigations would be required:-

Further Mitigations	Explanations	Value £'000
Release of contract penalty reserve	£500k has been reserved in the financial plan to mitigate an element of commissioner fines	500
Reduction in development funding	Development funding would be held back and potentially withdrawn to offset overspends	500
Non achievement of financial plan	The planned £0.5m surplus would not be delivered reducing funds for future investment & impacting on the credibility of the Trust	500
Other mitigations	More challenging measures such as vacancy controls, headcount reduction & reductions in discretionary spend (e.g. training) would be implemented.	500
	Total Further Mitigations	**2,000**

6. Risk Ratings

Historic healthy surpluses and cash balances have previously resulted in the Trust having significant headroom against the capital servicing capacity and liquidity ratios.

The table below shows that the Trust is aiming to continue to achieve a COSSR rating of at least 4 for 2014/15 therefore continue to maintain a strong financial position within a difficult local and health sector financial environment.

However, due to the significant strategic investments being made over the coming period in areas such as IT infrastructure and imaging capacity, cash and surplus balances will be necessarily lower, resulting in lower headroom over the ratings.

	2013/14		2014/15	
	Forecast	Rating	Forecast	Rating
Capital Servicing Capacity	3.8	4.00	2.7	4.00
Liquidity Ratio	76.7	4.00	44.5	4.00
Overall Rating		4.00		4.00

In light of the lower headroom, the Trust has performed some sensitivity analysis to show how much cash and profit would need to decline in order for a rating of 4 to not be achieved (assuming all other variables remain constant).

The ratings and sensitivities are based on outline balance sheet figures at present, and will be further clarified over the coming week. As such, the exact sensitivities may change slightly and should be considered as indicative.

Profit

	2014/15 £m	
	Sensitivity to achieve rating of 4	**Sensitivity to achieve rating of 3**
Profit forecast	0.5	0.5
Sensitised profit/(loss)	0.24	(1.05)
Difference	(0.26)	(1.55)

Cash

	2014/15 £m	
	Sensitivity to achieve rating of 4	**Sensitivity to achieve rating of 3**
Cash forecast	13.0	13.0
Sensitised cash	4.4	3.0
Difference	(8.6)	(10.0)

Note: If one of the ratings fell to a 3, but the other remained a 4, then the Trust would remain at a rating of 4 overall.

7. Recommendations

- Approve the 2014/15 revenue plan
- Approve the 5 year capital plan
- Support the planned mitigations if a downside scenario occurs

Appendix 1 – Directorate Start Point Budgets

	Pay		Non Pay	CIP**	Reserves	Income	Total
	wte	£'000	£'000	£'000	£'000	£'000	£'000
Directorate							
Clinical Support	198.34	(7,046)	(3,471)	265	0	408	**(9,843)**
Paediatrics	37.71	(1,644)	(92)	56	0	139	**(1,540)**
Oncology	66.15	(3,502)	(2,409)	196	0	235	**(5,479)**
Spinal	57.29	(3,055)	(1,792)	141	0	139	**(4,567)**
Small Joints	15.87	(1,129)	(9)	10	0	139	**(989)**
Large Joints	115.01	(5,198)	(732)	168	0	325	**(5,437)**
Theatres	215.59	(8,836)	(10,738)	621	0	46	**(18,907)**
Estates	15.57	(598)	(1,812)	91	0	218	**(2,101)**
Facilities	75.52	(1,573)	(1,929)	98	0	238	**(3,166)**
R&D	3.00	(115)	0	3	0	0	**(112)**
Corporate	100.07	(5,028)	(3,472)	212	0	465	**(7,824)**
Total Directorates	**900.12**	**(37,723)**	**(26,455)**	**1,862**	**0**	**2,352**	**(59,963)**
Trust Wide Income	0.00	0	0	0	0	71,507	**71,507**
General reserves	0.00	0	0	0	(268)	0	**(7,405)**
OD reserves					(1,000)		
Growth reserves					(2,000)		
Specific reserves*					(4,137)		
Financing Costs	0.00	0	(3,638)	0	0	0	**(3,638)**
Total Trust Wide	**900.12**	**(37,723)**	**(30,093)**	**1,862**	**(7,405)**	**73,859**	**500**

*Note – specific reserves include reserves for areas such as the 14/15 pay award, junior doctor cost pressures, non-pay inflation and the premium for outsourcing MRI.

**Note – CIP column does not balance precisely to Appendix 4 as some cost improvements have been actioned during budget setting as per table below:-

As Per CIP Tracker	**2,017**
Adjustments @ Start point	
Clinical Support Services	(82)
Small Joints	(21)
Theatres	(11)
Estates	(10)
Corporate	(30)
Total Adjustments	(155)
Start Point CIP	**1,862**

Appendix 2 – Cost Pressure Decisions by Directorate

Directorate	Fund	Hold in Reserves	Do Not Fund
Clinical Support	£42,733	£0	£0
Paediatrics	£5,500	£110,000	£1,500
Oncology & Histopathology	£25,700	£59,000	£43,400
Spinal	£168,500	£33,000	£26,500
Small joints	£4,203	£4,600	£500
Large joints	£220,067	£13,108	£204,339
Theatres	£208,211	£301,386	£201,023
Estates	£109,693	£2,119	£5,476
Facilities	£33,800	£21,488	£46,616
Management	£298,716	£54,329	£20,000
TOTAL	**£1,117,123**	**£599,030**	**£549,354**

Appendix 3 – Bids for which Full Business Cases are Being Developed

Directorate	Department	Description	WTE	2014/15
Nursing	Nursing	Supervisory Senior Sisters		50,488
Clinical Support	Imaging	PACS expansion	0.40	14,200
Clinical Support	Directorate	Senior Nurse	1.00	51,000
Spinal	Senior Medics	Consultant	1.00	105,540
HR	L+D	Support OD interventions on MSB report		40,000
IM&T	IM&T	Project Manager	1.00	11,000
Paediatrics	Senior Medics	Consultant	1.00	89,230
Nursing	Nursing	Supernumerary Bleep Holder		134,263
Clinical Support	POAC	Service expansion for Oncology	1.60	40,800
Oncology	Snr Medical Staff	Consultant	2.00	211,724
HR	HR	Band 6 workforce info analyst	1.00	30,538
Clinical Support	Therapies	ADCU support	0.32	13,000
Clinical Support	Therapies	Enhanced Recovery	0.80	43,100
Oncology	Histopathology	Senior Fellow	1.00	38,623
Clinical Support	IFC/BIU/TV	SSI Surveillance	2.00	42,600
Paediatrics	Junior Medics	Senior Clinical Fellow	1.00	35,277
Spinal	Ward 1	Ward Clerk B2	1.00	24,285
Clinical Support	Therapies	Oncology outreach clinics	0.08	23,400

Appendix 4 – Cost Improvement Programme progress by Directorate

Summary

			2014/15 by Directorate										
Scheme	**2014/15**	**2015/16**	**CSS**	**Paeds**	**Oncology**	**Spinal**	**Small**	**Large**	**Theatres**	**Estates & Facilities**	**R&D**	**Corporate**	**Total**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
BASELINE TARGET	1,855	1,855	304	48	169	141	31	168	585	163	3	242	1,854
c/f from Previous Year	162	-	43	9	27	-	-	-	47	36	-	-	162
FINAL TARGET	2,017	1,855	347	57	196	141	31	168	632	199	3	242	2,016
SAVINGS ACHIEVED TO DATE	256	-	82	18	-	15	21	-	65	8	-	45	254
PLANNING / IMPLEMENTATION	464	204	199	9	21	30	-	105	-	-	-	100	464
SCHEME IDEAS	1,206	263	-	7	130	48	4	25	100	169	3	97	1,207
TOTAL SCHEMES IDENTIFIED	1,926	467	281	34	151	93	25	130	165	177	3	242	1,301
UNIDENTIFIED BALANCE BEFORE MITIGATION	715	0	66	23	45	48	6	38	467	22	-	-	715
Percentage Green & Amber	36%	11%	81%	47%	11%	32%	68%	63%	10%	4%	0%	60%	36%
Mitigating schemes			624										
Unidentifed balance after mitigation			91										

Note excludes income

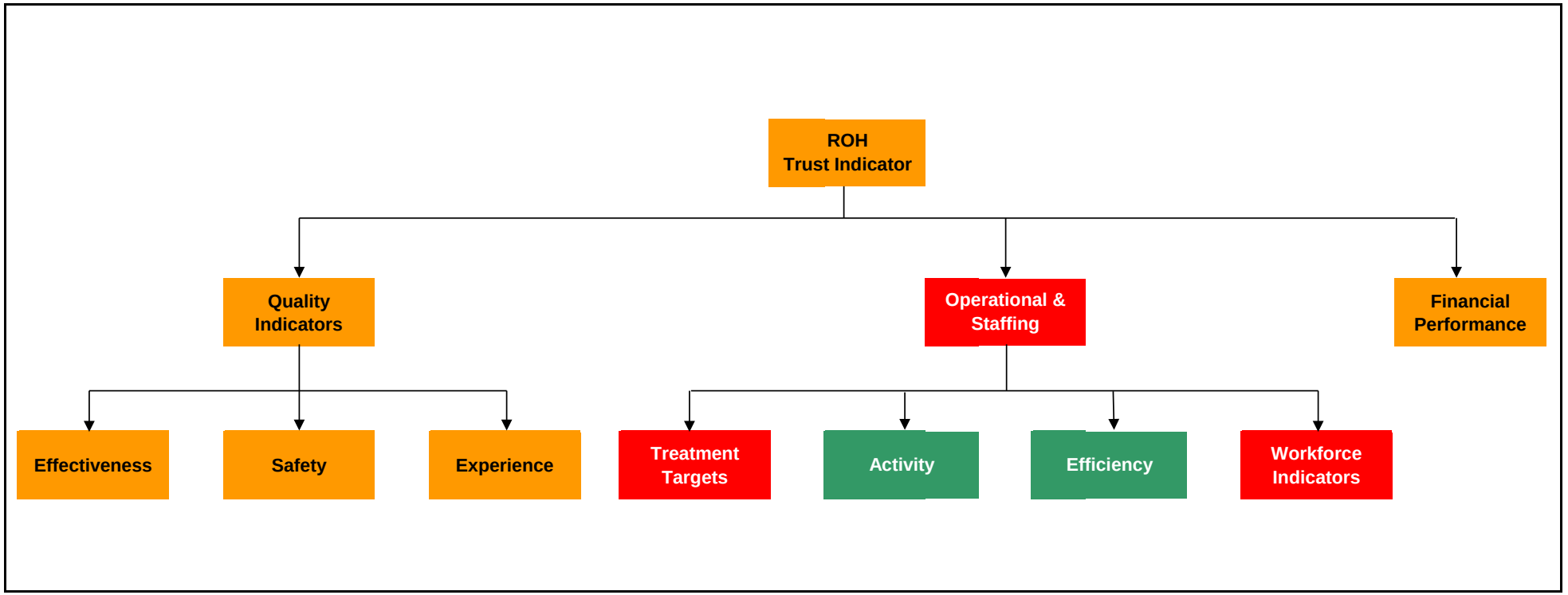
Appendix 5 – Mitigating schemes

SCHEME IDEAS	2014-15 £	2015-16 £
Reduced reliance on outsourcing - West Heath	30,000	90,000
Reduced reliance on outsourcing - Cromwell	45,000	100,000
Reduced reliance on outsourcing - Spire	60,000	120,000
Reduced premium rate working - ADHs, OOH, etc.		200,000
Improving list utilisation - % used	100,000	200,000
Reduced cancellations	50,000	100,000
Reduced DNAs	6,000	6,000
Reduced SSI	20,800	20,800
IM&T Efficiencies	-	200,000
Increased R&D contribution	19,000	74,000
Procurement & prosthesis	213,000	196,750
Reduced sickness	80,000	80,000
SCHEME IDEAS	**623,800**	**1,387,550**

Appendix 6 – Detailed Capital Plan

	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
B/f Schemes					
- Ambulatory Care	110				
- Ward 11 Upgrade	331				
Theatre Pad					
- Enabling Works	350				
- Demolition	100				
3-Storey Estates Build					
- 3 Storey Shell					3,800
Fire Damage Works	400				
R&T Centre (assumes external funding)			0		
General Site improvements / rationalisation		470	270	445	270
- Fire & DDA	35				
- Hospital Signage	10				
- Replacement Windows	50				
- Enabling Works Gas	75				
- Enabling Works Electricity	75				
- Legionella Works	25				
- Estates Rationalisation	50				
- Lifts	75				
- Asbestos Removal	50			400	
- Road works	100				
IT Infrastructure					
- Servers / Disaster Recovery / VDIs - Tenders	543				
- Servers / Disaster Recovery / VDIs - Other	180	21			
- Integration System	220				
- Data Warehouse	600				
- Ongoing replacement / maintenance	220	285	400	400	400
IT - New Systems					
- Pharmacy / E-Prescribing	1,500	1,000			
- Portal to support Electronic Patient Records		1,500			
- New clinical systems / Electronic Patient Record		2,000	500	500	500
- Clinical Outcomes	100				
- PACs replacement	125				
IT - PAS Replacement			3,000		
New MRI Scanner					
- Mobile MRI Scanner Works	40				
- Equipment		1,500			
- Build	100	1,400			
Radiology Equipment - Replacement					
- MRI Scanner					1,500
- Replacement equipment	1,090	1,520	560	200	200
- Building work linked to replacement equipment	250		400	0	500
Theatre Equipment - Replacement					
- Operating Tables	100	100	100	100	100
- Other Equipment	247	256	236	216	216
Other Equipment					
- Rolling Replacement Programme	50	50	50	50	50
- Emergency Equipment replacement	100	100	100	100	100
TOTAL	**7,301**	**10,202**	**5,616**	**2,411**	**7,636**

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending February 2014



Monthly Report

Executive Summary as at February 2014

Headlines

- The Trust has breached the admitted RTT target for the 4th month as was expected. An action plan is being followed to improve the position.
- For the month of February the Trust made a surplus before impairments of £95,000 compared to a planned deficit of £155,000.
- Activity was above original plan for all activity streams.

Monitor Compliance Framework Targets	Target	February 2014 Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.00%	95.07%	0	6
Referral to treatment time - Admitted %	90%	86.69%	85.13%	1	6
Referral to treatment time - Incomplete Pathways %	92%	93.20%	92.96%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	100%*	86%	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)	1	1	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating					

* 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.
^ The performance for failed RTT targets is based upon the lowest month performance as per Monitor Guidance

Indicative Monitor Governance Risk Rating	**Green**
Indicative Monitor Continuity of Service Rating	**4**

Key Trust Targets		February 2014 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	3		3
	Complaints	<=12	16		4
	CQUINS	100%	90%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<400	452		6
	Incomplete 14 - 18 Week Waiters	<450	516		6
	Total Discharged Elective Patients vs Plan	100%	102%		7
	Unused Theatre Sessions	<44	21		8
	Sickness	4.1%	4.7%		9
Financial	Surplus	£1,871	£1,598		10
	CIP	£2,831k	£2,351		10
	Agency Expenditure	£91k	£173		11
	Locum Doctor Expenditure	£46k	£117		11

Trust Summary

For the month of January the Trust made a **surplus before impairments of £95,000** compared to a planned **deficit of £155,000**. The Trust therefore has a year to date surplus of £1,598,000. The surplus excluding impairments stands at £1,738,000 against a plan of £2,071,000 which is a shortfall of £333,000. This is largely as a result of the failure to meet activity rectification targets.

All categories of activity exceeded the original plan in month. Elective activity YTD however remains below plan, and despite rectification plans this position has not been recovered.

Workforce continues to be rated as red, driven by higher than planned sickness levels and underperformance against contractual targets for mandatory training and appraisals, although these targets are improving in most areas.

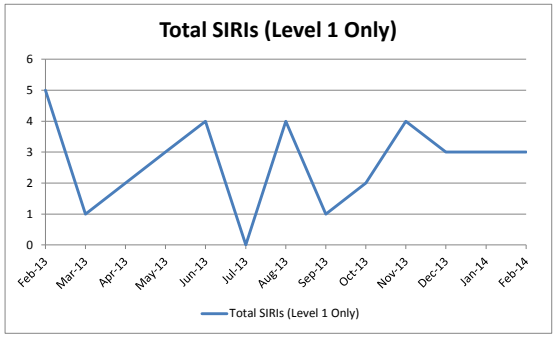
As predicted, the trust failed the Admitted RTT in February for the 4th month. It is predicted that the target will be breached again in March, but will be met in April. An action plan continues to be followed and is submitted to Monitor and CCG on a monthly basis. The overall number of patients in backlog (waiting over 18 weeks for their care) continued to reduce to 452 in month (down from 511).

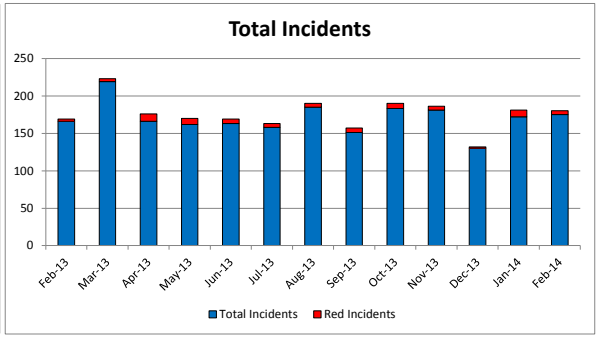
Quarterly Detailed Report
Safety Indicators as at February 2014

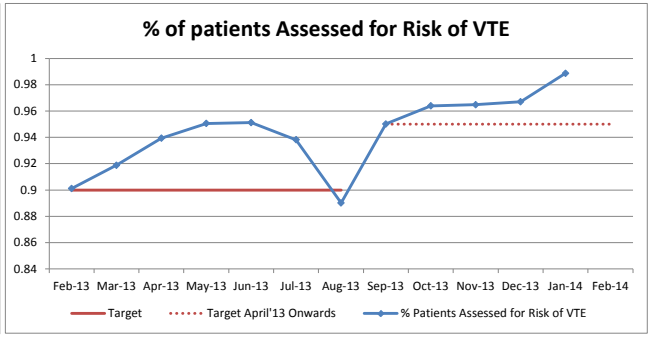
Headlines

- 6 reportable falls in month, compared to 3 in January 14, although the number of falls is roughly consistent with previous months.
- There were 3 SIRIs in month
- Total drug errors have increased since prior month, but are in line with the average for the year.

	Monitor	National	CQC Standard		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	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)	5	1	2	3	4	0	4	1	2	4	3	3	3	**29**
			4,16	SIRI per 1000 bed days	1.36	0.34	0.62	1.12	1.32	0.00	1.27	0.36	0.62	1.39	1.01	0.90	0.85	**0.84**
			4,16	Total Incidents	166	**219**	166	162	163	158	185	151	183	181	130	172	175	**1826**
			4,16	Incidents per 1000 bed days	56.23	**74.19**	51.83	60.23	53.95	47.07	58.96	54.12	56.82	62.70	43.61	51.71	49.30	**52.73**
			4,16	Red Incidents	3	4	10	8	6	5	5	6	7	5	2	9	5	**69**
			9,16	Total Drug Errors	**19**	**66**	**31**	**21**	**15**	**15**	**23**	**18**	**21**	**16**	8	11	**18**	**197**
			9,16	Drug Errors per 1000 bed days	**6.44**	**22.36**	**9.68**	**7.81**	**4.96**	4.47	**7.33**	**6.45**	**6.52**	**5.54**	2.68	3.31	**5.07**	**5.69**
		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	90.11%	91.88%	**93.94%**	95.06%	95.13%	**93.82%**	**89.02%**	95.02%	96.40%	96.48%	96.71%	98.87%		**95.16%**
			9	Incidence of Hospital Related VTE	1	1	0	0	1	1	0	1	1	0	1	1	1	**7**
			4	Patient Falls - Inpatients	**6**	**7**	4	**7**	**6**	4	**9**	2	4	**8**	**6**	3	**6**	**59**
			4	Patient Falls per 1000 bed days	**2.03**	**2.37**	1.25	**2.60**	**1.99**	1.19	**2.87**	0.72	1.24	**2.77**	**2.01**	0.90	**1.69**	**1.70**
			4,16	% Harm Free Care	93.26%	93.26%	97.89%	96.19%	97.94%	98.90%	97.85%	98.70%	97.00%	98.90%	97.50%	97.41%	100.00%	**97.69%**







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

There have been 3 SIRIs reported in month, which is comparable to Jan 14.

There has been an increase in incidents reported in month to 175, although this is still largely in line with the usual pattern of incidents.

Patient falls have increased from 3 last month to 6 this month. However, this is consistent with the pattern for the year.

There have been 5 red incidents in month, compared to 9 in January.

Drug errors have increased in month to 18 from the previous months 11. However, this is roughly in line with the average for the year.

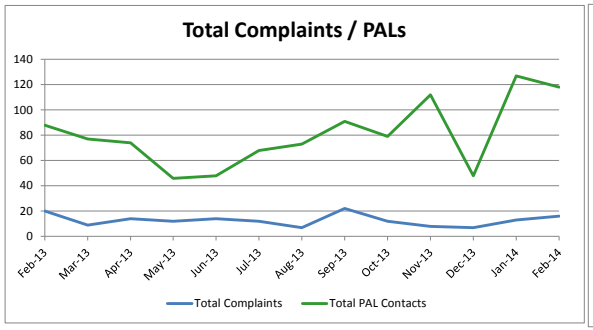
Additional information on all of the above is included in the Quality Report.

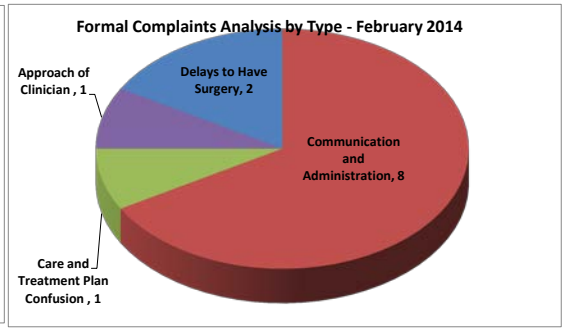
Quarterly Detailed Report
Experience Indicators as at February 2014

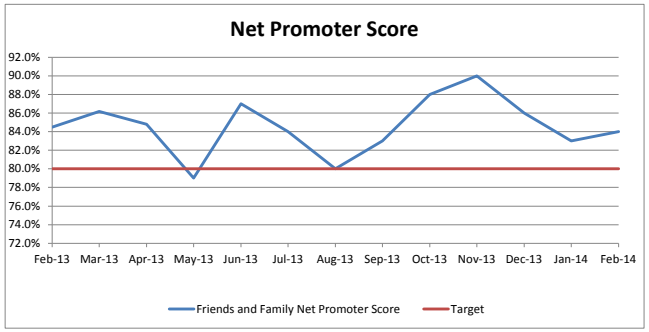
Headlines

- Although lower than prior month, the total compliments remains very high
- The number of PALs contacts has decreased by 7%, but remains red rated
- Complaints increased in the month by 23%

	Monitor	National	CQC Standard		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	13/14 Full Year Position
Experience			17	Complaints to Complements Ratio	1:20	1:46	1:25	1:25	1:29	1:32	1:46	1:14	1:34	1:16	1:63	1:37	1:27	**1:29**
			17	Total Complaints	20	9	14	12	14	12	7	22	12	8	7	13	16	**137**
			17	Complaints reverted to informal <48 hrs	1	0	1	0	1	1	3	3	0	1	0	0	0	**10**
			17	Formal	19	9	13	12	13	11	4	19	12	7	7	13	16	**127**
			17	Complaints per 1000 bed days	6.78	3.05	4.37	4.46	4.63	3.57	2.23	7.89	3.73	2.77	2.35	3.91	4.51	**3.96**
			17	Total PAL Contacts	88	77	74	46	48	68	73	91	79	112	48	127	118	**884**
			17	PALS Contacts per 1000 bed days	29.81	26.08	23.11	17.10	15.89	20.26	23.27	32.62	24.53	38.80	16.10	38.18	33.24	**25.53**
			17	Total Compliments	404	414	347	295	404	386	320	298	409	124	440	481	439	**3943**
			17	Compliments per 1000 bed days	136.86	140.24	108.35	109.69	133.72	114.99	101.99	106.81	127.00	42.96	147.61	144.62	123.66	**113.87**
				Food - Real Time Patient Survey	69.75%	77.54%	77.50%	85.43%	86.67%	90.48%	92.40%	90.00%	90.60%	92.00%	96.60%	95.00%	93.00%	**89.08%**
			17	Friends and Family Net Promoter Score	84.50%	86.18%	84.8%	79.00%	87.0%	84.0%	80.0%	83.0%	88.0%	90.0%	86.0%	83.0%	84.0%	**80.00%**







Experience Commentary

COMPLAINTS
16 complaints received (all formal) up from 13 last month. Most of the complaints were in relation to communication and administration.

PALS:
Number of contacts this month was 118 which is a similar volume to January 2014 (127) which shows a decrease of 9 or 7%. 65 of the contacts were concerns.

COMPLIMENTS:
Number of compliments received this month is 439 down from last month's total of 481 (-42 or 9%).

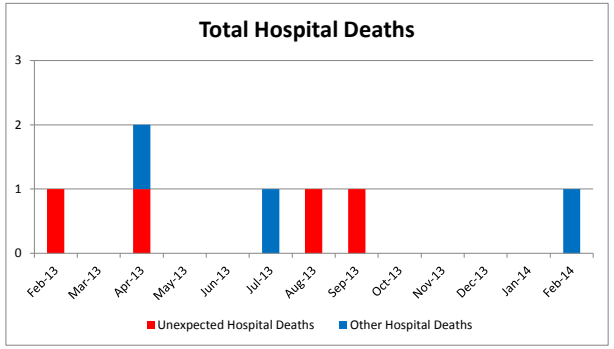
All of the above is discussed in further detail in the Quality Report.

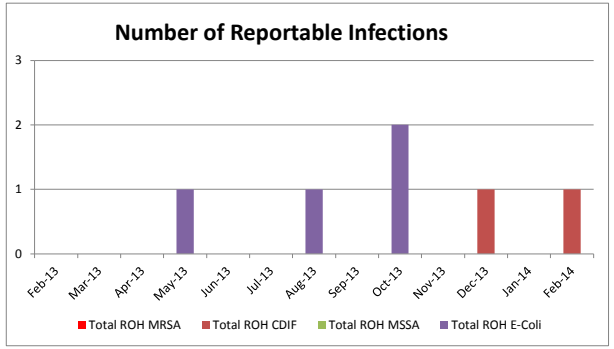
Quarterly Detailed Report
Effectiveness Indicators as at February 2014

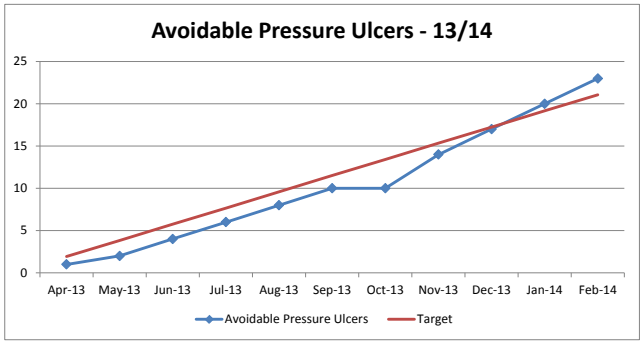
Headlines

- There were 3 avoidable Grade 1 & 2 pressure ulcers in month, which was consistent with January.
- There was a case of *C. difficile* in month, but this was unavoidable.
- There was one expected death in month.

	Monitor	National	CQC Standard		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	13/14 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	1	0	2	0	0	1	1	1	0	0	0	0	1	6
			4,18	Hospital Deaths per 1000 bed days	0.34	0.00	0.62	0.00	0.00	0.30	0.32	0.36	0.00	0.00	0.00	0.00	0.28	0.17
			4,18	Unexpected Hospital Deaths	1	0	1	0	0	0	1	1	0	0	0	0	0	3
				Other Hospital Deaths	0	0	1	0	0	1	0	0	0	0	0	0	1	3
			8	MRSA % Screened	135.5%	114.3%	129.56%	129.13%	140.59%	145.53%	127.51%	146.00%	132.00%	114.30%	100.10%	135.40%	102.00%	125.57%
	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	1	0	1	2
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	0	1	0	0	1	0	2	0	0	0	0	4
			8	HCAIs not attributable to ROH	1	0	0	0	0	0	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	0	1	1	0	2	1	0	0	5
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	5	5	1	1	2	2	1	1	0	2	2	3	3	23
			4	Avoidable Pressure Ulcers per 1000 bed days	1.69	1.60	0.31	0.37	0.66	0.60	0.64	2.51	0.00	1.39	1.01	0.90	0.85	0.81







Effectiveness Commentary

There was one death in month; this was an expected death of a patient undergoing palliative care.

There were 3 avoidable pressure ulcers of grade 1 or 2. There were no grade 3 or 4 avoidable pressure ulcers in month. This is consistent with prior month.

There was one case of *C. difficile* in month - this was unavoidable.

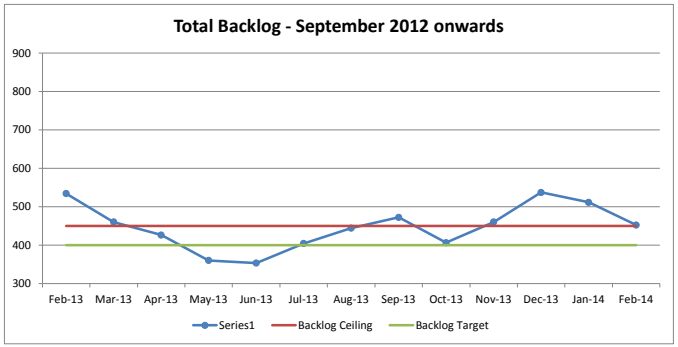
Further information on effectiveness is included in the Quality Report.

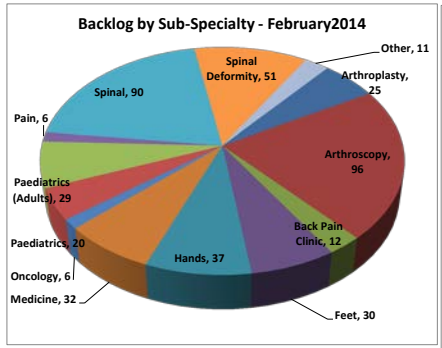
Quarterly Detailed Report
Treatment Targets as at February 2014

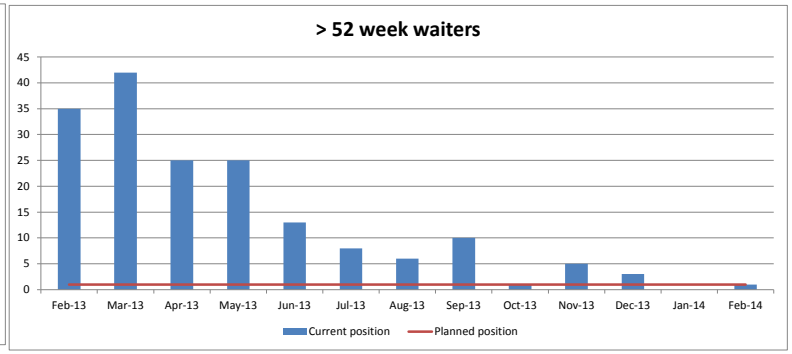
Headlines

- The Trust has breached the admitted RTT target for the 4th month as was expected.
- The percentage of patients waiting less than 6 weeks from referall has improved on prior month, and the draft result suggests this is now being met.
- 62 cancer waits has improved on prior month.

	Monitor	National	CQC Standard		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	13/14 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	35	42	25	25	13	8	6	10	1	5	3	0	1	3
	M	N	4	Referral to treatment time - Non Admitted %	95.07%	95.18%	95.24%	95.08%	95.35%	95.29%	95.78%	95.42%	95.24%	95.13%	95.12%	95.13%	95.00%	95.25%
	M	N	4	Referral to treatment time - Admitted %	90.37%	90.00%	90.22%	90.39%	91.37%	92.05%	90.33%	90.19%	90.09%	88.12%	83.25%	83.57%	86.69%	88.75%
	M	N	4	Referral to treatment time - Incomplete Pathways %	91.09%	92.01%	92.77%	94.36%	94.77%	94.18%	93.71%	93.34%	94.01%	93.33%	92.12%	92.71%	93.20%	93.50%
			4	Non admitted Backlog - Pathways waiting >18 wks	199	187	155	121	110	131	159	163	160	167	259	260	199	171
			4	Admitted Backlog - Pathways waiting >18 wks	335	273	271	239	243	273	285	309	246	293	278	251	253	267
			4	Total Backlog - 18 week pathways waiting >18 wks	534	460	426	360	353	404	444	472	406	460	537	511	452	439
			4	Incomplete 14 -18 Week Waiters	629	535	388	411	504	477	630	654	565	640	721	721	516	566
	M	N	4	Cancer 2 week (all cancers)	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.0%	100.0%	93.33%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	99.15%
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.0%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.0%	100.0%	90.00%	100.00%	66.67%	80.00%	100%*	83.30%	100.00%	85.70%	66.70%	85.70%	100%*	87.84%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	100.00%	100.00%	99.24%	100.00%	99.52%	99.20%	99.09%	99.70%	99.43%	99.36%	99.37%	98.90%	99.82%	99.37%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	0	1	0	0	1
			1,21	Data Quality on Ethnic Group - Inpatients	95.11%	91.99%	97.64%	95.29%	96.43%	94.86%	95.22%	98.35%	95.65%	95.70%	95.47%	96.19%	95.98%	96.02%







Treatment Targets Commentary

The Trust has breached the admitted RTT target for the 4th month as was expected, although the position is improving. In addition, backlog has declined from 511 in January to 452 in February. Both the non-admited and incomplete RTT targets were met.

Incomplete waiters has improved from 721 in Januuary to 516 in the current month.

The Trust is on target to meet the quarterly 62 day cancer wait target as it currently stands at 86.4%.

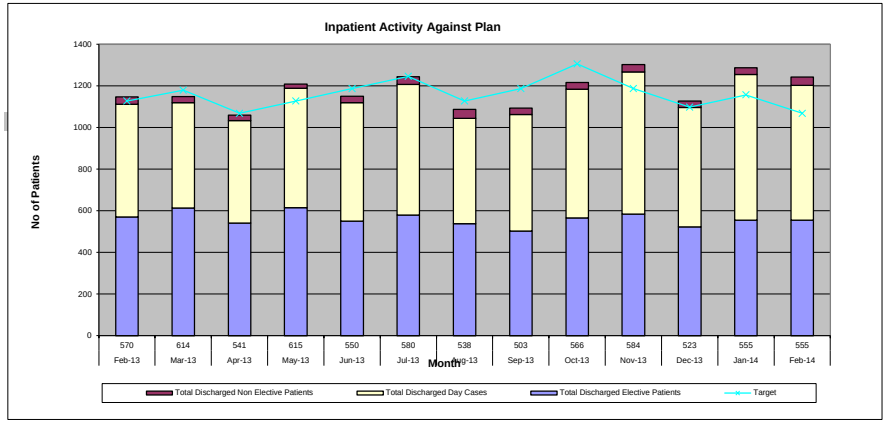
In February however the Trust had once shared breach and achieved 80.00%

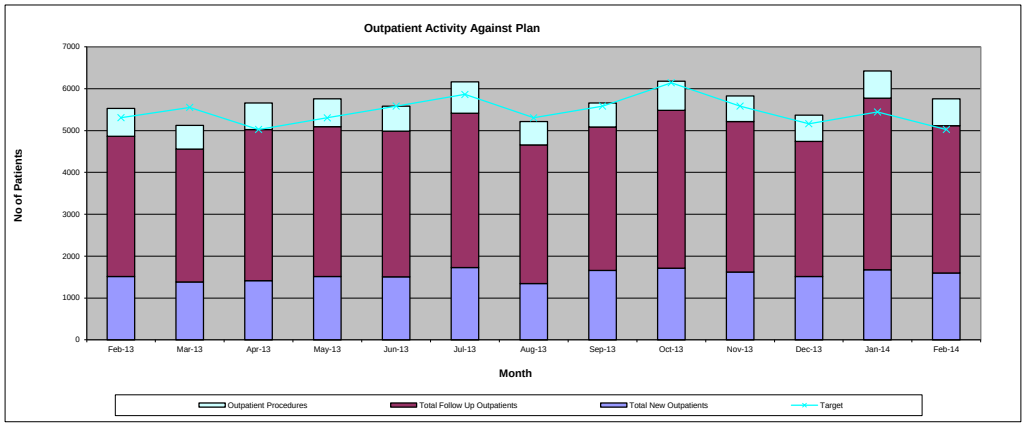
Quarterly Detailed Report
Activity Targets as at February 2014

Headlines

All categories of activity exceeded the original plan in month.
Elective activity YTD still remains behind plan.
All indicators are green rated for the first time this year.

	Monitor	National	CQC Standard		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	13/14 Full Year Position
Activity			4	Total Discharged Elective Patients	570	614	541	615	550	580	538	503	566	584	523	555	555	6110
			4	Total Discharged Non Elective Patients	35	29	25	20	30	38	44	30	33	35	31	32	41	359
			4	Total Discharged Day Cases	542	506	493	574	570	627	506	560	618	683	573	700	647	6551
			4	Total New Outpatients	1510	1381	1416	1513	1508	1728	1343	1659	1713	1619	1509	1672	1594	17274
			4	Total Follow Up Outpatients	3356	3179	3611	3583	3481	3691	3314	3428	3774	3595	3231	4101	3519	39328
			4	Outpatient Procedures	662	562	635	662	594	743	560	575	697	618	627	652	643	7006
			4	Elective as % Against Plan	100.5%	108.3%	99.43%	107.1%	91.0%	91.4%	93.7%	83.2%	85.1%	96.6%	93.5%	94.2%	102.0%	94.01%
			4	Non Elective as % Against Plan	91.4%	75.8%	72.4%	54.8%	78.1%	94.3%	120.6%	78.1%	78.1%	91.2%	87.3%	85.5%	118.7%	86.99%
			4	Day Cases as % Against Plan	103.8%	96.9%	100.7%	111.1%	104.8%	109.8%	97.9%	103.0%	103.3%	125.6%	113.9%	132.0%	132.2%	112.04%
			4	% New Outpatients Against Plan	111.0%	101.5%	111.1%	112.5%	106.5%	116.2%	99.8%	117.2%	110.0%	114.3%	115.2%	121.1%	125.1%	113.49%
			4	% Follow Up Outpatients Against Plan	103.3%	97.8%	114.2%	107.4%	99.1%	100.1%	99.3%	97.6%	97.7%	102.3%	99.4%	119.7%	111.3%	104.15%
			4	% Outpatient Procedures Against Plan	94.9%	80.6%	107.6%	106.3%	90.6%	108.0%	89.9%	87.7%	96.7%	94.3%	103.4%	102.0%	109.0%	99.44%





Activity Commentary

All categories of activity exceeded the original plan in month. Elective activity YTD however remains below plan, and despite rectification plans this position has not been recovered.

Day case activity continues to over perform and dialogue with the Commissioners and GP stakeholders has commenced to attempt to understand the reasons for this case mix shift.

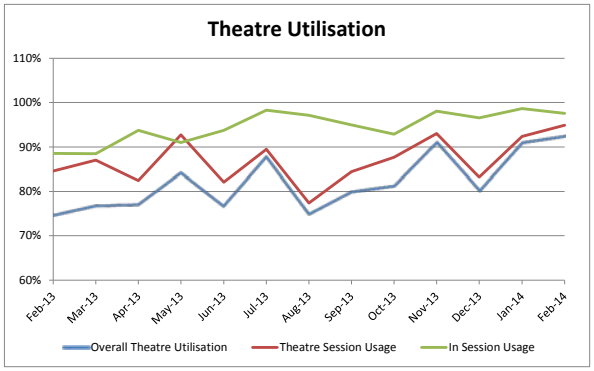
There is now daily focus on optimising theatre utilisation and day case injection suit activity. Work has commenced on activity monitoring and optimisation for 2014-15

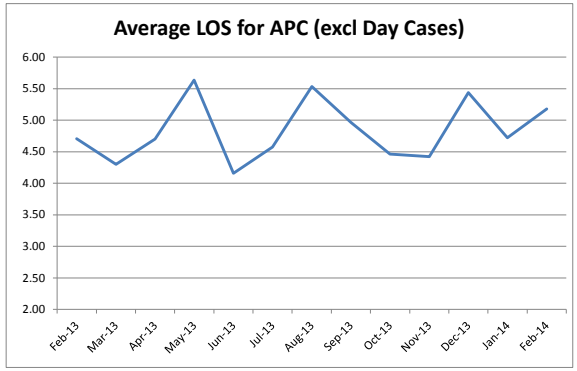
Quarterly Detailed Report
Efficiency Indicators as at February 2014

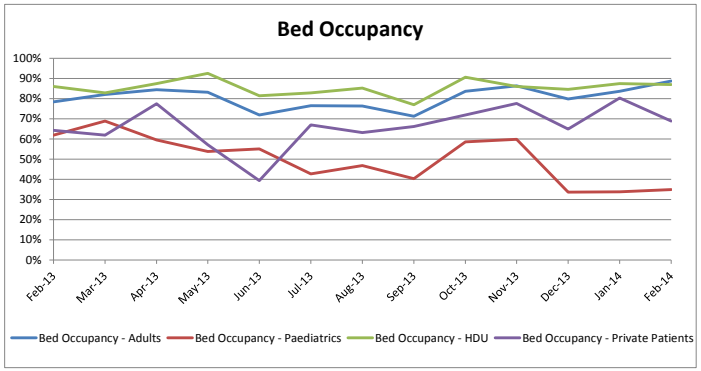
Headlines

- Total cancelled patients on the day and day before surgery totalled 71, a reduction for the third consecutive month.
- Total patients cancelled by the hospital on the day have decreased from 9 in January to 3 in February.
- Theatre utilisation, session useage and in session useage remain high.

	Monitor	National	CQC Standard		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	13/14 Full Year Position
Efficiency			4	Overall Theatre Utilisation	74.9%	77.0%	77.30%	84.41%	76.95%	87.98%	75.15%	80.19%	81.51%	91.23%	80.41%	91.13%	92.59%	81.68%
			4	Theatre Session Usage	84.60%	87.07%	82.45%	92.72%	82.09%	89.50%	77.38%	84.42%	87.73%	93.02%	83.26%	92.37%	94.88%	85.84%
			4	In Session Usage	88.5%	88.5%	93.76%	91.04%	93.73%	98.31%	97.11%	94.99%	92.92%	98.07%	96.58%	98.66%	97.59%	95.17%
			4	Unused Theatre Sessions	63	53	76	30	77	50	102	67	61	30	72	36	21	622
			4	Number of Cases per Theatre Session	3.13	3.11	2.82	3.01	3.08	2.79	2.95	2.91	2.67	3.09	2.97	2.83	3.07	2.92
			4	Total Cancelled Operations (On Day or Day Before)	78	52	91	72	63	88	58	62	82	120	84	78	71	869
			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)	4	2	4	5	5	11	14	4	2	11	10	9	3	78
			4	% Cancelled Operations by Hospital	0.37%	0.18%	0.40%	0.43%	0.46%	0.93%	1.36%	0.38%	0.17%	0.89%	0.94%	0.73%	0.25%	0.63%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.30	2.59	2.78	2.45	2.55	2.25	2.54	2.36	2.32	2.34	2.29	2.58	2.44	2.48
			4	Pain Review-To-New Ratio	3.70	2.99	3.53	4.65	2.90	4.02	4.24	1.89	3.59	2.70	3.38	3.72	3.85	3.69
			4	Outpatient DNAs	9.05%	10.52%	7.70%	8.79%	9.23%	8.70%	9.33%	8.49%	8.46%	8.51%	8.61%	9.59%	8.31%	8.63%
			4	Bed Occupancy - Adults	78.34%	81.96%	84.37%	83.16%	71.91%	76.53%	76.26%	71.19%	83.58%	86.36%	79.80%	83.60%	88.61%	80.40%
			4	Bed Occupancy - Paediatrics	61.90%	68.89%	59.44%	53.76%	55.00%	42.71%	46.77%	40.28%	58.60%	59.72%	33.67%	33.78%	34.87%	46.21%
			4	Bed Occupancy - HDU	86.06%	82.89%	87.36%	92.53%	81.44%	82.76%	85.15%	77.01%	90.67%	85.92%	84.62%	87.45%	86.89%	87.09%
			4	Bed Occupancy - Private Patients	64.29%	61.91%	77.47%	57.14%	39.29%	66.96%	63.13%	66.19%	71.89%	77.62%	64.94%	80.28%	68.88%	67.45%
			4	Admissions on the Day of Surgery	400	457	381	433	403	418	374	371	417	405	386	421	411	1635
			4	AVLOS for APC (excl day cases)	4.71	4.30	4.70	5.63	4.16	4.58	5.54	4.97	4.46	4.42	5.44	4.72	5.18	4.75







Efficiency Commentary

Total cancelled patients on the day and day before surgery totalled 71, a reduction for the third consecutive month.

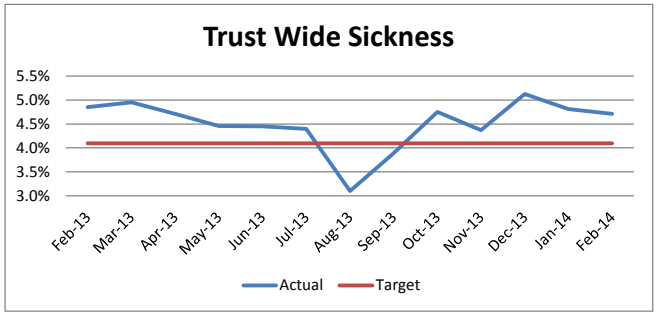
Hospital cancelations for February decreased to 3 from 9 in the previous month, resulting in the first green rating in 4 months.

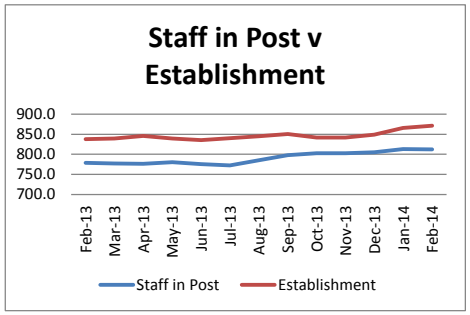
Monthly Report
Workforce Indicators as at February 14

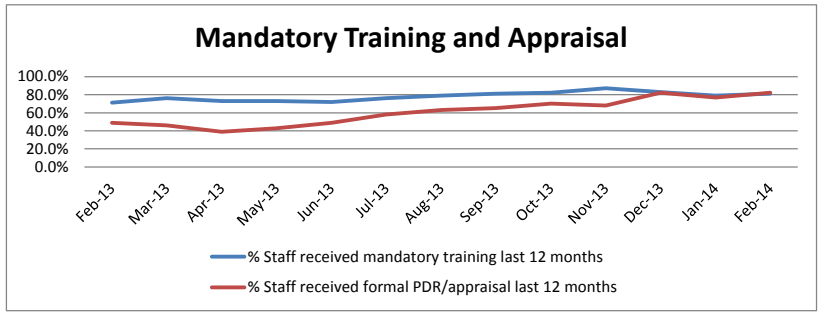
Headlines

- The WTE staff employed continues to rise.
- Sickness has continued to reduce.
- Agency spend as a % of staff costs has increased significantly in month.

	Monitor	National	CQC Standard		Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	13/14 Full Year Position
Workforce			13	Total WTE Employed	778.6	777.5	776.5	780.5	775.8	772.5	784.9	797.7	802.6	802.9	805.3	813.0	812.5	798.9
			13	Total WTE Employed as % of Establishment	93.0%	92.7%	91.8%	93.0%	92.9%	92.0%	92.9%	93.8%	95.3%	95.4%	94.8%	94.0%	93.3%	93.9%
			13	Staff Turnover (%)	12.6%	12.7%	11.6%	12.0%	12.6%	12.5%	12.5%	12.7%	12.8%	12.9%	13.1%	12.2%	11.8%	12.6%
			13	% of Sickness - Trust wide	4.9%	5.0%	4.7%	4.5%	4.5%	4.4%	3.1%	3.9%	4.8%	4.4%	5.1%	4.8%	4.7%	4.4%
			13	Agency % of Staff Cost	6.4%	8.7%	6.1%	8.0%	8.4%	6.1%	6.5%	6.4%	6.2%	5.6%	5.8%	6.9%	9.7%	6.7%
			13	Temporary staffing hours as a % of establishment														
			13	% Staff received mandatory training last 12 months	71%	76%	73%	73%	72%	76%	79%	81%	82%	87%	83%	79%	81%	81%
			13	% Staff received formal PDR/appraisal last 12 months	49%	46%	39%	43%	49%	58%	63%	65%	70%	68%	82%	77%	82%	71%
			13	% of required staff receiving safeguarding training			33%	30%	21%	51%	51%	54%	60%	58%	66%	66%	68%	59%
			13	Qualified Nurse / Bed ratio														
			13	Staff Net Promoter score														







Workforce Commentary

Sickness has reduced marginally and the underlying trend continues to be 0.5% less than April 2013.

Agency useage has increased due to additional ward capacity and additional locum doctors.

The majority of directorates saw positive improvements within their mandatory training and PDR data during February, with only theatres showing a slight decrease in PDR completions.

Quarterly Detailed Report
Financial Performance as at January 2014

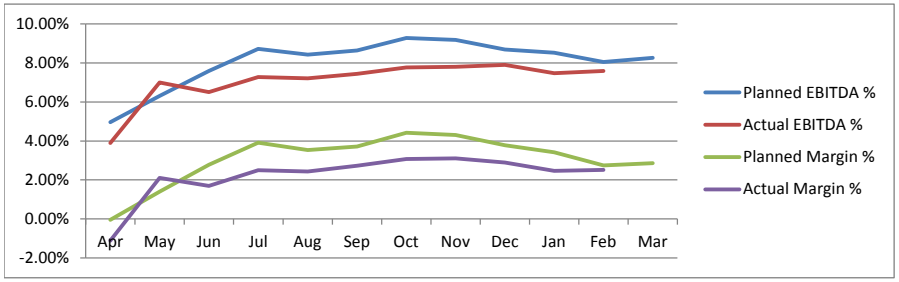
Headlines

- For the month of February the Trust made a surplus before impairments of £95,000 compared to a planned deficit of £155,000.
- The Trust has a year to date surplus of £1,598,000. The surplus excluding impairments stands at £1,738,000 against a plan of £2,071,000 which is a shortfall of £333,000.
- CIP achievement currently sits at £2,351,000 of which 95% is recurrent. This is £480,000 behind the target after Month 11.

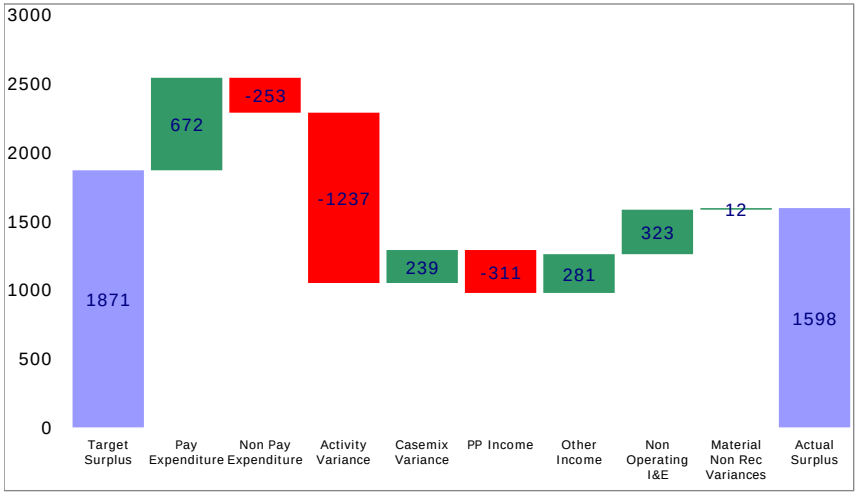
Trust Financial Metrics

	Year to Date		
	Actual	Plan	Risk
Capital Servicing Capacity	3.7	4.5	4
Liquidity Ratio	80.1	79.2	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 February the Trust made a surplus before impairments of £95,000 compared to a planned deficit of £155,000. The Trust therefore has a year to date surplus of £1,598,000. The surplus excluding impairments stands at £1,738,000 against a plan of £2,071,000 which is a shortfall of £333,000. 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

All categories of activity exceeded the original plan in month resulting in income being in excess of Monitor planned levels for February.

Pay

The total paybill has increased in January, and is the highest it has been this year. The substantive paybill has increased by £55,000, but there are significant increases in bank pay (£39k or 21% increase from January) and ADHs (£22k or 17% increase). An element of this overspend will be as a result of efforts to increase activity to reach the rectification plan. In addition, locum spend is £37k higher than last month, due to an underaccrual against actual spend.

Non Pay

Non pay spend was relatively high for the month. This was driven primarily by additional costs in relation to attempting to deliver the rectification plan, such as continuing to run the extra capacity ward, and funding drugs costs for the extra theatre useage. In addition, these has been higher than average MRI costs in light of the continued outstourcing to Alliance Medical to meet demand, with the monthly cost pressure in February totalling £51,000.

CIP

CIP achievement currently sits at £2,351,000 of which 95% is recurrent. This is £480,000 behind the target at Month 11.

Balance Sheet & Cash Flow

The Trust finished February with a Statement of Position £0.2m behind plan, with the main variances relating to higher than anticipated closing stock, debtor and creditor balances and a higher than planned cash balance.

Quarterly Detailed Report

Financial Efficiency Indicators as at February 14

Headlines

- The paybill has been the highest in this financial year. This is in line with the increase in activity for this month due to the rectification plan.
- Agency pay has been highest since October.
- Both the Trust surplus before impairments and CIP performance remain below planned levels

		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
Cost of Staffing	Total Paybill	£3,388,000	£3,216,996	£3,313,000	£3,259,000	£3,324,000	£3,252,000	£3,233,418	£3,279,000	£3,311,000	£3,274,000	£3,315,000	£3,471,000
	Substantive Pay	£2,841,000	£2,809,592	£2,852,000	£2,822,000	£2,864,000	£2,806,000	£2,805,483	£2,861,500	£2,919,000	£2,877,100	£2,893,700	£2,949,000
	Bank Pay	£246,000	£203,441	£187,000	£197,000	£252,000	£230,000	£213,956	£208,000	£195,000	£201,000	£187,000	£226,000
	Overtime Pay	£5,000	£9,915	£4,000	£4,000	£4,000	£5,000	£7,612	£5,500	£4,000	£4,900	£6,300	£5,500
	Agency Pay (excluding Medical Locums)	£234,000	£139,565	£241,000	£191,000	£150,000	£144,000	£138,048	£177,000	£133,000	£109,000	£148,000	£173,000
	Medical Locum Pay	£62,000	£54,484	£28,000	£81,000	£54,000	£67,000	£68,319	£52,000	£60,000	£82,000	£80,000	£117,000
	ADH Payments - Surgical	£40,000	£26,000	£38,000	£20,000	£17,000	£26,000	£23,000	£22,000	£31,000	£22,000	£38,000	£45,000
	ADH Payments - Clinics	£17,000	£11,000	£14,000	£7,000	£17,000	£9,000	£13,000	£15,000	£19,000	£17,000	£18,000	£28,000
	ADH Payments - Anaesthetics	£84,000	£46,000	£47,000	£48,000	£63,000	£46,000	£53,000	£48,000	£53,000	£62,000	£71,000	£76,000
	ADH Payments - Spot Work & Strategy	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Income & Efficiency	Trust Surplus	£2,203,000	-£66,000	£250,000	£305,000	£602,000	£729,000	£978,000	£1,305,000	£1,509,000	£1,599,000	£1,503,000	£1,598,000
	Normalised Surplus	£1,853,000	-£66,000	£250,000	£443,000	£891,000	£912,000	£977,000	£1,228,000	£1,431,000	£1,587,000	£1,491,000	£1,586,000
	Total Income	£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	£6,436,000	£5,849,000	£6,371,188
	CIP	£3,820,000	-	£339,000	£561,000	£869,000	£1,125,000	£1,378,000	£1,537,000	£1,787,000	£2,039,000	£2,161,000	£2,351,000

Summary

The paybill this month is the highest for this financial year. Bank usage also at its highest for current year and agency usage is at its highest for last eight months .

The Trust has a year to date surplus before impairments of £1,598,000 against a plan of £1,871,000 which is a shortfall of £273,000.

CIP achievement currently sits at £2.4m of which 95% is recurrent. This is £480,000 behind the target after Month 11.

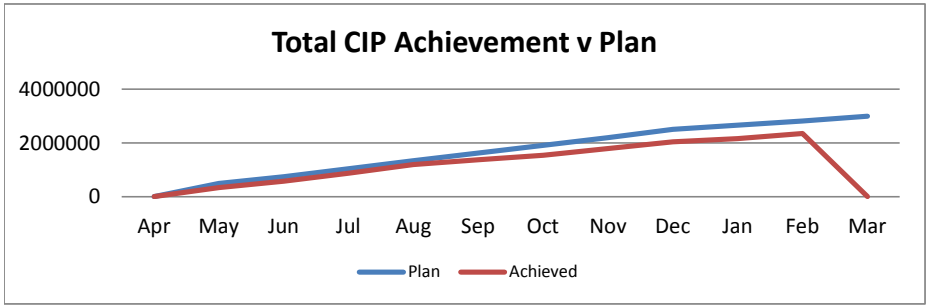
Monthly Report

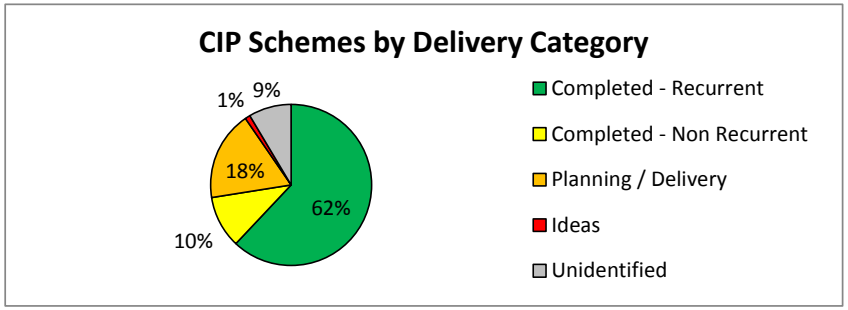
Cost Improvement Programme Indicators as at February 14

Headlines

- CIP achievement currently sits at £2,351,000 of which 95% is recurrent. This is £480,000 behind the target after Month 11.
- To date 83% of the required annual CIP value is completed and implemented. 9% is not identified or ideas at this stage
- No medium or 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	862	9	21	216	1,082	80%	220
Corporate Areas	774	677	47	10	40	756	90%	79
Income	1,100	812	288	0	0	993	82%	181
Total	**2,982**	**2,351**	**344**	**31**	**255**	**2,831**	**83%**	**480**



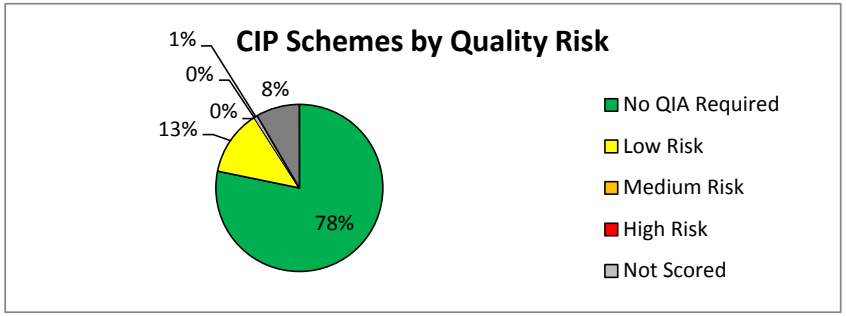


Significant Exceptions

Theatres & Anaesthetics. To date only 52% of the £473k target has been implemented. 45% is unidentified at this stage.

Income. To date 74% of the £1.1m plan has been implemented.

Management. To date 28% is yet to be identified.



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26th March 2014 **ENCLOSURE NUMBER: 8**

SUMMARY OF REPORT TO BOARD

DIRECTOR LEAD:	Helen Shoker, Director of Nursing & Governance
AUTHORS:	Lisa Pim, Interim Deputy Director of Nursing & Governance Alison Braham, Governance Manager
SUBJECT:	**Patient Quality Report – February 2014**

SUMMARY

This paper will provide the Board with an update on patient quality, safety and experience activity during February 2014.
Patient quality, safety and experience must remain a high priority for the organisation and it is anticipated this report will assist the Board in bringing together key quality issues.

The Board are asked to note the following specific areas:

- The quality indicator for Falls risk assessments & care planning has not been achieved for February,
- A comprehensive inpatient assessment pack is to be launched in April 2014, led by Matron Okane,
- CDiff target of 2 cases has been reached,
- Infection Prevention Society Quality Improvement Tool to be launched in April with support by Commissioners,
- WHO checklist achieved 100% compliance, internal progress to be maintained,
- Friends and Family Test response rate has improved this month
- February deadline for NJR 2013 data and compliance achieved, resulting in developing backlog for 2014.

Patient Quality Report developments this month include:

- the inclusion of Patient Safety Alerts as an additional aspect of reporting
- the modifications as recommended by EMT and Trust Board last month

Proposed additional updates from April 2014 include:

- Nutrition
- National Joint Registry (NJR)

RECOMMENDATIONS

The Board is asked to:

- **discuss** the Patient Quality Safety and Experience report
- **identify** areas of risk requiring further assurance by Directorate and/or Corporate teams
- **identify** any other patient safety and experience issues for inclusion in future reports

PATIENT SAFETY

1.1 Serious Incidents requiring investigation (SIRI)

There have been 3 SIRIs reported in February; the same number as reported for January. These include a confidentiality issue, a patient transfer/death outside the Trust, and an incident concerning anaesthetist absence from the operating theatre. (See Appendix 1)

1.2 All other incidents requiring an investigation

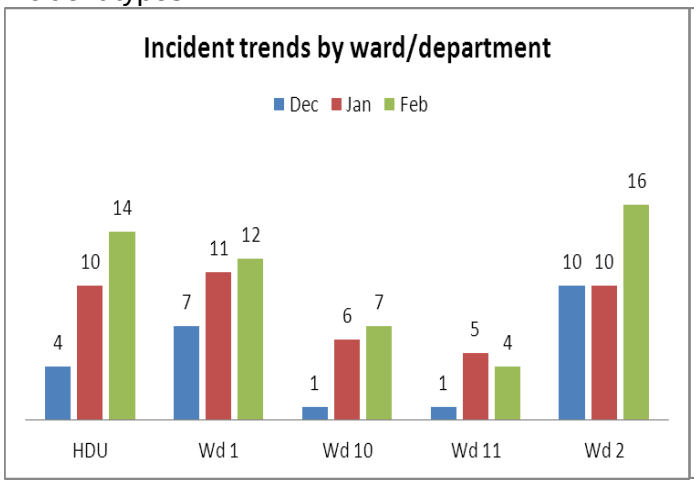
5 additional incidents were reported that subsequently required an RCA investigation to be undertaken (See Appendix 2).

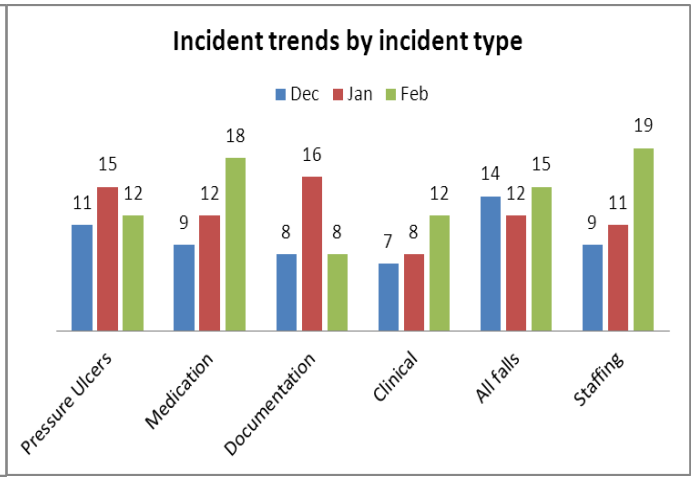
1.3 Deaths

There has been 1 in-hospital expected death reported during February 2014. The patient was undergoing palliative care and had been admitted from a local hospital after a dislocation of EPR. Cause of death: metastatic carcinoma. There is also an RCA investigation being undertaken into the transfer of another patient to a local hospital. The patient died shortly after transfer (SIRI as above).

1.4 Incident trends

There were 175 incidents reported during February, compared to 172 incidents reported during January. Notable trends by ward/department and by incident are outlined below, e.g. Top 5 clinical areas and Top 6 incident types

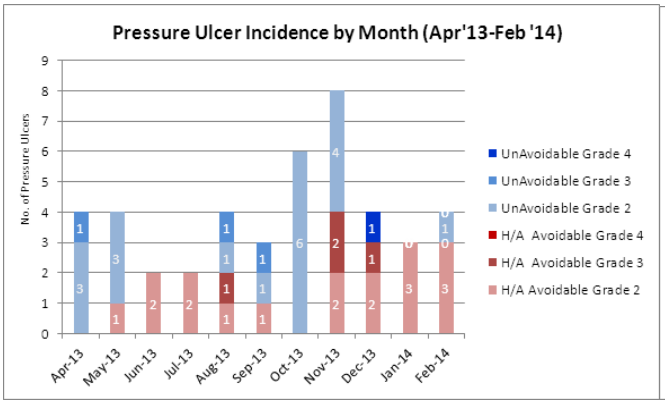


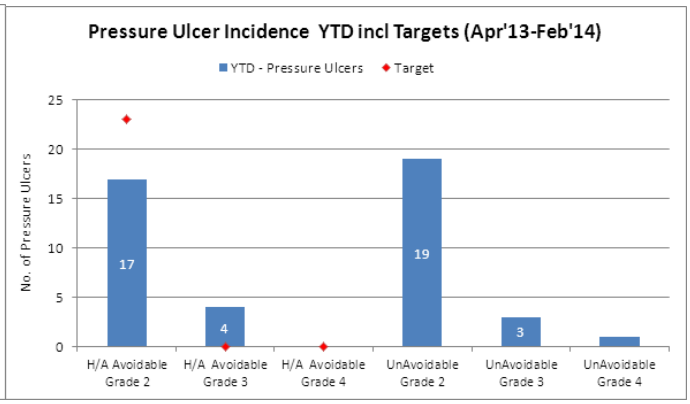


1.5 Pressure Ulcers

During February there were 3 avoidable grade 2 pressure ulcers and 1 unavoidable grade 2 pressure ulcer

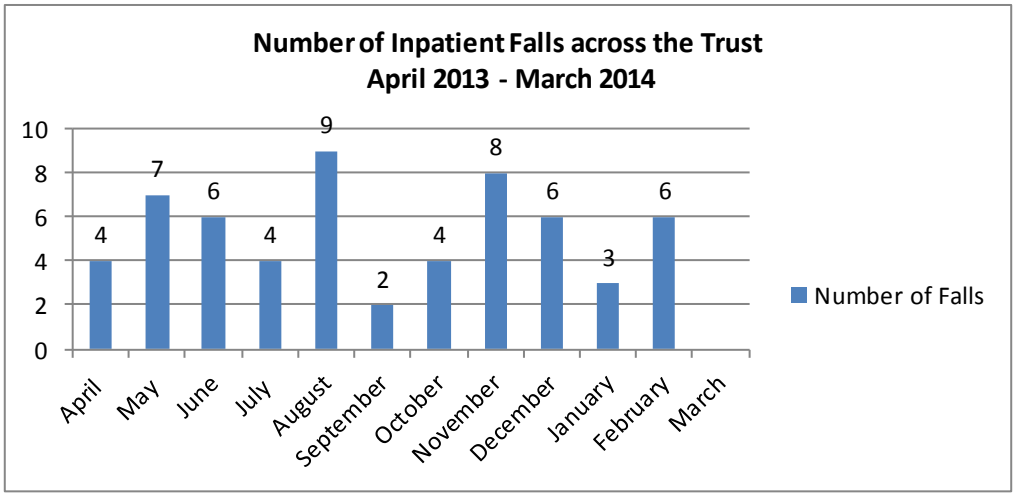
- 1 avoidable grade 2 on ward 2, equipment had been provided this was not documented and mattress had not been turned on.
- 1 avoidable grade 2 on ward 10 this patient had complex surgery which affected repositioning, his skin deteriorate to grade 1 damage whilst in HDU and preventative provisions were only then put in place, skin later deteriorated to grade 2, but as there was a delay in these provisions.
- 1 avoidable grade 2 HDU spinal patient with infected spine whose mobility deteriorated and the appropriate upgrade of mattress was not provided.
- 1 unavoidable grade 2, ward 3 terminal care oncology patient with all provisions in place and skin deteriorated with general condition towards the end of life.





1.6 Falls

There have been 6 reportable falls incidents for the month of February, categorised as (adult) in-patient falls, of which 5 have been deemed unavoidable. All incidents have been reviewed. This month two falls were categorised as causing no harm and four resulting in minor harm. Although there are peaks in the number of falls across the organisation none have caused serious patient harm.
All falls resulting in more than minor harm are investigated with a root cause analysis and are detailed within this report. There has been one episode of moderate harm sustained in November.



- 3 of the 6 falls were sustained by a single patient, each on separate occasions. All possible falls prevention strategies are in place and the patient specific falls documentation is up to date.
- 2 of the reportable falls relate to patients attempting to stand independently without asking for help and consequently losing their balance.
- 1 fall is an alleged fall, this will be categorised as avoidable/unavoidable once the investigation is completed (Incident 12416). This relates to an unwitnessed fall on Ward 2. A formal complaint has been made by the patient's partner and is being investigated by the ward manager and matron. Full details regarding the outcome will be presented in next month's report.

Wards 3 (20), 2 (18), and 1 (15) remain the inpatient wards reporting the highest number of falls in the current financial year.
The additional actions for improvement identified this month include:

- Planning of a new campaign around Falls awareness and prevention with a bid to fund the whole campaign, including hi-lo beds, slipper exchange, Call don't Fall posters etc. from charitable funds. This application will take place in May.
- Requests have been sent to IT to get "Call don't Fall" posters advertised on Trust screensavers and showing on Outpatient waiting area screens.
- Ongoing training and development of staff in balancing independence and rehabilitation of our patients with careful consideration of falls triggers/factors and preventative measures.

The quality indicator for Falls risk assessments & care planning has not been achieved for February.

Qu1.	Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	91% compliance required each month by ward
Qu2.	If the patient is identified as high risk is a care plan in place? Yes/ N/A	91% compliance required each month by ward

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	
Qu1.	100%	100%	95%	96%	96%	98%	92%	92%	96%	96%	90%	
Qu2.	95%	95%	95%	92%	84%	96%	81%	92%	96%	90%	80%	

Audit demonstrates that all patients admitted via the ADCU have a falls risk assessment completed within 6 hours of admission and the absence of risk assessment occurs when patients are admitted either via an emergency route, or directly to wards as per their speciality (Wards 1 & 3).
In comparison to January data Ward 3 has fallen by 20% for high risk care planning, ward 3 Nurse leads are aware.

1.7 Infection Prevention and Control.

In the year to date there have been a total of 2 C.*Diff* cases , both were unavoidable and were BIU patients. The places the Trust at the limit of the annual contractual target, wards and departments must remain vigilant and ensure all appropriate measures are in place for the remainder of the financial year. (see Appendix 2).

The Trust has reached agreement from the Commissioners to commence the use of The Infection Prevention Society (IPS) Quality Improvement Tools (QIT) which are specific and evidence based which will elicit clearer and more beneficial information regarding environmental and practical standards throughout the Trust. The new tools will be used from April 2014.

1.8 Patient Safety Alerts

Reference	Alert Title	Issue Date	Response	Deadline
MDA/2014/006	Electrosurgical devices. CUSA CEM nosecones for use with the CUSA® Excel/Excel+ ultrasonic aspirator. Risk of burns to patient or user	26-Feb-14	Assessing Relevance	19-Mar-14

MDA/2013/077 - Action taken:

All suctions machines are being replaced by Serres machines on the 5th March. The Trust will no longer have Hospira machines on site.

NPSA/2011/PSA001 and NPSA/2009/PSA004B - Action taken:

These alerts have been closed off - NPSA/2009/PSA/004B and NPSA/2011/001 Part A following an update from NSPA which was tagged onto a new alert for Non-luer spinal (intrathecal) devices for chemotherapy, the comments stated as follows:-"This alert refers to Non-luer spinal (intrathecal) devices for chemotherapy for which a complete range of devices in now available. As yet there is not a full range of devices on the market for other procedures. Whilst awaiting non luer products to come to market for all procedures trusts may close off NPSA/2009/PSA/004B and NPSA/2011/PSA/001 Part A update following a risk assessment and entry of identified risks in the trust's risk register which should be reviewed regularly. Trust should continue to trial new devices for epidural and regional procedures as they become available."

The Theatres Directorate has noted the above alerts within the risk register and assessments in place.

1.9 WHO compliance

Full compliance of 100% completed checklists has been achieved in February. There have been additional actions following the January Report which include a staff awareness raising session at TBALD focusing on patient safety, regular review meetings with Team Leaders to share data and to reinforce the process, and spot checks being performed whilst the patient is in theatre.

1.10 CQUIN Schemes

The trust has achieved all monthly compliance targets for 2013/2014 schemes.

A total of 3 avoidable Grade 3 and 1 avoidable Grade 4 pressure ulcers have occurred in the year to date. This is a breach of the agreed target of no avoidable pressure ulcers and will affect the quarter 4 contractual position; this is currently being negotiated with local Commissioners.

New CQUINS for 2014/2015 have been agreed with our partner Commissioners and include local schemes of the vulnerable patient, staff safety culture, post -operative telephone follow up, and SSI monitoring. National schemes will be Dementia, Safety thermometer, and Friends and Family.

2 PATIENT EXPERIENCE

2.1 Compliments, PALS and Complaints

Directorate	PALS	Complaints	Compliments
Clinical Support	39	5	43
Corporate	23	0	23
Small Joint	7	2	4
Large Joint	22	5	153
Oncology	4	1	17
Paediatrics	2	1	26
Spinal	20	1	80
Theatres	1	1	93
Total	**118**	**16**	**439**

The number of compliments received this month is 439, down from last month's total of 481.
PALS contacts in February totalled 118, a similar volume to January 2014 (127), of which 53 were general enquiries (45%) and 65 were concerns (55%).
The greatest areas of concern were:

- Care and treatment plans to be confirmed – clinic letters, next appointment and TCI dates
- Delays in clinic/imaging departments
- "rushed" discharge
- Parking and transport

Highest volumes of general enquiries were:

- Directions to departments and hospital itself
- Advice to non ROH patients
- Contact details for colleagues within the hospital
- Where to send referrals
- Work experience
- Copy medical records
- Private patient enquiries

In February 16 complaints were received, compared to 13 January. The most frequent areas of concern raised were:

- Administration, communication or organisation x 8
- Nursing care x 3 (ADCU x 1, Ward 2 x 2)
- Delays to have surgery x 2
- Care and treatment plan confusion x 1
- Clinical care x 1
- Approach of clinician x 1

2.2 Friends and Family Test (Net Promoter)

The net promoter ROH score is 84 and the response rate is 43% for the month of February 2014. This compares to the national average of 72 promoter and 29% response rate.
This score keeps us in the top quartile nationally, and both the response rate and score meet our CQUIN requirements. The response rate has shown a slight improvement from last month. Public and Patient Services Staff will continue to attend wards in person to remind staff of the importance of continuing to encourage responses. We have had two requests in the last month from NHS England (via commissioners) to verify data:
Confirm the reason for the drop in surveys undertaken in January 2014 compared to December 2013: Explanation given was that there were a lower number of patients admitted in January than December but % return was roughly the same for both months. Explanation was accepted.
Confirm the reason for the drop in % return rate from earlier in the year: Explanation given was that absence of key administrator for 6 months together with time constraints of paper return had affected response rate. However, as Trust still has much higher return than national average and we are developing the IT infrastructure to support electronic data capture, we were not overly concerned by this. Explanation was accepted.

2.3 Litigation

The Trust has received notification of 1 new potential claims in February. The patient's solicitor has requested copies of medical records with a view to making a claim for clinical negligence against the Trust.

Ref	Date of incident	Details	Directorate
T436	June 2012	nerve damage following TKR	Oncology

The following disclosure of patient records to solicitors and formal letters of claim have been received in the following cases.

Ref	Date of initial notification	Date of Incident	Details	Directorate
T398	5.3.13	Feb-10	Failure to explain procedure and alternative treatments; inappropriate traction leading to nerve damage	Spinal
T391	14.3.13	Jan-10	Lack of advice about pain & function prior to surgery; pain following surgery; need for 4 revision procedures	Paeds (adult patient)
T356	23.7.12	2008	Incorrect diagnosis, non-Hodgkins lymphoma. Also a claim against UHB	Spinal/ Histopathology
T322	20.10.11	Aug-10	Surgical outcome – removal of rods & fusion	Spinal

Closed Cases

Ref	Date of incident	Details	Settlement	Directorate
T304	May 2011	Visitor fall on wet fall	Liability admitted Damages £2,400; Claimant costs £6,800; Defence costs £409; CRU* £600	Corporate
T327	20.1.12	Hip replacement – negligent care & treatment, Metal on metal	Discontinued by claimant's solicitors. Damages £0, Claimant costs £0; Defence costs £950.	Large Joints
T239	21.5.09	DVT prophylaxis. Aspirin prescribed instead of clexane but no evidence aspirin administered	Liability admitted Damages £16.5k; Claimant costs £40k; Defence costs £8.5k	Oncology

***CRU – payment to Compensation Recovery Unit for NHS charges associated with the claimant's injury**

2.4 Single Sex Compliance

There were no single sex compliance breaches in February.

2.5 Patient Reported Outcome Measures (PROMs)

The Trust has met the 90% target compliance rate for completed questionnaires for both hip and knee replacement surgery. The figures are based upon the actual theatre activity according to ORMIS and are checked against the patient details in PAS. The PROMS questionnaire compliance data for February 2014 is detailed below:

	Indicator	February 2014
4A N13ii	PROMs: Hip replacement - % patients completing questionnaires.	98.1%
4A N13iv	PROMs: Knee Replacement- % patients completing questionnaires.	94.3%

For 2012/13 current position is

- *Primary Knee Replacement EQ5d – below national average but not an outlier.*
- *Primary Knee Replacement, Oxford Knee Score –below the national average but not an outlier.*
- *Revision Knee Replacement EQ5d – below national average but not an outlier.*
- Revision Knee Replacement, Oxford Knee Score –above the national average
- Primary Hip Replacement EQ5d –above the national average.
- Primary Hip Replacement Oxford Hip Score – above the national average.
- Revision Hip Replacement EQ5d –above the national average.
- Revision Hip Replacement Oxford Hip Score – above the national average.

2.6 **National Joint Registry (NJR) Monitoring Report**

The following compliance progress relates to January to December 2013 with an end submission date of 28th February 2014 for the 2013 data. 2237 forms were submitted and include Hip, Knee, Shoulder, Ankle, Elbow replacements and revisions. Based on the number of NJR forms submitted, the Trust is above the 90% (overall) compliance rate for 2013. The provisional NJR Consent progress for January to December 2013 is approximately 88%. NJR Consent relates specifically to patients giving consent to their personal data being recorded on the NJR database.

The NJR will publish the Trust's compliance rate for 2013 in September 2014 as part of the NJR annual report.

Compliance Progress: February 2014 - given the focus on ensuring compliance with the 2013 NJR returns, this has resulted in a backlog of 2014 NJR data being inputted (covering January and February). There are plans in place to address this and specific details of progress will be outlined in future updates.

3. EFFECTIVENESS OF CARE

3.1 **Safety Thermometer**

At the time of reporting this data is currently not available but will be tabled at EMT.

3.2 **Matron KPI**

The following specifics are noted for reported month;

Large/Small Joints Directorate

Sustained performance is noted across Wards 2, 10, and 12. Wards 2 and 12 remained amber this month. Ward 10 was not complete at time of report. Areas requiring focus appear to be training, complaints, and budget management, with some areas of elevated sickness.

Theatres/Anaesthetics and Critical Care Directorate

Sustained performance is noted for this Directorate, with all clinical areas achieving an overall rating of amber. Overall sickness levels remain high throughout the Directorate

Support Services Directorate

There is some reduced performance noted within the Directorate with 1 area reduced to an amber rating (OPD) the other clinical areas continue to achieve an overall green rating, OPD, ROCS, and Pain Management. POAC has achieved an amber rating with areas of focus required on training (Resus and Manual Handling) and safety checks. There are also elevated levels of sickness within the department.

Spinal Directorate

There remains sustained performance in Ward 1, with key areas of focus being training. There were an elevated number of falls this month on Ward 1.

Paediatric Directorate

Ward 11 has sustained amber rating. Key areas of focus remain to be safety checks, and there were elevated levels of sickness notable in February.

Oncology Directorate

Ward 3 has sustained performance as an amber rating. There is a focus on completion of incident reviews by the Matron and Ward Managers as there has been a back log accumulated.

APPENDIX 1

1.1 New SIRIs February 2013

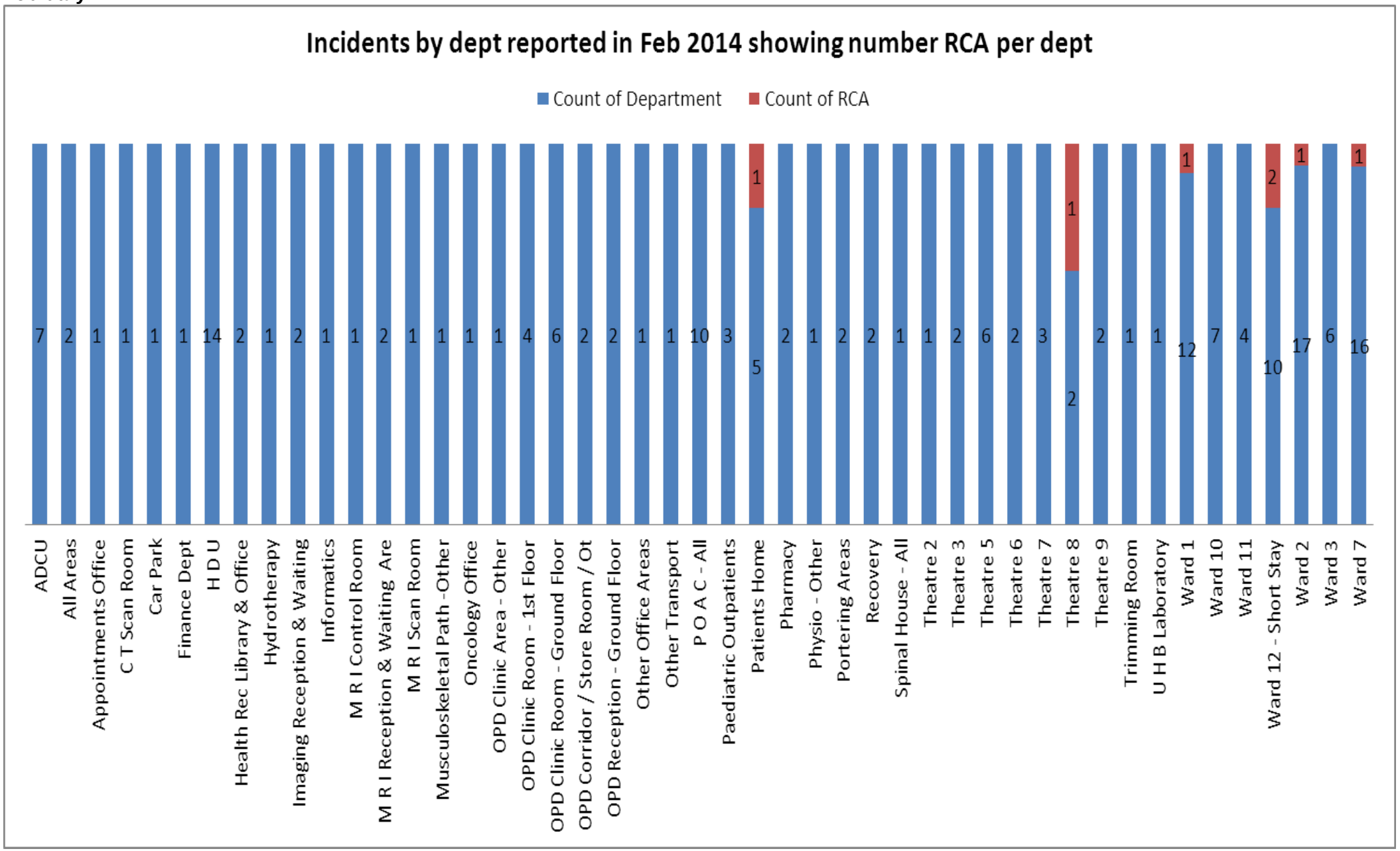
Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final report due
12164/8 STEIS 2014/4900	07/01/14	12/02/14	Anaesthetist absence	No harm	Theatres & Anaesthetics	Investigation underway	16/04/14
12383 STEIS 2014/4895	10/02/14	12/02/14	Confidentiality breach	Minor	Corporate	Investigation underway	16/04/14
12412 STEIS 2014/5869	11/02/14	19/02/14	Pt transfer	Moderate	Theatres & Anaesthetics	Investigation underway	25/04/14

1.2 Ongoing/Submitted SIRIs:

Ref	Incident date	Description	Directorate	Progress/ date submitted	Date report due	Findings summary
12004 STEIS 2013/ 36811	28/11/13	Confidentiality leak	Spinal	Submitted on time	19/02/14	It has not been possible to identify who or how a letter on the nurses station ended up being put in a bag of belongings of a patient who was in a side room down the corridor from the station. However the incident has brought to light failings in administration and filing and faxing procedures which have been rectified.
11959 STEIS 2013/ 36088	21/11/13	Grade 3 pressure ulcer	Theatres & Anaes-thetics	Submitted 18/2/14	12/2/14	In view of theatre time (14+ hours) and repositioning, deemed unavoidable.

11994 STEIS 2013/ 35356	25/11/13	Anaesthetic concerns	Theatres & Anaesthetics	Investigation underway (further extension)	19/02/14	.
12093 STEIS 2014/ 78	18/12/13	02/01/14	Grade 4 pressure ulcer	Submitted 7/3/214	6/3/14	On admission Grade 2 deteriorated despite interventions grade 4. Skin condition poor as previously - had radiotherapy
12189 STEIS 2014/ 2378	16/12/13	21/1/14	Diathermy burn	Investigation underway	25/03/14	
12278 2014/ 2878	23/01/14	27/01/14	Consent not done	Investigation underway	31/03/14	

****NB. These figures also include 2 incidents that were not initially reported in February, however the RCA investigations commenced in February.**



APPENDIX 2: INFECTION CONTROL REPORTS: INTERNAL REPORT - FEBRUARY 2014

2013-14		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	2	0	0	0	1	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
Narrative:	1 unavoidable case of C.difficile - complex Bone infection patient who required antimicrobials for infected revision												
Pressure Ulcers	Target	Ward 1	Ward 2	Ward 3	Ward 7	Ward 10	Ward 11	SSW	HDU	Recovery	DU	POAC	OPD
Avoidable	23-G2 / 0-G3 / 0-G4	0	1 x G2	0	0	1 x G2	0	0	1 x G2	0	0	0	0
Unavoidable		0	0	1 x G2	0	0	0	0	0	0	0	0	0
Narrative:	Wd 3 - 1 x Unavoidable - terminal patient - all care and equipment in place - part of the dying process. Wd 2 - 1 x Avoidable - not stepped up onto mattress in time - soft form premiere not switched on until after damage occurred. Wd 10 - 1 x Avoidable - gaps in documentation therefore not able to identify that good practice was in place. HDU - 1 x Avoidable - gaps in documentation - not stepped up onto specialist mattress early enough.												
Audit	Target	Ward 1	Ward 2	Ward 3	Ward 7	Ward 10	Ward 11	SSW	HDU	Recovery	ADCU	POAC	OPD	Xray	MRI
Hand Hygiene	> 90%	95%	99%	98%	93%	97%	92%	80%	97%	100%	91%	100%	100%	0%	0%
C4C - Environment	>95%	98%	97%	95%	97%	86%	96%	95%	85%	78%	96%	93%	100%		
Peripheral IV	>95%	100%	100%	100%	100%	100%	100%	100%	87%						
Commode	100%	100%	100%	100%	100%	100%	100%	100%	100%						
Action plan received	Yes / No	Yes	Yes	yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	No	No
IPC Attendance	Yes / No														
Saving Lives PVC	compliance - 90%	100%	100%	100%	100%	100%	100%	100%	100%						
No. of Obs	20 per ward	8	19	15	16	13	20	18	19						

Theatres		Th1	Th2	Th3	Th4	Th5	Th6	Th7	Th8	Th9	Th10	Plaster Room	Additional monthly au	audit Th 1
Hand Hygiene	>90%	84%	83%	98%	100%	99%	82%	100%	95%	100%	95%	98%	Main corridor ent	100%
Environment	>95%	100%	91%	68%	91%	91%	95%	89%	95%	100%	100%	92%	Changing Area	100%
Clinical Practice	>95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Kitchen	100%
Action plan	Yes / No		yes	No	yes	Yes	Yes	Yes	yes	Yes		Yes	Reception	100%
Compliance:	Green	≥90%	Amber	80%-89%	Red	≤79%	No audit	0					Co-Ord's office	100%
													Anaesthetic room	100%
													Surgeon office	100%
													Action Plan	

Date of Board: 26th March 2014 **ENCLOSURE NUMBER: 9**

SUMMARY OF REPORT TO BOARD

NAME OF DIRECTOR	Helen Shoker, Director of Nursing and Governance
SUBJECT	Board Assurance Framework (BAF)
AUTHORS	Lisa Pim, Deputy Director of Nursing and Governance; Alison Braham, Governance Manager; Jane Moore, Litigation Assistant and Governance Facilitator

SUMMARY

The attached report gives details of the:

1. Board Assurance Framework (BAF)

The Board is asked to note the following since the last report:

New risk(s)

- A new risk on 'Management of Change' to be added (agreed at EMT on 19/2/14)

Closed risk(s)

- Risk no 35 'Admin Review' closed as the actions overlap with risk 12 KPIs (agreed at EMT on 19/2/14)

Increasing risk(s)

- none

Decreasing risk(s)

- 269 'Activity Targets' - original plan over-achieved but remains red owing to financial position

IMPLICATIONS

Insufficient monitoring and review of these risks, actions, progress and quality of information therein may have implications for the Trust in meeting its objectives and expected standards of service delivery.
Consideration should be given to the impact of risks on the Trust's compliance with the Care Quality Commission (Registration) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities).

RECOMMENDATIONS

The Board is asked to:

- **Note** the BAF update.

BOARD ASSURANCE FRAMEWORK UPDATE - March 2014

BAF Risk 1: Failure to deliver high standards of care

Lead Director(s): Director of Nursing & Governance & Medical Directors

Risk 178 “poor compliance of WHO safety procedure”

- escalated - need to improve data collection process - Theatres Directorate are taking a series of actions supported by the Medical and Nursing Director to create a comprehensively standardised and fully embedded procedure.

BAF Risk 2: Failure to Comply with Monitor license
Lead Director(s): Company Secretary

Risk 11 “Executive Director Continuity and Corporate Memory” - this risk currently mitigated due to a full complement of staff being in executive roles and sufficient handover from predecessors having happened. Colleagues near the executive team are able to provide longer term corporate memory in support of executive actions.
Risk 269 – failure to deliver activity targets - at present, despite some targets having not been met, the trust is not in breach of its license.
Risk 275 – ability to consistently demonstrate learning from serious events/claims/complaints is embedded in practice

BAF Risk 3. Failure to comply with CQC registration requirements
Lead Director(s): Director of Nursing & Governance

CQC unannounced visit in January 2014 fully compliant with assessed criteria, final report now published.
Internal process of assurance continues.
In development: the action plan to enable the organisation to transition to the new CQC inspection regime and align to the new key domains.

BAF Risk 4. Interruption to business continuity
Lead Director(s): Director of Operations

No updates of note

BAF Risk 5. Failure to deliver contract to Commissioners
Lead Director(s): Director of Operations, Director of Finance, Director of Nursing & Governance, Director of WFOD

Ongoing negotiations with Commissioners re: pressure ulcer targets.
2014/15 quality schemes agreed with the contract.

BAF Risk 6. Staff Engagement
Lead Director(s): Director of WFOD, Medical Director

No updates of note.

BAF Risk 7. Organizational Leadership
Lead Director(s): Director of WFOD, Medical Director

No updates of note.

BAF Risk 8. Long-term Viability
Lead Director(s): Director of Finance

No updates of note.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of MEETING: 26th March 2014 **ENCLOSURE NUMBER: 10**

SUMMARY OF REPORT TO BOARD

DIRECTOR LEAD:	**Anne Cholmondeley / Director of Workforce and OD**
AUTHORS:	**David Richardson / Head of Learning and OD**
SUBJECT:	**Annual Equalities Report – March 2014**

SUMMARY

This is the Annual Equalities Report that is a legislative requirement under the Equality Act 2010, and the Public Sector Equality Duty. The report provides both an analysis of equalities information in relation to staff and patients, plus a review and update on the Trusts Equality Objectives and actions taken towards delivering these over the last 12 months.

The issues that the equality report highlights are contained within the Summary on pages 5 and 6 with the priority actions to mitigate these concerns summarised on page 8.

This report includes the amendments requested by the Trust Board at the February meeting.

RECOMMENDATIONS

The Trust Board is asked to sign off the revised (see pahge 8) report for publication.

The Royal Orthopaedic Hospital
NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

Publication of equalities information and update on Equality Objectives

January 2014

CONTENTS

SUMMARY

Overview

The Trust continues to make steady progress towards the effective implementation of its Equality Objectives which were established in April 2012, and reviewed and updated in January 2013. This report provides our annual equality information, which includes a summary of the key activities from the last 12 months in relation to our equality objectives and a detailed analysis of our patient and staff equalities information.

Progress on the Equality Objectives during 2013:

Equality Objective 1:

The trust is able to monitor and report on all personal protected characteristics as required by the Equality Act 2010 for patients and service users.

In May 2013 a working party was established to assess the Trust's current situation and future ability to monitor and report on the protected characteristics of patients and service users. To date it has identified that 6 out of the 9 protected characteristics can be monitored through the PAS system, however there is currently no facility within the system to monitor the remaining 3 characteristics. This situation is currently under review. The working party are currently developing an approach to collect and record protected characteristics, where reasonably possible, in line with the timescales of the equality objective. The project lead of the working party provided an update report to the Trusts Equality and Diversity group in November 2013, identifying actions to explore the possibility of developing a paper-based questionnaire for patients, and scoping out how personal protected characteristics could be captured for patients who attend services not linked to the PAS system.

Equality Objective 2:

The Trust has considered diversity implications for our current services and future PMO projects and activities

A new Programme Board was formed in September 2013 to monitor and review projects and services. It has been agreed that Equality Impact Assessments (EQIA) are to be included in the stage gateway process for the programme board. The Director of Workforce is member of the Programme Board, identified within the Terms of Reference, and will oversee and monitor implementation of this. The Programme Board will report biannually to the Equality and Diversity group.

Equality Objective 3:

All staff are aware of the Equality Act and Public sector duties, and Equality & Diversity is embedded into training and development activity

A new Equality and Diversity group was established in January 2013 to be the driving force behind the effective delivery of the Trusts requirements of the Equality Act 2010, and to ensure the achievement of the Equality Objectives.

In April 2013, an Equality and You – How much do you know about the Equality Act 2010? Leaflet was issued to all staff, and all new staff receive and equality and diversity awareness session during their Corporate Induction.

On September 13th 2013, we held an "Equality and You – Raising Awareness" day to increase awareness around the Equality act, the Equality and Diversity group, contact officers and how to eliminate harassment and bullying. We were also supported on the day by BRAP, a national equalities charity. 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 and views. A quiz to test people's knowledge of key elements of the Equality Act 2010 was also provided with 63% of entries achieving 100%.

Equality Objective 4:
The trust is able to monitor and report on all personal protected characteristics for staff.
In September 2013 the HR department conducted a data quality exercise with a return request attached to payslips. This was to check on the accuracy of personal data held in the Electronic Staff Record (ESR), and to request additional information regarding personal protected characteristics. We had a great response, with over 400 staff (45%) updating and returning their data. This data was uploaded into the ESR (Employee database system) during December 2013, to ensure this additional data was included in the annual equalities analysis.

An ESR Self Service project team has been established in October 2013, to implement ESR self-service across the Trust over the next 12 months. In the future this facility will enable staff to update and amend their own personal details within ESR.

Equality and Diversity Policy:
The Equality and Diversity Policy is due for final sign off in February 2014. The revised policy includes the procedure for completing Equality Impact Assessments. All Trust policies have included an Equality Impact Assessment screening during 2013; however none have been identified as requiring a full impact assessment. An essential part of the policy implementation plan during 2014 will include training and awareness on the effective completion of Equality Impact Assessments.

NHS Staff Survey Results 2013:
From the initial raw scores of the NHS Staff Survey 2013, the Trust again achieved some positive results. For the second year running, positive responses have been received in relation to personal development and training received within the Trust. Staff are seeing the increased focus from senior management on involving them in decision making and acting on feedback received. And we continue to see an increase in favourable responses in relation to the Trust being a good place to work and to receive treatment.

Areas for opportunity identified within the Survey highlight the requirement to involve staff more in decision making and improving communication between senior management and staff.

In addition, continued improvements are required in encouraging staff to report incidents, however the Trust needs to increase confidence in staff that it will act on incidents reported, and will do so with fair blame. It has been highlighted that this is predominantly important to encourage staff to report incidents in relation to incidents of physical violence, harassment and bullying. Particularly with the report identifying no change in the number of staff reporting that they have experienced discrimination and the sense that the Trust may not act fairly with regard

to career progression and promotion. The final results comparing all NHS Trusts are expected in March 2014, and these will be considered and integrated into a Staff Survey Action Plan.

Findings from this year's Equalities information review:

(N.B: We are still awaiting data disaggregated by protected characteristic for some indicators from the Staff Survey 2013 (i.e. appraisals, job-relevant training and experiences of discrimination experienced by staff). Once received this will be analysed and included as an addendum to the report).

Overall Staff Profile

- Disclosure rates have improved significantly since last year, but still remain low particularly in relation to disability, religion or belief and sexual orientation.
- Slightly younger workforce profile in 2013 than in 2012
- Disabled people are underrepresented in employment;
- Largely similar ethnic make-up of the workforce in 2013 as there was in 2012 (slight increase in White British and some ethnic minorities)
- Similar breakdown in 2013 as there was in 2012 in relation to gender of employees – men underrepresented compared to overall population – but staff cohort more representative than NHS workforce profile

Promotions

- Staff between 26 and 45 are more likely to be promoted than their counterparts aged between 57 and 65
- White British, Bangladeshi, 'Other Asian background' and people from 'any other ethnic group' are more likely to be promoted. No promotions have been observed within staff from other ethnic backgrounds (e.g. Indian and Black) during 2013 and this is disproportionate when compared to their presence in the staff cohort as a whole.
- No LGB staff were promoted in 2013 (though there are challenges around disclosure)
- In percentage terms, disabled people were proportionally more likely to be promoted when compared to their promotion in the staff population as a whole (though it should be noted there was a higher disclosure rate relating to information about promotions).

Gender Pay Gap

- On average the gap between men and women (with men being paid more than women) has remained relatively unchanged between 2012-2013.
- There are significant differences between bands. In bands 1-4 women are paid more than men. In bands 5-7 men were paid more than women. For Band 8 and above details about a small amount of posts heavily affect the results. For some roles men are paid more, for others women are paid more.

Recruitment

- Figures for 2012 were not available thus a trend analysis could not be done.
- Applicants between 20 and 29 and applicants who were older than 50 were less likely to be appointed compared to the proportion of applicants from those age ranges
- Women were more likely to be appointed in 2013 when compared to the proportion of applications as a whole.
- White British applicants were more likely to be appointed when compared to the proportion of applications from that ethnic background. Indian, Pakistani and Black

Caribbean applicants would be shortlisted but were less likely to be appointed. These trends are consistent with other Trusts in and around Birmingham when viewing comparable data. BRAP advise us that this is a recognised problem within the NHS and due to this NHS England and the Equality and Diversity Council have made "values based recruitment" one of their nine priorities.

Training

- People in 46-55 age band slightly more likely to attend learning events compared to their proportion of the overall workforce (16-25 year olds less likely to attend)
- Men less likely to attend learning events compared to their proportion of the overall workforce
- White British people more likely to attend learning events compared to their proportion of the overall workforce and some ethnic groups (e.g. Caribbean and White and Black Caribbean) less likely to attend.

Leavers

- Proportionally more leavers in the 26-40 year old age range and a reduction in proportion of 16-25 year olds leaving the trust
- Disability of leavers less likely to be captured that it is through more general workforce data collection processes. Also disabled people more likely to be leavers than would be expected given their proportion in the workforce
- White British staff make-up smaller percentage of leavers than make up of the trust staff profile might suggest. This was apparent in 2012 too, but is less pronounced in 2013. Pakistani, Irish, Black African and Filipino employees are more likely to be a leaver compared to their proportion in the workforce.
- Men are slightly more likely to be leavers compared to their proportion in the overall workforce

Experiences of discrimination

- Small reduction in percentage of staff who, in the last 12 months, have personally experienced discrimination at work from patients/ service users/ relatives/ members of the public
- Similar proportion of staff who, in the last 12 months, have personally experienced discrimination at work from manager/ team leader/ other
- Majority of discrimination is on the grounds of ethnic background (57%) (Similar figures to 2012). There have been slight increases in proportion of discrimination on grounds of gender, sexual orientation and age.

Patient Information

- Increase in proportion of ethnic minority inpatients between 2012 and 2013 (around 35% of inpatients in 2013). Whilst this is broadly in line with the West Midlands population, there are about 46.9% ethnic minority people living in Birmingham. There has been less change in the proportion of outpatients (73% White British).
- Most patients (inpatients and outpatients) did not specify their religion or belief. Where this is recorded, most patients are Christian.
- Patients are also unlikely to disclose their marital status – data is not available for 55% of inpatients and 58% of outpatients
- In 2012 and 2013 most patients were between 42 and 81.

- A review of 'Serious Incidents Requiring Investigation' (SIRIs) indicates that whilst in 2012 there appeared to be relatively few noticeable inequalities. In 2013, White British patients were more likely to experience a SIRI than would be expected given their proportion in the overall patient population.

Conclusions / actions:
From the analysis undertaken and continued delivery of the equality objectives the following conclusions and actions will be taken during 2014:

Action	By Who	By When
In order to further develop Equality monitoring and reporting - effectively implement the ESR (electronic staff record) self-service project; continue to enhance the collection of data relating to staff Personal Protected Characteristics	ESR Project Lead	March 2015
To implement best practice and address perceived inequality in promotion/progression - Update and refine interviewing processes and skills, embedding a values-based approach to recruitment to include the Trust's Values to ensure a fair and equitable approach; developing interviewing skills, equality awareness of line managers and considering the diversity of interview panels.	Director of Workforce and OD	March 2015
To further progress the Trust's Public sector equality duty - enhance the effective use and application of Equality Impact Assessments (EQA) within policy and procedure development to improve equality of services.	Head of Learning and OD	December 2014
To further assist in reducing discrimination in the Trust – raise awareness of the role of contact officers within the Trust to increase support and opportunity for staff to raise concerns and issues regarding discrimination / harassment and bullying. Provide contact officers with appropriate training to meet this requirement.	Head of Learning and OD	November 2014
To identify if there are any areas of concerns in the identified gender pay gap - undertake an Equal Pay Audit on an annual basis.	Director of Workforce and OD	September 2014
Conduct additional research into exit interviews and leavers information to identify any trends or themes in reasons for leaving - identify themes and any actions required.	Director of Workforce and OD	September 2014
Continue with the actions of the operational working group on enhancing the data collection of information relating to the protected characteristics of patients and service users – audit this data on an annual basis and trigger mitigating actions as necessary	Director of Operations	January 2015

PART 1: STAFF PROFILE

1.0 OVERALL WORKFORCE PROFILE

Disclosure rate

The need to increase disclosure rates continues, but significant improvements in disclosure rate have been seen in all the equality strands identified in the 2012 report (disability, religion or belief and sexual orientation):

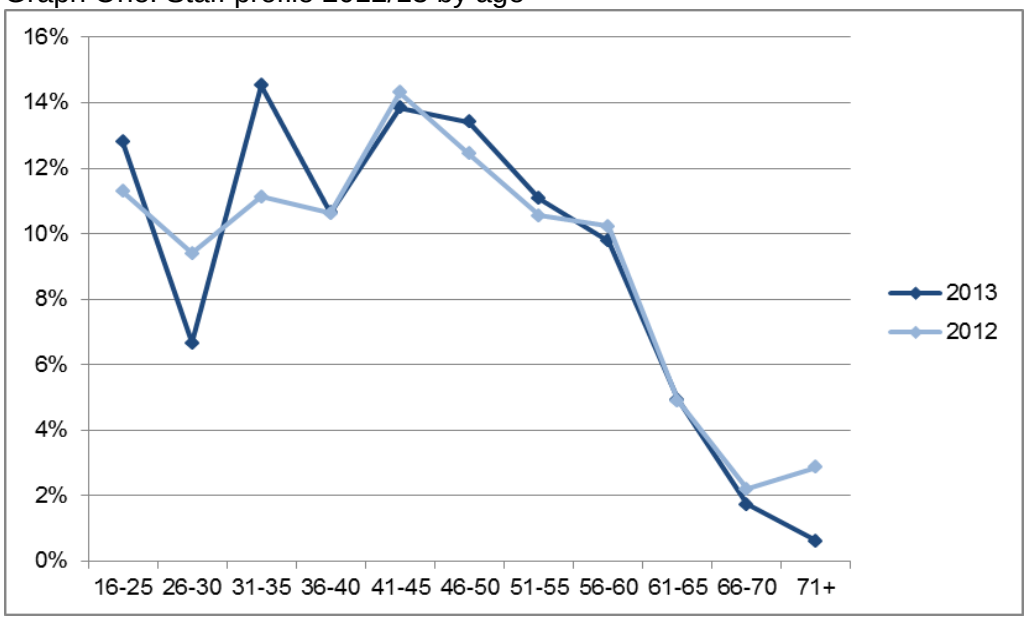
Equality Strand	2012	2013
Disability	26%	49%
Religion or belief	28%	51%
Sexual Orientation	30%	53%

1.1 Age

Most staff are now around the 31-35 age (most staff were around the 41-45 range in 2012). There has been a decrease in the percentage of people aged 66 years and older in the trust.

Age	2012	2013
16-25	11.29%	12.80%
26-30	9.41%	6.66%
31-35	11.12%	14.53%
36-40	10.63%	10.64%
41-45	14.32%	13.84%
46-50	12.44%	13.41%
51-55	10.56%	11.07%
56-60	10.23%	9.78%
61-65	4.91%	4.93%
66-70	2.21%	1.73%
71+	2.86%	0.61%

Graph One: Staff profile 2012/13 by age



1.2 Disability

Despite good improvements in disclosure rate, this is still an area requiring further data capture in the trust. Data that is available indicates that disabled people are still significantly underrepresented in the trust workforce compared to their representation in national employment statistics. There has been a slight increase in the level of disabled people disclosing this.

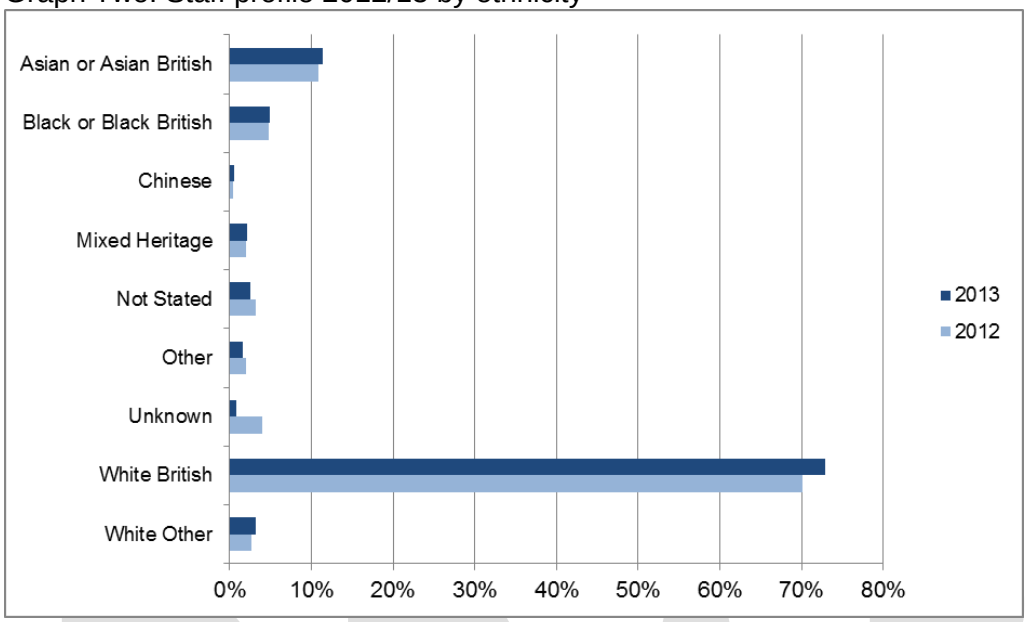
Disability status	2012	2013
Registered Disabled	0.65%	0.86%
Not Registered Disabled	25.04%	48.36%
Not Disclosed	74.3%	50.78%

1.3 Ethnicity

There has been an increase in the level of disclosure and availabilty of information about staff members' ethnicity. This updated data for 2013 indicates that the majority of staff are from a White British background (approximately 73% compared to 70% in 2012). There have been slight increases in staff from 'Other White backgrounds' (Greek, Polish, other European), Asian / Asian British staff, Black Caribbean and Chinese staff – and slight decreases in the proportion of staff from other ethnic minority categories.

Ethnic category	2012	2013
White - British	70.13%	72.84%
White - Irish	1.47%	1.21%
White - Any other White background	1.23%	1.99%
Mixed - White & Black Caribbean	1.23%	1.21%
Mixed - White & Black African	0.16%	0.09%
Mixed - White & Asian	0.25%	0.17%
Mixed - Any other mixed background	0.41%	0.69%
Asian or Asian British - Indian	6.46%	6.75%
Asian or Asian British - Pakistani	1.72%	1.82%
Asian or Asian British - Bangladeshi	0.33%	0.52%
Any other Asian background	2.37%	2.34%
Black or Black British - Caribbean	2.54%	2.94%
Black or Black British - African	1.72%	1.47%
Any other Black background	0.33%	0.35%
Black British	0.16%	0.17%
Chinese	0.41%	0.52%
Any other Ethnic Group	1.96%	1.64%
Unknown	3.93%	0.78%
Not Stated	3.19%	2.51%

Graph Two: Staff profile 2012/13 by ethnicity



Statistical note:
White Greek, White Polish and White Other European are included in the 'Any other White background' category as these were not used in the equality report in 2012. In addition 'Asian British' is included in the 'Any other Asian Background' category as this was not included in the equality report in 2012. Categories from 2013, Vietnamese, Filipino, Other Specified are included in the 'Any other Ethnic group category' used in 2012. The 'Undefined' category from 2013 is described as 'Unknown' in line with the 2012 indicator.

1.4 Sex

The majority of staff (71%) are women, compared to 29% who are men. Whilst men are underrepresented when compared to the national and local demographics the profile is actually more representative than the NHS workforce as a whole. Figures remain broadly unchanged between 2012 and 2013.

Gender	2012	2013
Female	71.03%	70.93%
Male	28.97%	29.06%

1.5 Marriage and Civil Partnership

Most people working at the trust are married (44%), with over a third (35%) single. The next largest grouping is 'Unknown'. Whilst levels of disclosure have improved since last year, this category still accounts for nearly 15% of staff not declaring their marital status.

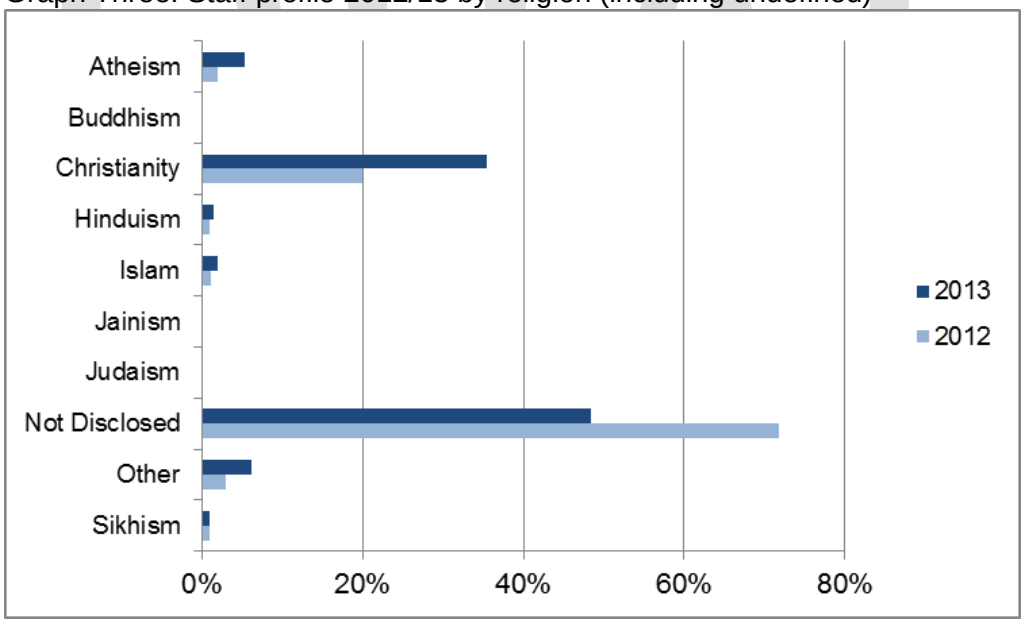
Marriage/civil partnership	2012	2013
Single	31.83%	35.29%
Married	43.94%	44.20%
Divorced	3.68%	4.24%
Widowed	0.57%	0.52%
Civil Partnership	0.32%	0.61%
Legally Separated	0.41%	0.35%
Unknown	19.23%	14.79%

1.6 Religion or Belief

Disclosure rates in relation to this protected characteristic are still relatively low though they have improved since last year. In the table below we have included percentage figures for those whose status has actively been identified (the sample, 596, is about 50% of the trust workforce, which makes it quite robust). There are no large changes between 2012 and 2013, other than a slight increase in the proportion of staff describing themselves as atheist.

Religion/belief	Including Undefined		Excluding Undefined	
	2012	2013	2012	2013
Atheism	1.96%	5.36%	6.98%	10.40%
Buddhism	0.16%	0.17%	0.58%	0.34%
Christianity	20.05%	35.38%	71.22%	68.62%
Hinduism	0.98%	1.47%	3.49%	2.85%
Islam	1.15%	1.99%	4.07%	3.86%
Jainism	0%	0.09%	0%	0.17%
Judaism	0%	0%	0%	0%
Sikhism	0.9%	0.95%	3.2%	1.85%
Other	2.95%	6.14%	10.47%	11.91%
Not Disclosed	71.85%	48.44%		

Graph Three: Staff profile 2012/13 by religion (including undefined)



1.7 Sexual Orientation

Disclosure of information pertaining to sexual orientation is limited. Moreover, the number of people revealing their LGB (lesbian, gay, bisexual) status was very low. It is good practice not to release data that can potentially identify individuals (the Department of Health's guidance on gender reassignment, for example, suggest figures relating to this protected characteristic should not be released for the sake of confidentiality). As such, we have refrained from publishing this data here.

2.0 PROMOTIONS

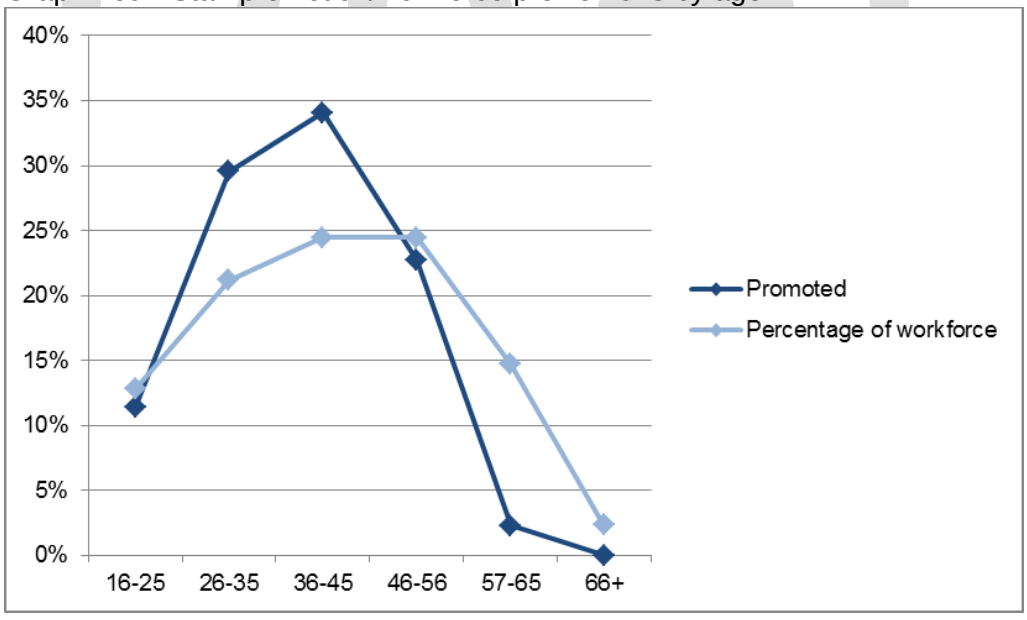
All of the data in this section relations to promotions during 2013 (information was unavailable for the 2012 Equalities Data report). However this data can be used as a benchmark against which to judge progress in 2014 next year. The tables below show the percentage of staff who were promoted that year in relation to different protected characteristics. This is also compared to the proportion of staff from that protected characteristic in the broader staff cohort. It should be noted that the number of people promoted was relatively small (44) compared to the staff population, so the data should be read with this caveat in mind.

2.1 Age

The table below indicates that staff between 26 and 45 are more likely to be a staff member that received a promotion than would be expected from their proportion in the broader staff cohort. Staff between 57 and 65 are less likely to be promoted compared to their proportion in the broader staff cohort.

Age	Number	Percentage	Percentage of workforce
16-25	5	11.36%	12.8%
26-35	13	29.55%	21.19%
36-45	15	34.09%	24.48%
46-56	10	22.7%	24.48%
57-65	1	2.27%	14.71%
66+	0	0%	2.34%
Total	44	-	-

Graph Four: Staff promotion/workforce profile 2013 by age



2.2 Sex

Women are more likely to be promoted than men when compared to the proportion of women in the broader staff cohort.

Sex	Number	Percentage	Percentage of workforce
Male	8	18.18%	29.06%
Female	36	81.82%	70.93%
Not Disclosed	0	0%	0%
Total	44	-	-

2.3 Ethnicity

White British, Bangladeshi, 'Other Asian background' and people from 'any other ethnic group' are more likely to be promoted than would be expected given their proportions in the workforce as a whole. No promotions have been observed within staff from other ethnic backgrounds (e.g. Indian and Black) and this is disproportionate when compared to their presence in the broader staff cohort.

Ethnicity	Number	Percentage	Percentage of workforce
White - British	35	79.55%	72.84%
White - Irish	0	0%	1.21%
White - Any other White background	1	2.27%	1.99%
White Greek	0	0%	
White Polish	0	0%	
White Other European	0	0%	
Mixed - White & Black Caribbean	1	2.27%	1.21%
Mixed - White & Black African	0	0%	0.09%
Mixed - White & Asian	0	0%	0.17%
Mixed - Any other mixed background	0	0%	0.69%
Asian or Asian British - Indian	0	0%	6.75%
Asian or Asian British - Pakistani	0	0%	1.82%
Asian or Asian British - Bangladeshi	1	2.27%	0.52%
Asian or Asian British - Any other Asian background	3	6.82%	2.34%
Asian British	0	0%	
Black or Black British - Caribbean	0	0%	2.94%
Black or Black British - African	0	0%	1.47%
Black or Black British - Any other Black background	0	0%	0.35%
Black British	0	0%	0.17%
Chinese	0	0%	0.52%
Any Other Ethnic Group	1	2.27%	1.64%
Vietnamese	0	0%	
Filipino	0	0%	

Other Specified	0	0%	
Undefined	1	2.27%	0.78%
Not Stated	1	2.27%	2.51%
Total	44	-	-

2.4 Sexual Orientation

Figures indicate that no LGB staff were promoted in 2013, though disclosure rates are relatively low for this protected characteristic.

Sexual Orientation	Number	Percentage
Lesbian	0	0%
Gay	0	0%
Bisexual	0	0%
Heterosexual	32	72.73%
Not Disclosed	12	27.27%
Total	44	-

2.5 Religion or Belief

Non-disclosure is a significant issue with this protected characteristic, however from available information it appears that there are no significant trends relating to religion or belief and the tendency of staff to be promoted in 2013.

Religion or Belief	Number	Percentage	Percentage of workforce
Atheism	4	9.09%	5.36%
Buddhism	1	2.27%	0.17%
Christianity	18	40.91%	35.38%
Hinduism	0	0%	1.47%
Islam	1	2.27%	1.99%
Jainism	0	0%	0.09%
Judaism	0	0%	0%
Sikhism	1	2.27%	0.95%
Other	6	13.64%	6.14%
Not Disclosed	13	29.55%	48.44%
Total	44	-	-

2.6 Registered Disabled

There was a higher disclosure rate for the disability status of staff who were promoted in 2013 compared to the disclosure rates for staff as a whole in the trust. This may explain the fact that both disabled and non-disabled staff were more likely to be promoted than would be expected from their appearance in the broader staff cohort. In percentage terms, disabled people were proportionally more likely to be promoted when compared to their proportion in the staff population as a whole.

Registered Disabled	Number	Percentage	Percentage of workforce
Yes	1	2.27%	0.86%
No	28	63.64%	48.36%
Not Disclosed	15	34.09%	50.78%
Total	44	-	-

2.7 Marital Status

Marital status does not appear to have had a significant bearing on whether staff were more likely to be promoted in 2013.

Marital Status	Number of promotions	Percentage promoted	Percentage of workforce
Single	18	40.91%	35.29%
Married	17	38.64%	44.2%
Separated	0	0%	0.35%
Civil Partnership	0	0%	0.61%
Divorced	1	2.27%	4.24%
Not Disclosed	8	18.18%	14.79%
Total	44	-	-

3.0 GENDER PAY GAP

The table on the next page describes the number of staff in particular bands that are female or male; the difference in the average pay rates for staff in that band (between men and women); and the percentage pay gap between men and women. Numbers in red and in brackets indicate a pay gap where women are paid less than men. This information is provided for 2012 and 2013.

The table indicates that, on average, the pay gap between men and women (with men being paid more than women) has remained relatively unchanged between 2012 and 2013. However, there are significant differences between bands.

In lower bands (bands 1-4) women are being paid more than men (and are more likely to be working in those bands than men). In Bands 5-7 men were paid more than women in 2012 and 2013 (though this is not true for Band 7 in 2013). For Band 8 and above there are much fewer staff and less reliable results are available about average pay/average pay gap. Details about a small amount of posts heavily affect the results in these bands. Women are paid slightly more on average than men (apart from in Band 8c) and in Speciality Doctor/Trust grade posts. However, there are significant differences at Director level with men being paid more than women. There are also more consultants and doctors in training that are men and they are likely to be paid more than women in this role.

An equal pay audit is required to identify whether there are any inappropriate themes or trends.

	2012				2013			
	Count of NI Number		Difference in average pay £	Pay Gap %	Count of NI Number		Difference in average pay £	Pay Gap %
	Female	Male			Female	Male		
Band 1	75	41	298.19	2.05%	79	39	165.75	1.13%
Band 2	217	72	47	0.30%	200	68	137.10	0.85%
Band 3	59	21	418.44	2.28%	55	21	534.40	2.90%
Band 4	66	12	143.88	0.68%	75	16	178.48	0.83%
Band 5	178	27	(201.15)	(0.80%)	178	23	(718.88)	(2.83%)
Band 6	125	37	(801.52)	(2.58%)	122	32	(755.91)	(2.41%)
Band 7	54	9	(1,235.46)	(3.39%)	47	9	274.76	0.73%
Band 8a	21	10	1,418.89	3.13%	24	9	(472.79)	(1.05%)
Band 8b	6	0	-	-	5	0	-	-
Band 8c	6	1	(3,750.17)	(5.92%)	7	1	(3,228.43)	(5%)
Band 8d	2	2	9,634	12.20%	1	1	3,768	4.62%
Band 9	0	1	-	-	0	1	-	-
Consultant	1	62	(4,014.61)	(4.79%)	2	61	(443.32)	(0.51%)
Directors	2	1	(67,500)	(69.23%)	2	2	(33,691)	(38.15%)
Doctors in Training	9	29	(3,408.75)	(9.08%)	9	31	(4,407.73)	(11.25%)
Hospital Practitioner	0	1	-	-	0	1	-	-
Physician	0	1	-	-	0	1	-	-
PT Med Off/Gen Dental Practitioner	0	1	-	-	0	1	-	-
Specialty Doctor	3	6	3,218.33	4.92%	2	6	5,370.33	8.33%
Trust Grade	1	3	12,124.20	11.16%	0	1	-	-

4.0 RECRUITMENT

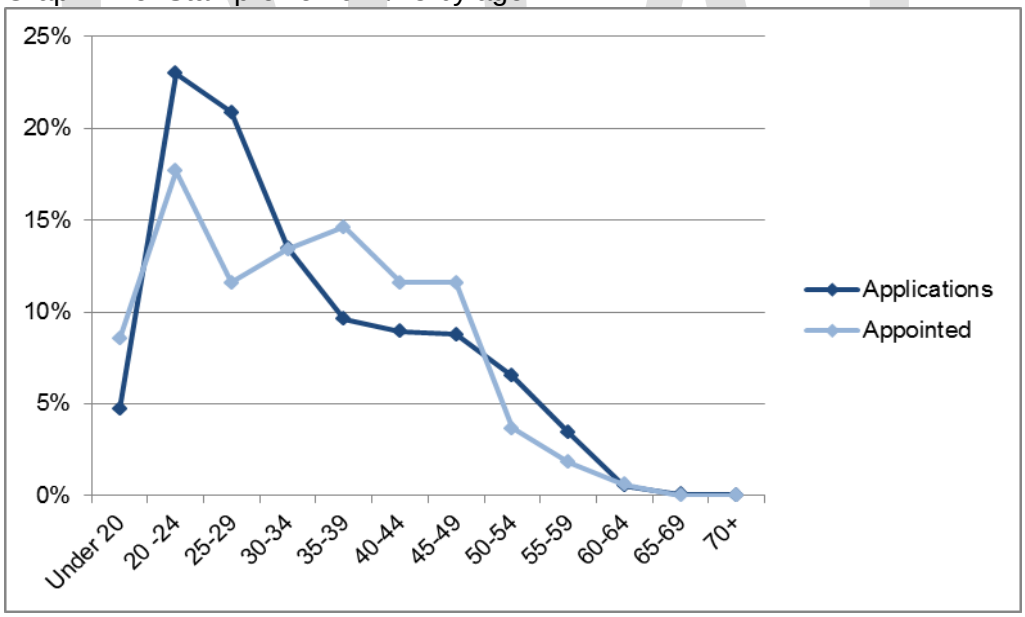
The data in this section is only available for 2013 as this information was not provided for the 2012 equality information report. This data for 2013 can be used as a benchmark against which to judge progress in 2014.

4.1 Age

Applicants aged under 20 and between 35 and 49 were more likely to be shortlisted and appointed when compared to the proportion of applicants from those age ranges. Applicants between 20 and 29 and applicants who were older than 50 were less likely to be appointed compared to the proportion of applicants from those age ranges.

Age	Applications		Shortlisted		Appointed	
	Number	%	Number	%	Number	%
Under 20	519	4.71%	81	4.43%	14	8.54%
20 -24	2533	22.98%	287	15.68%	29	17.68%
25-29	2301	20.87%	328	17.92%	19	11.59%
30-34	1486	13.48%	242	13.22%	22	13.41%
35-39	1061	9.62%	212	11.58%	24	14.63%
40-44	988	8.96%	242	13.22%	19	11.59%
45-49	967	8.77%	224	12.24%	19	11.59%
50-54	720	6.53%	156	8.52%	6	3.66%
55-59	379	3.44%	70	3.83%	3	1.83%
60-64	59	0.54%	16	0.87%	1	0.61%
65-69	9	0.08%	0	0%	0	0%
70+	3	0.03%	0	0%	0	0%
Undisclosed	0	0%	0	0%	0	0%
Total	11025	-	1858	-	156	-

Graph Five: Staff profile 2012/13 by age



Statistical note:
Age bands used for recruitment statistics are not compatible with age-bands for overall workforce and as a result have not been used in this table.

4.2 Sex

Women were more likely to be appointed in 2013 when compared to the proportion of applications that were made by women in that year and men were less likely to be appointed. The figures reveal a gradual process where slightly fewer men were shortlisted compared to the proportion of applicants from men and then fewer men were appointed compared to the proportion shortlisted.

Sex	Applications		Shortlisted		Appointed		% of current workforce
	Number	%	Number	%	Number	%	
Male	3061	27.76%	422	23.06%	28	17.07%	29.06%
Female	7943	72.05%	1400	76.50%	136	82.93%	70.93%
Undisclosed	21	0.19%	8	0.44%	0	0%	0%
Total	11025	-	1830	-	164	-	-

4.3 Ethnicity

White British applicants were significantly more likely to be appointed when compared to the proportion of applications that have a White British background. Indian, Pakistani, Black Caribbean applicants would broadly make it through to shortlisting, but were then less likely to be appointed. Black African and Bangladeshi applications were proportionally less likely to make it through to shortlisting. These trends are consistent with other Trusts in and around Birmingham when viewing comparable data. BRAP advise us that this is a recognised problem within the NHS and NHS England and the Equality and Diversity Council have made “values based recruitment” one of their nine priorities.

Ethnicity	Applications		Shortlisted		Appointed		% of current workforce
	Number	%	Number	%	Number	%	
White - British	5466	49.58%	1084	59.23%	118	71.95%	72.84%
White - Irish	97	0.88%	14	0.77%	1	0.61%	1.21%
White - any other white background	444	4.03%	58	3.17%	5	3.05%	1.99%
Asian or Asian British - Indian	1322	11.99%	163	8.91%	9	5.49%	6.75%
Asian or Asian British - Pakistani	948	8.60%	92	5.03%	3	1.83%	1.82%
Asian or Asian British - Bangladeshi	238	2.16%	25	1.37%	2	1.22%	0.52%
Asian or Asian British - Any other Asian background	196	1.78%	35	1.91%	5	3.05%	2.34%
Mixed - white and Black Caribbean	255	2.31%	40	2.19%	3	1.83%	1.21%
Mixed - White and Black African	42	0.38%	7	0.38%	0	0%	0.09%
Mixed - White and Asian	56	0.51%	5	0.27%	0	0%	0.17%
Mixed - Any other mixed background	104	0.94%	11	0.60%	2	1.22%	0.69%
Black or Black British -	682	6.19%	123	6.72%	7	4.27%	2.94%

Caribbean							
Black or Black British - African	671	6.09%	79	4.32%	4	2.44%	1.47%
Black or Black British - Any other black background	50	0.45%	14	0.77%	0	0%	0.35%
Other ethnic group - Chinese	52	0.47%	13	0.71%	0	0%	0.17%
Other ethnic group - Any other ethnic group	220	2%	38	2.08%	4	2.44%	0.52%
Undisclosed	182	1.65%	29	1.58%	1	0.61%	3.29%
Total	11025	-	1830	-	164	-	-

4.4 Disability

Disclosure rates at application stage appear to be much higher than for employees working in the trust. The proportion of applicants appointed is broadly similar to the proportion that applied for applicants who are and those who are not disabled.

	Applications		Shortlisted		Appointed		% of current workforce
	Number	%	Number	%	Number	%	
Yes	409	3.71%	64	3.50%	7	4.27%	0.86%
No	10512	95.35%	1747	95.46%	156	95.12%	48.36%
Undisclosed	104	0.94%	19	1.04%	1	0.61%	50.78%
Total	11025	-	1830	-	164	-	-

4.5 Religion or Belief

Disclosure rates are much higher for applicants than for existing employees. There are no particularly significant trends other than a slightly higher percentage of applicants from Christian and atheist backgrounds being appointed when compared to the overall proportion of applicants from those backgrounds – and a lower proportion of applicants who are Muslim, Hindu or Sikh being appointed (this is largely in line with patterns relating to ethnicity described above too).

Religion or Belief	Applications		Shortlisted		Appointed		% of current workforce
	Number	%	Number	%	Number	%	
Atheism	906	8.22%	165	9.02%	17	10.37%	5.36%
Buddhism	39	0.35%	11	0.60%	0	0%	0.17%
Christianity	5443	49.37%	1014	55.41%	93	56.71%	35.38%
Hinduism	502	4.55%	73	3.99%	2	1.22%	1.47%
Islam	1544	14%	160	8.74%	10	6.10%	1.99%
Jainism	9	0.08%	1	0.05%	0	0%	0.09%
Judaism	10	0.09%	1	0.05%	0	0%	0%
Sikhism	449	4.07%	48	2.62%	4	2.44%	0.95%

Other	1091	9.90%	200	10.93%	15	9.15%	6.14%
Not Disclosed	978	8.87%	151	8.25%	15	9.15%	48.44%
Total	10971	-	1824	-	156	-	-

4.6 Sexual Orientation

Sexual orientation does not appear to significantly affect applicants' likelihood of being shortlisted or appointed.

Sexual Orientation	Applications		Shortlisted		Appointed	
	Number	%	Number	%	Number	%
Lesbian	45	0.41%	9	0.49%	1	0.61%
Gay	98	0.89%	15	0.82%	1	0.61%
Bisexual	117	1.06%	14	0.77%	1	0.61%
Heterosexual	9924	90.01%	1662	90.82%	144	87.80%
Not Disclosed	841	7.63%	130	7.10%	9	5.49%
Total	11025	-	1830	-	156	-

4.7 Marital Status

Information is unavailable for this protected characteristic.

5.0 TRAINING

5.1 Receipt of Job Relevant Training

Full detailed results from the NHS Staff Survey have yet to be received disaggregated by protected characteristics – this data will be analysed and included as an addendum as and when this data becomes available.

5.2 Attendance at Learning Events

Number and proportion of people that attend trust learning events held in 2012 and 2013 (January – November) disaggregated by protected characteristics are included in the tables below:

5.2.1 Age

Proportion of staff is largely what would be expected given the trust workforce profile, though people in the 46-55 age band are slightly more likely to attend learning events compared to their proportion in the trust workforce –and 16-25 year olds are slightly less likely to attend learning events.

Age	2012		2013	
	Number	Percentage	Number	Percentage
16-25	533	8.85%	291	9.02%
26-35	1102	18.31%	639	19.80%
36-45	1336	22.19%	884	27.39%
46-55	1524	25.32%	919	28.48%
56-65	793	13.17%	455	14.10%
66+	47	0.78%	39	1.21%
Undefined	685	11.38%		
Total	6020	-	3227	-

5.2.2 Disability

Staff are less likely to disclose their disability status at learning events than they are in data processes used to capture employee data. However, percentage of disabled attendees is largely in line with workforce proportions (0.86% of staff are registered disabled and 0.71% of attendees at learning events were disabled).

Disabled	Number	Percentage
Yes	23	0.71%
No	1116	34.58%
Not Disclosed	2088	64.70%
Total	3227	-

5.2.3 Sex

Men are less likely to be attendees at learning events when compared to their proportion in the overall workforce. Whilst men make up 29% of the workforce, they only make up 22% of learning event attendees.

Gender	Number	Percentage
Male	707	21.91%
Female	2520	78.09%
Not Disclosed	0	0%
TOTAL	3227	-

5.2.4 Ethnicity

Attendees at learning events are slightly more likely to be White British when compared to their proportion of the overall workforce. Whilst White British people make up 73% of the overall workforce, 76% of attendees at learning events are White British. Some ethnic minority groups are less likely to attend learning events – for example, Caribbean and Mixed Heritage (White and Black Caribbean) staff are less likely to attend compared to their proportion of the workforce: 2.95% of attendees are from these ethnic groups compared to 4.15% of the overall staff cohort.

Ethnicity	Number	Percentage
White - British	2445	75.77%
White - Irish	27	0.84%
White - Any other White background	26	0.81%
White Greek	5	0.15%
White Polish	2	0.06%
White Other European	2	0.06%
Mixed - White & Black Caribbean	29	0.90%
Mixed - White & Black African	6	0.19%
Mixed - White & Asian	2	0.06%
Mixed - Any other mixed background	23	0.71%
Asian or Asian British - Indian	221	6.85%
Asian or Asian British - Pakistani	44	1.36%

Asian or Asian British - Bangladeshi	22	0.68%
Asian or Asian British - Any other Asian background	106	3.28%
Asian British	1	0.03%
Black or Black British - Caribbean	66	2.05%
Black or Black British - African	49	1.52%
Black or Black British - Any other Black background	2	0.06%
Black - Somali	0	0%
Black British	9	0.28%
Chinese	11	0.34%
Any Other Ethnic Group	49	1.52%
Vietnamese	0	0%
Filipino	6	0.19%
Other Specified	1	0.03%
Undefined	7	0.22%
Not Stated	66	2.05%
Total	3227	-

5.2.5 Religion or Belief

Disclosure levels remain low in this area (as it is with overall workforce). However attendance at learning events is largely in line with proportions within the overall workforce.

Religion or Belief	Number	Percentage
Atheism	140	4.34%
Buddhism	1	0.03%
Christianity	1272	39.42%
Hinduism	48	1.49%
Islam	82	2.54%
Jainism	0	0%
Judaism	0	0%
Sikhism	26	0.81%
Other	186	5.76%
Not Disclosed	1472	45.62%
Total	3227	-

5.2.6 Sexual Orientation

Less than one per cent (0.87%) of attendees at learning events were LGB staff, although the sexual orientation of 44% of attendees is not known.

Sexual Orientation	Number	Percentage
Lesbian	2	0.06%
Gay	22	0.68%
Bisexual	4	0.12%
Heterosexual	1776	55.04%

Not Disclosed	1423	44.10%
Total	3227	-

5.3 Appraisals

Data relating to the percentage of staff appraised in last 12 months is taken from the Staff Survey 2013. This data has not yet been received broken down by protected characteristic and will be analysed and included as an addendum upon receipt.

6.0 LEAVERS

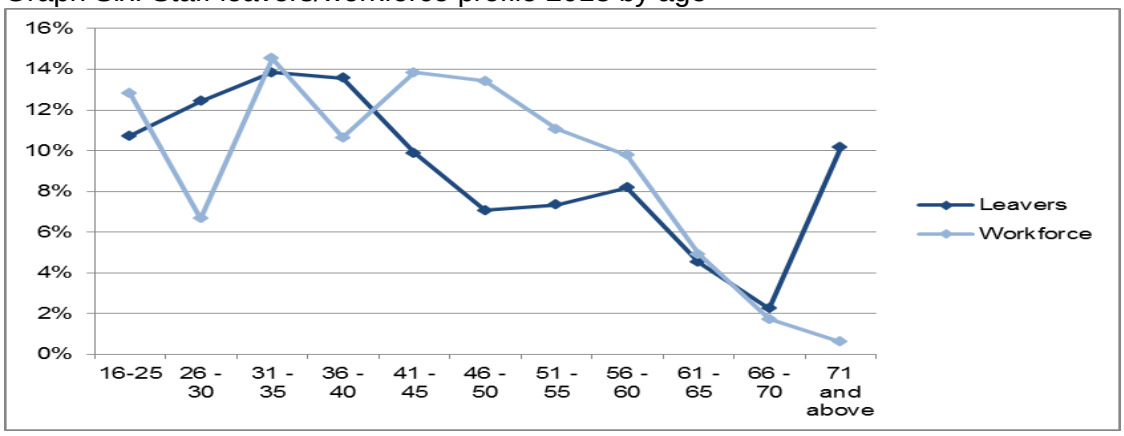
6.1 Age

There were proportionally more leavers in the 26-40 age range compared to the proportion of staff from that age range in the trust (40% of leavers were from this age range and 32% of the staff cohort work in that age range). A similar pattern was picked up last year – however it should be noted that in 2013 there was a relative reduction in the proportion of leavers between 16-25 years old compared to the previous year.

As with 2012, in 2013 people aged 41-60 were much less likely to leave compared to the make-up of the trust as a whole.

Age	2012		2013	
	% of leavers	% of workforce	% of leavers	% of workforce
16 - 20	2.28%	11.29%	2.26%	12.80%
21 - 25	10.38%		8.47%	
26 - 30	14.18%	9.41%	12.43%	6.66%
31 - 35	11.65%	11.12%	13.84%	14.53%
36 - 40	12.66%	10.63%	13.56%	10.64%
41 - 45	5.57%	14.32%	9.89%	13.84%
46 - 50	4.81%	12.44%	7.06%	13.41%
51 - 55	4.81%	10.56%	7.34%	11.07%
56 - 60	6.08%	10.23%	8.19%	9.78%
61 - 65	5.82%	4.91%	4.52%	4.93%
66 - 70	4.05%	2.21%	2.26%	1.73%
71 and above	17.72%	2.86%	10.17%	0.61%

Graph Six: Staff leavers/workforce profile 2013 by age



6.2 Disability

With low disclosure levels, it is difficult to draw meaningful conclusions about the distribution of the figures below. However, an initial review of the data would suggest that disability data is less likely to be captured about leavers than it is through more general workforce data collection. In addition, people with disabilities are more likely to be leavers in 2013 than would be expected given their proportion in the workforce.

Registered Disabled?	2012		2013	
	% of leavers	% in workforce	% of leavers	% in workforce
No	11.39%	25.04%	32.49%	48.36%
Not Disclosed	88.36%	74.3%	66.1%	50.78%
Yes	0.25%	0.65%	1.41%	0.86%

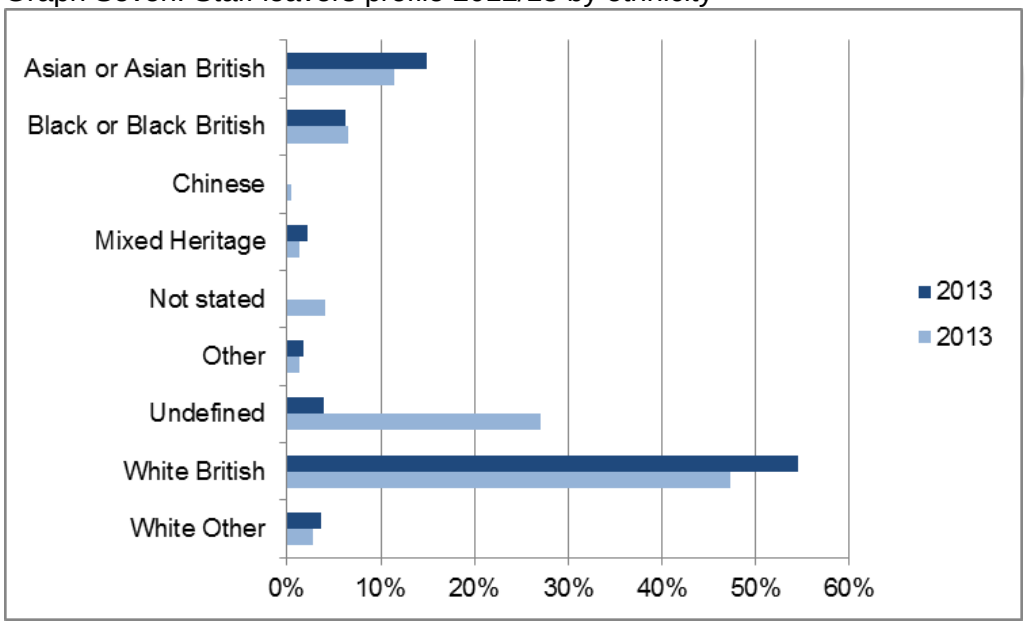
6.3 Ethnicity

White British staff make up a much smaller percentage of leavers than the makeup of the trust might suggest. This was apparent in 2012 too, though the difference between leavers and workforce proportions has reduced slightly. Pakistani, Irish and Black African employees are about twice as likely to be a leaver compared to their proportion in the workforce profile. Filipino employees are significantly more likely to be leavers when compared to their proportion in the overall workforce.

Ethnicity	2012		2013	
	% of leavers	% in workforce	% of leavers	% in workforce
White - British	47.34%	70.13%	54.52%	72.84%
White - Irish	1.27%	1.47%	2.26%	1.21%
White - Any other White background	1.52%	1.23%	1.13%	1.99%
White Greek			0.28%	0.09%
Mixed - White & Black Caribbean	0.25%	1.23%	0.85%	1.21%
Mixed - White & Black African	0.25%	0.16%	0.28%	0.09%
Mixed - White & Asian	0.25%	0.25%	0.56%	0.17%
Mixed - Any other mixed background	0.50%	0.41%	0.56%	0.69%
Asian or Asian British - Indian	7.34%	6.46%	9.89%	6.75%
Asian or Asian British - Pakistani	1.77%	1.72%	3.39%	1.82%
Asian or Asian British – Bangladeshi	0%	0.33%	0.28%	0.52%
Asian or Asian British - Any other Asian background	2.28%	2.37%	1.41%	2.34%
Black or Black British - Caribbean	0.76%	2.54%	1.41%	2.94%
Black or Black British - African	2.78%	1.72%	3.95%	1.47%

Black or Black British – Any other Black background	0.76%	0.33%	0.56%	0.35%
Black British	0%	0.16%		0.17%
Black Nigerian**			0.28%	
Chinese	0.51%	0.41%		0.52%
Any Other Ethnic Group	1.27%	1.96%		1.64%
Filipino			1.69%	0.09%
Undefined	27.09%	3.93%		0.78%
Not Stated	4.05%	3.19%		2.51%

Graph Seven: Staff leavers profile 2012/13 by ethnicity



Statistical Note:
Black Nigerian was recorded as an ethnic category in 2013 but not in 2012. It is most likely that this category was recorded as 'Black or Black British African' in 2012.

6.4 Sex

As with 2012, in 2013 the proportion of leavers is largely in line with the workforce profile, though men are more likely to be leavers when compared to their proportion in the overall workforce.

Sex	2012		2013	
	% of leavers	% of overall workforce	% of leavers	% of overall workforce
Female	64.97%	71.03%	64.97%	70.93%
Male	35.03%	28.97%	35.03%	29.06%

6.5 Religion of Belief

As discussed above, there are large gaps in the proportion of staff who disclose their religion or belief. A similar pattern emerges here. The table below describes the data but we should be wary of data robustness when making comparisons to 2012 data/to the overall workforce.

Religion or Belief	% of leavers
Atheism	0.76%
Christianity	13.67%
Hinduism	0.25%
I do not wish to disclose my religion/belief	18.23%
Islam	1.27%
Other	1.01%
Sikhism	0.76%
Undefined	64.05%

6.6 Sexual Orientation

Outlined below are raw figures pertaining to staff leaving the organisation by sexual orientation. As mentioned, comparison to the trust profile is not possible.

Sexual Orientation	% of leavers
LGB	0.28%
Heterosexual	37.29%
I do not wish to disclose my sexual orientation	11.86%
Undefined	50.56%

7.0 EXPERIENCES OF DISCRIMINATION

The data in this section will be taken from the 2013 National Staff Survey. It shows the number of people experiencing discrimination from patients and staff. Staff survey results are not yet available disaggregated by protected characteristic for particular questions relating to experience of discrimination. However, overall scores for each question are provided and an overview of the grounds on which staff have experienced discrimination is provided below.

"In the last 12 months, have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public?"

	2012		2013	
	Number	Percentage	Number	Percentage
Yes	12	4%	6	2%
No	274	96%	289	98%
Missing	11		11	
Total	297	-	306	-

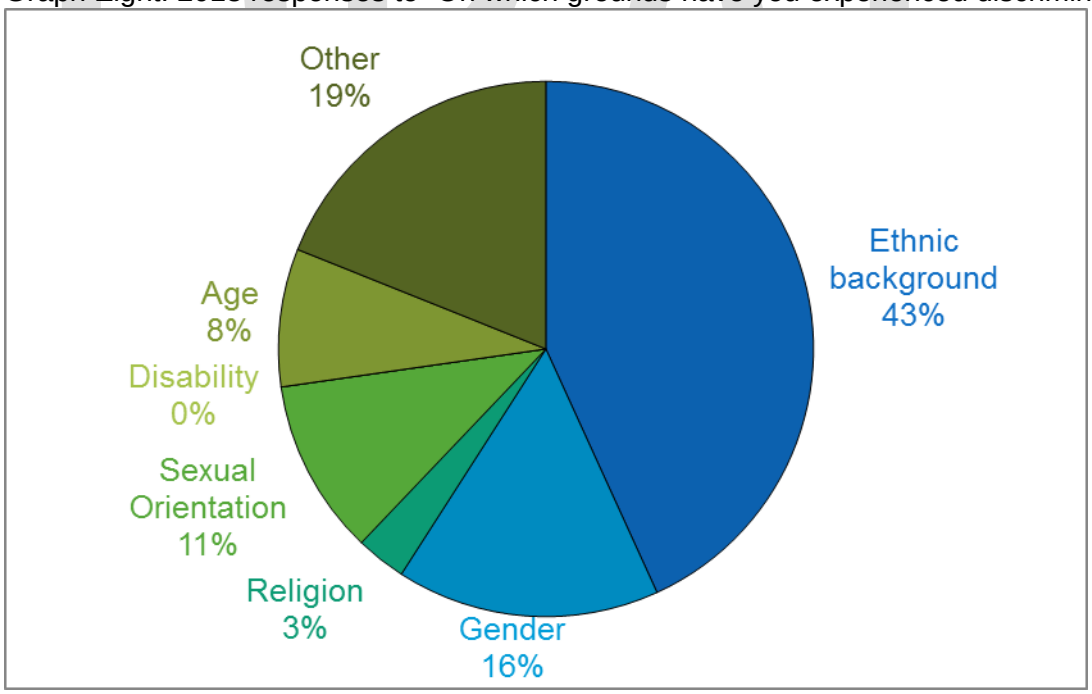
"In the last 12 months, have you personally experienced discrimination at work from your manager/team leader or other?"

	2012		2013	
	Number	Percentage	Number	Percentage
Yes	22	8%	24	8%
No	262	92%	273	92%
Missing	13		9	
Total	297	-	306	-

"On which grounds have you experienced discrimination?"

	2012		2013	
	Number	Percentage	Number	Percentage
Ethnic background	16	57%	16	57%
Missing	12		12	
Gender	2	7%	6	21%
Missing	26		22	
Religion	3	11%	1	4%
Missing	25		27	
Sexual Orientation	3	11%	4	14%
Missing	25		24	
Disability	3	11%	0	0%
Missing	25		28	
Age	2	7%	3	11%
Missing	26		25	
Other	7	25%	7	25%
Missing	21		21	
Total	196	-	196	-

Graph Eight: 2013 responses to "On which grounds have you experienced discrimination?"



PART 2: PATIENT PROFILE

This section outlines the trust's patient profile. In many cases it tries to compare this data with the demographics of Birmingham and the surrounding West Midlands area. This is a very, very rough indication of patient access to the trust since the organisation's actual catchment area is national. However, analysis of the relevant figures show that the vast majority of patients are referred from PCT areas in the West Midlands, so, if treated with care, such comparisons might throw up useful messages.

1.0 ETHNICITY

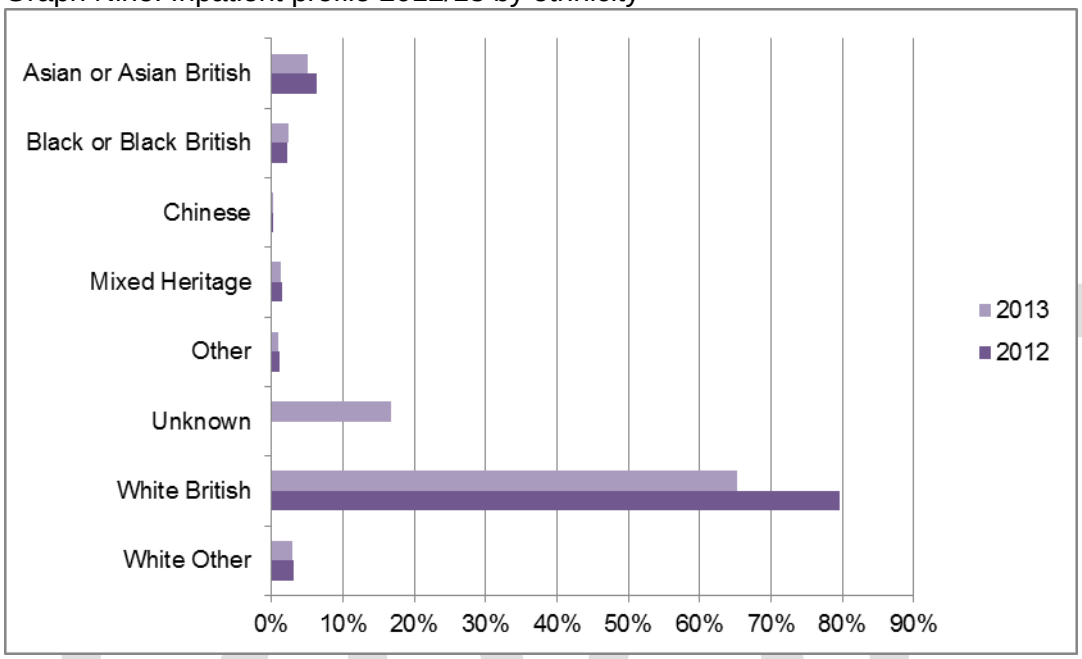
There has been an increase in the proportion of 'ethnic minority' patients between 2012 and 2013. In 2012 about 80%of inpatients were White British, whereas in 2013, 65% were White British. The 2012 figure is broadly in line with the proportion of White British people living in West Midlands as a whole recorded in the 2011 census (79%). However when compared to the Birmingham population, the White British population accounts for 53.1% of the population. There appears to have been a larger proportion of 'Not known' returns for ethnicity in 2013 for inpatients and the reasons for this would merit further investigation (e.g. is this a relevant disclosure challenge or a statistical issue?).
There have been fewer changes in the ethnic background of outpatients.

Inpatient

Ethnic Background	2012		2013	
	Number	Percentage	Number	Percentage
Asian or Asian British - Any other	98	0.94%	91	0.71%
Asian or Asian British - Bangladeshi	20	0.19%	20	0.16%
Asian or Asian British - Indian	290	2.77%	258	2.02%
Asian or Asian British - Pakistani	255	2.43%	275	2.15%
Black or Black British - African	38	0.36%	58	0.45%
Black or Black British - Any other	48	0.46%	45	0.35%
Black or Black British - Caribbean	147	1.40%	206	1.61%
Mixed - Any other	35	0.33%	27	0.21%
Mixed - White & Asian	14	0.13%	29	0.23%
Mixed - White & Black African	22	0.21%	18	0.14%
Mixed - White & Black Caribbean	88	0.84%	80	0.63%
Not stated	605	5.77%	706	5.53%
Other ethnic groups - Any other	121	1.15%	110	0.86%
Other ethnic groups -	18	0.17%	18	0.14%

Chinese				
White - Any other	146	1.39%	163	1.28%
White - British	8352	79.69%	8334	65.25%
White - Irish	183	1.75%	196	1.53%
Not Known			2139	16.75%
Total	10480	-	12773	-

Graph Nine: Inpatient profile 2012/13 by ethnicity

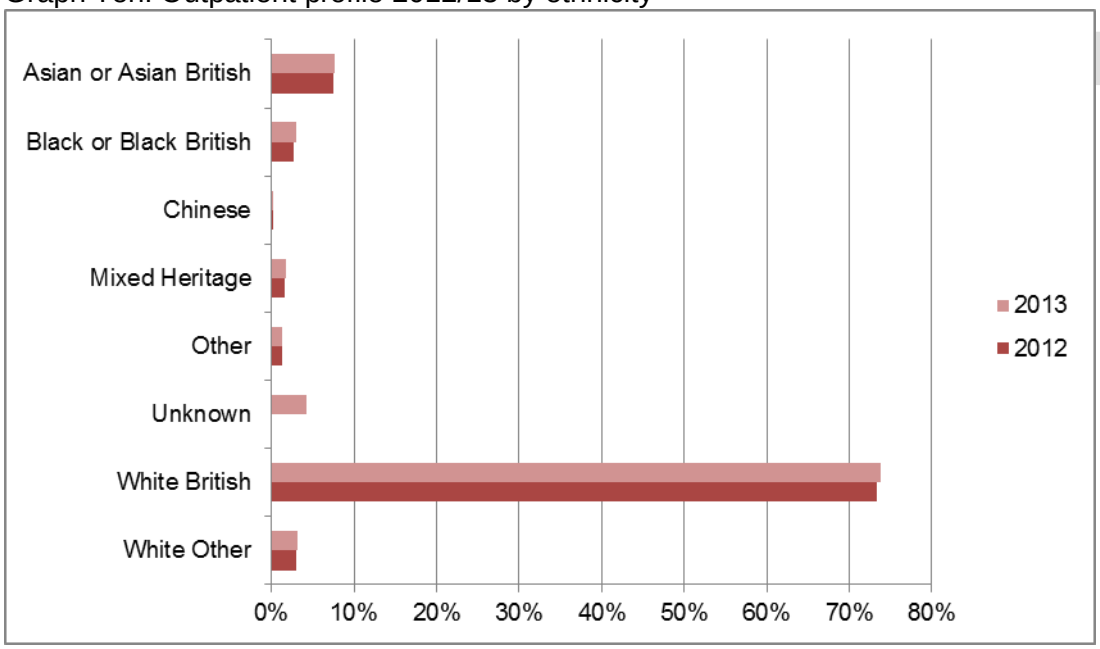


Outpatient

Ethnic background	2012		2013	
	Number	Percentage	Number	Percentage
Asian or Asian British - Any other	674	1.05%	939	1.13%
Asian or Asian British - Bangladeshi	175	0.27%	204	0.25%
Asian or Asian British - Indian	2032	3.16%	2669	3.22%
Asian or Asian British - Pakistani	1892	2.94%	2503	3.02%
Black or Black British - African	242	0.38%	373	0.45%
Black or Black British - Any other	304	0.47%	428	0.52%
Black or Black British - Caribbean	1206	1.88%	1654	1.99%
Mixed - Any other	213	0.33%	326	0.39%
Mixed - White & Asian	150	0.23%	237	0.29%
Mixed - White & Black	107	0.17%	176	0.21%

African				
Mixed - White & Black Caribbean	562	0.87%	736	0.89%
Not stated	6712	10.45%	4243	5.11%
Other ethnic groups - Any other	813	1.27%	984	1.19%
Other ethnic groups - Chinese	83	0.13%	139	0.17%
White - Any other	871	1.36%	1336	1.61%
White - British	47151	73.39%	61214	73.76%
White - Irish	1060	1.65%	1314	1.58%
(blank)/ Not Known	2	0%	3513	4.23%
Total	64249	-	82988	-

Graph Ten: Outpatient profile 2012/13 by ethnicity



2.0 RELIGION OR BELIEF

The majority of inpatients did not specify their religion or belief (56% in 2012 and 59% in 2013). There was a slight increase in the proportion of patients with non-religious beliefs (atheism, agnosticism) and an increase in the proportion of Church of England patients. Outpatients are significantly more likely to indicate they are 'Church of England' – but this is likely to be due to the absence of a 'Christian (non-Catholic, non-specific)' indicator for outpatients (inpatients do have this choice as an indicator). As with inpatients, the majority of outpatients did not specify their religion or belief (62% in both 2012 and 2013)

Inpatients

Religion	2012		2013	
	Number	Percentage	Number	Percentage
Adventist	4	0.04%	3	0.02%

Afro-Caribbean Religions	2	0.02%		0%
Agnosticism	14	0.13%	89	0.70%
Anglican	2	0.02%	5	0.04%
Animism		0%	2	0.02%
Atheist	53	0.51%	134	1.05%
Babi & Baha'l Faiths	2	0.02%		0%
Baptist	21	0.20%	27	0.21%
Christadelphian		0%	1	0.01%
Christian (non-Catholic, non-specific)	1371	13.08%	1541	12.06%
Church of England	157	1.50%	680	5.32%
Church of Ireland		0%	1	0.01%
Church of Scotland		0%	2	0.02%
Declined to give	1	0.01%	27	0.21%
Free Daism	1	0.01%		0%
Greek Orthodox		0%	2	0.02%
Hinduism	47	0.45%	49	0.38%
Independent	8	0.08%	7	0.05%
Islam	158	1.51%	228	1.79%
Jainism		0%	1	0.01%
Jehovah's Witnesses	23	0.22%	21	0.16%
Judaism	22	0.21%	21	0.16%
Latter Day Saints	1	0.01%		0%
Mahayana	1	0.01%		0%
Methodism	63	0.60%	66	0.52%
non-Roman Catholic		0%	1	0.01%
Not Known	1870	17.84%	1395	10.92%
Not Specified	5840	55.73%	7554	59.14%
Orthodox	6	0.06%	5	0.04%
Paganism	3	0.03%	1	0.01%
Pentecostal	11	0.10%	15	0.12%
Quaker		0%	1	0.01%
Reformed/Presbyterian	2	0.02%		0%
Roman Catholic Church	696	6.64%	788	6.17%
Salvation Army	1	0.01%		0%
Scientology	1	0.01%	1	0.01%
Sikhism	92	0.88%	90	0.70%
Spiritualism	2	0.02%	8	0.06%
Unitarian-Universalism	2	0.02%	1	0.01%
Universal Life Church	1	0.01%	2	0.02%
Wicca		0%	1	0.01%
Zen Buddhism	1	0.01%	2	0.02%

Zoroastrianism	1	0.01%	1	0.01%
Total	10480	-	12773	-

Outpatients

Religion or Belief	2012		2013	
	Number	Percentage	Number	Percentage
Adventist	17	0.03%	23	0.03%
Afro-Caribbean Religions	14	0.02%		0%
African Religions	1	0%	1	0%
Agnosticism	67	0.10%	630	0.76%
Anglican	24	0.04%	33	0.04%
Animism	5	0.01%	15	0.02%
Athiest	72	0.11%	104	0.13%
Babi & Baha'l Faiths	11	0.02%	7	0.01%
Baptist	163	0.25%	174	0.21%
Bon		0%	1	0%
Buddhist		0%	13	0.02%
Christadelphian	25	0.04%	51	0.06%
Church of England	16347	25.44%	20429	24.62%
Church of Ireland	15	0.02%	24	0.03%
Church of Scotland	65	0.10%	63	0.08%
Church of Wales	6	0.01%	17	0.02%
Cyber Culture Religions	1	0%		0%
Divination		0%	1	0%
Druidism	2	0%	2	0%
Fourth Way	2	0%	1	0%
Free Daism	5	0.01%	1	0%
Greek Orthodox	19	0.03%	17	0.02%
Hindu	384	0.60%	478	0.58%
Humanism	4	0.01%	4	0%
Independent	17	0.03%	32	0.04%
Jainism	1	0%	8	0.01%
Jehovah's Witness	109	0.17%	156	0.19%
Jewish		0%	149	0.18%
Judaism	136	0.21%		0%
Latter Day Saints	2	0%	4	0%
Mahayana Buddhist	8	0.01%	3	0%
Messianic Judaism		0%	3	0%
Methodist	323	0.50%	355	0.43%
Islam	1323	2.06%	1817	2.19%
New Age	1	0%	3	0%

None	39912	62.12%	51522	62.0%
Occult	2	0%	4	0%
Orthodox Christian	34	0.05%	36	0.04%
Other	489	0.76%	884	1.07%
Paganism	8	0.01%	18	0.02%
Pentecostalist	59	0.09%	125	0.15%
Presbyterian	7	0.01%	3	0%
Quaker	14	0.02%	28	0.03%
Rastafari		0%	13	0.02%
Roman Catholic	3989	6.21%	5004	6.03%
Russian Orthodox	2	0%	2	0%
Scientologist	2	0%	1	0%
Sikhism	510	0.79%	666	0.80%
Spiritualist	30	0.05%	36	0.04%
Unitarian-Universalism	6	0.01%	5	0.01%
Universal Life Church	6	0.01%	8	0.01%
Voo Doo	2	0%	6	0.01%
Zen Buddhism	7	0.01%		0%
Zoroastrainism	1	0%	8	0.01%
Total	64249	-	82988	-

3.0 MARITAL STATUS

Inpatients are most likely to not disclose their marital status (48% did not disclose in 2012 and 55% did not in 2013). For outpatients information about marital status is unavailable about similar proportions of people (this is described as 'not known' in the outpatient returns).

Inpatients

Marital Status	2012		2013	
	Number	Percentage	Number	Percentage
Civil Partner	15	0.14%	15	0.12%
Dissolved Civil Partnership	1	0.01%		0%
Divorced	285	2.72%	281	2.20%
Engaged	2	0.02%	5	0.04%
Married	3227	30.79%	3136	24.55%
Not Disclosed	5020	47.90%	7034	55.07%
Single	1611	15.37%	1993	15.60%
Surviving Civil Partner		0%	1	0.01%
Widowed	319	3.04%	308	2.41%
Total	10480	-	12773	-

Outpatients

Marital Status	2012		2013	
	Number	Percentage	Number	Percentage
Civil Partnership	48	0.07%	58	0.07%
Dissolved Civil Partnership	3	0%		0%
Divorced	1409	2.19%	1769	2.13%
Engaged	14	0.02%	27	0.03%
Married	16593	25.83%	19130	23.05%
Not Disclosed	8	0.01%	12	0.01%
Not Known	35857	55.81%	48260	58.15%
Other	82	0.13%	137	0.17%
Separated	218	0.34%	212	0.26%
Single	8548	13.30%	11809	14.2%
Widowed	1469	2.29%	1574	1.90%
Total	64249	-	82988	-

4.0 AGE

In 2012 and 2013 most patients were between 42 and 81.

Inpatients

Age Group	2012		2013	
	Number	Percentage	Number	Percentage
≤16	916	8.90%	1114	8.72%
17 - 21	359	3.49%	443	3.47%
22 - 31	646	6.28%	780	6.11%
32 - 41	877	8.52%	1116	8.74%
42 - 51	1450	14.09%	1796	14.06%
52 - 61	1878	18.24%	2238	17.52%
62 - 71	1959	19.03%	2575	20.16%
72 - 81	1700	16.51%	2057	16.10%
82 - 91	487	4.73%	629	4.92%
92 - 101	22	0.21%	25	0.20%
≥102	0	0%		
Total	10294	-	12773	-

Outpatients

Age group	2012		2013	
	Number	Percentage	Number	Percentage
≤16	3662	6.04%	5507	6.64%
17 - 21	2192	3.62%	3006	3.62%
22 - 31	4426	7.31%	5424	6.54%
32 - 41	6133	10.12%	7811	9.41%

42 - 51	10273	16.96%	13160	15.86%
52 - 61	12317	20.33%	15820	19.06%
62 - 71	13215	21.81%	16825	20.27%
72 - 81	9180	15.15%	11841	14.27%
82 - 91	2718	4.49%	3432	4.14%
92 - 101	129	0.21%	156	0.19%
≥102	4	0.01%	6	0.01%
Total	60587	-	82988	-

5.0 SAFETY

The data in this section shows the age, ethnicity, and gender of patients involved in serious incidents requiring investigation (SIRIs) between January and November 2013. Whilst data for 2012 indicated a lack of significant inequalities in the incidence of SIRIs compared to the patient profile, in 2013, there appears to be a higher proportion of patients from White British backgrounds who experience SIRIs.

5.1 Age

Patients at opposite ends of the age spectrum are more likely to be involved in SIRIs. As the trust works to reduce the overall number of SIRIs, this is something to bear in mind.

Age	2012
15-25	4
26-40	0
40-60	2
60+	5
Unknown	3
Total	14

Statistical note:
Data on the age of patients for 2013 has not yet been submitted: this will be included as an appendix as and when it becomes available.

5.2 Ethnicity

In 2012 the most populated category in this grouping is ‘Not stated’. Of the defined data, the largest category was ‘White British’ in 2012. In 2013, data has improved regarding the ethnicity of patients who have experienced serious incidents requiring investigation. A large majority of patients were from ‘White British’ backgrounds in 2013 (85%) – ‘White British’ patients feature disproportionately compared to their make-up within the broader patient population at the hospital.

Ethnicity	2012	2013
White – British	5	23
White-Irish		2
Asian or Asian British Pakistani	1	
Mixed - White & Black	1	

Caribbean		
Mixed – White & Asian		1
Not stated	7	3
Total	14	29

5.3 Sex

Women are more likely to be involved in a SIRI than men in both 2012 and 2013.

Sex	2012	2013
Female	7	17
Male	5	11
Unknown	2	1
Total	14	29

6.0 EFFECTIVENESS

In 2012 and 2013, arthroscopy was used as a sample indicator for assessing equality patterns in relation to one aspect of clinical effectiveness. This indicator was chosen because performance reports had flagged this indicator as a 'red' on the RAG rating system and information was available disaggregated by ethnicity. For both years 2012 and 2013, there was found to be little relationship between ethnicity and waiting times for arthroscopy. Rather than include that data here again, we are committing to review over the coming year (2014) potential indicators of clinical effectiveness where we understand there to be particular equality challenges and where data is available disaggregated by protected characteristics.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26th March 2014 **ENCLOSURE NUMBER:11**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**Implementing the recommendations of the Francis Report and the government's response, 'Hard Truths'.**

SUMMARY

This paper provides a high level summary of the actions taken by the trust to date and indicates areas for further scrutiny and development. The following actions have been undertaken to date by the ROH in response to Francis Report:

- Board, governor and staff workshops were held
- Short life working groups led by executives and comprising staff and stakeholders, were established to explore the specific recommendations of the report around the following themes:

-accountability and implementation,
-putting patients first,
- Inquests
-openness, transparency and candour,
-nursing,
-information,
-complaints
-caring for the elderly

The appendix provides a simple gap analysis of where the trust is compared to where it needs to be. Much of the work undertaken in groups has led to changes in practice now already embedded within the organisation and the trust's developing strategy will re-enforce the spirit and detail of the Francis report.

The trust has complied with the emerging requirements for trusts to develop their approach to the Francis Report and has placed a statement of intent on the website.

The Board will be invited to discuss these issues at a workshop to ensure continued ownership from the top and to allow prioritisation in support of local need.

IMPLICATIONS eg. financial, operational, risk, etc

Detailed consideration of the Francis report focuses the trust Board on issues affecting:

- Patient safety and experience.
- Staff satisfaction.
- Organisational reputation.
- Financial.

It is recognised that failure to address these concerns can lead to breach of licence and forced closure of an organisation.

RECOMMENDATIONS

Trust Board is asked to:

1. Note the progress to date and outcomes of the working groups.
2. Be reminded of the responsibility for ensuring learning is applied to this organisation thereby providing safe, quality focused patient care in an open culture with trained, competent and compassionate, supported staff.
3. Consider at a workshop, the priorities for implementing the recommendations as identified by the gap analysis; confirm reporting and escalation mechanisms and committee ownership to ensure recommendations are implemented in a timely manner becoming usual organisational business and confirm the risk management structure of failure to implement.

Implementing the recommendations of the Francis Report

and the government's response, 'Hard Truths'.

Introduction

This paper outlines the current position of The Royal Orthopaedic Hospital NHS Foundation Trust when measured against the government approved recommendations from the Francis Report into the failings at Mid Staffordshire NHS Trust. The Board are responsible for ensuring learning is applied to this organisation thereby providing safe, quality focused patient care in an open culture with trained, competent and compassionate supported staff.

A number of approved recommendations are not directed at health care providers. Whilst these have not generally been included within this review, awareness of the impact on other organisations is relevant knowledge for this trust. (For example recommendations for educational institutes, commissioners, regulators and government.)

Gap Analysis and Key Findings, Recommendations and Implementation

Appendix One summarises the current position of the organisation as identified by the working groups, the areas where action is required. The output from groups was variable according to the perceived relevance of the recommendations to this trust, the trust's ability to influence matters (for example the NHS constitution) and the size of the group. To take things forward, a discussion of the priorities and timescales for delivery will be sought from the Board at a workshop, ensuring that decisions and recommendations made are reflective of the organisation's developing two/five year strategy.

A comprehensive action plan will then be developed to assist the implementation and monitoring of the recommendations, as agreed by the Board.

Reporting and Escalation Options

The recommendations of Robert Francis have been largely accepted by the government and place significant responsibility with Trust Boards to ensure that the lessons of Mid Staffordshire NHS Trust are learnt and implemented by all providers of health care. There are sufficient risks to patient safety and experience, contractual requirements, organisational reputation and the newly developed two year organisational strategy to suggest that monthly reporting to EMT, with a quarterly progress report to Trust Board affords an appropriate level of scrutiny.

To meet recommendations 253, access to quality profile, and 173/177, principles of openness, transparency and candour/ openness in public, the quarterly report should be made available on the Trust website as a separate document and located in an area of the site that is easily accessed by the public.

Risk management

A full risk assessment of the agreed recommendations, implementation and timescales of delivery will be developed following approval from the Trust Board. The risks will be managed within the appropriate committee with devolved responsibility from the Trust Board; escalation may lead to the risks being incorporated within the corporate risk register and BAF.

Summary

The Trust Board is asked to note the report and to use a workshop to discuss and confirm the priorities for implementing the recommendations as identified by the gap analysis, confirm the reporting, escalation, risk management and committee ownership to ensure recommendations are implemented in a timely manner becoming usual organisational business.

Appendix 1

Recommendation Number	**Assessment of ROH Position**	**Action to be taken**
Accountability for implementation of recommendation		
1 Implementation	Outline Board paper Dec 2013 Short Life Working Group completed Dec 2013 Gap analysis Jan-Feb 2014 Recommendations to Board March 2014	Identify priorities, ownership, timescales for delivery and reporting structure Communication to organisation, external stakeholders and public
2 Shared culture patient priority	Core values date to 2009, refreshed in 2012 & not fully disseminated or integrated Leadership development Some evidence of staff empowerment	Promote and support staff empowerment to raise concerns Honesty and candour- see other sections Cultural barometer Staff risk barometer- 2014 CQUIN Standards of behaviour Values aligned to 2 year strategy Consideration of use of NHS values, as per constitution – linked to rec.4 below Challenge of poor behaviour
Putting Patients First		
Putting Patients First	Quality agenda	Continue to develop and share Robust challenge of failures Education and development to focus on this
3 Clarity of values and principles	NHS constitution	Linked to rec 4 below
4 Core values of NHS Constitution to be given overriding value	Support for principle, not commonly used or publicised	ROH to adopt NHS values and standards, which are promoted widely rather develop and use its own
5 Reaching out to patients	Supports all the recommendations in practice	Of note - may necessitate deviation within specific circumstances, such as best interest actions
7 NHS staff enter an express commitment to abide by NHS values and constitution, incorporated into contracts of employment	Not currently undertaken, discussions have taken place in the past	Re visit the discussions Engage to adopt for existing staff New contracts adopt

8 Contractors abide by points those raised within Putting Patients first as applicable	Considered difficult to enforce other than by catch-all phrase in contracts	Department leads adopt within contracted activity
Inquests		
45 CQC to be notified directly of upcoming healthcare – related inquests, either by Trusts or more usefully by the Coroner	Not currently undertaken	ROH to discuss with Coroner and CQC to implement from April 2014

Openness, transparency and candour		
173 Principles of openness, transparency and candour. All duty to be honest, open and truthful with patients, public. Organisational or personal interests must never be allowed to outweigh the duty	SIRI feedback +ve responses from CQC and CCG, WMQRS etc Governors link to Quality Account Being Open within Serious Incident Policy	Develop independent 'Being Open' policy Launch with training
174 Candour about harm. Death or serious harm through act or omission full disclosure and offer of support, irrespective of being asked	SUI/SIRI investigation system Family meetings	Remind and link to Being Open Revisit SUI definitions Cross reference SIRI/SUI investigation
175 Full and truthful answers		Confirm check of complaints handling
176 Openness with regulators	+ve relations CCG, CQC, WMWRS HDU, Theatres	Continue, no specific action required
177 Openness in public statements, must be truthful and not misleading		Exec team 'sign off' of all press releases and intranet entries to ensure truthfulness
179 Restrictive contractual clauses, gagging clauses	Confirmed by Remuneration Committee as inappropriate.	No further action required
180 Candour about incidents	Being Open within another policy	Develop independent being Open policy, as above
181 Enforcement of duty, where harm has occurred	TBC	TBC
182 Statutory duty on all directors to be truthful with commissioner or regulator	TBC	TBC
183 Criminal liability Clinical, director or healthcare organisation to		Awareness to be raised as part of Being Open launch

knowingly obstruct, mislead or dishonest statements		
184 Enforcement by the CQC	CQC action plan and workshops	CQC 5 domain preparedness
Nursing		
185 Culture of caring	Mandatory training Competencies PDR Performance management KPI of services L&D support 6C launch & competition Recognition of achievement Feedback on performance Reporting culture	Continue to strengthen Nurse leadership model now in place Review competencies Review PDR of senior nurses L& D strategy linked
188 Aptitude test for compassion and caring	Interview Incident follow up Patient Harm meetings	Continue and:- Values based recruitment Ward Values Welcome to Trust- DoN Staff nominations by patients
191 Recruitment for values and commitment		Values based recruitment Ward Values
192 Strong Nursing voice		This point relates to national voice Locally nurse leadership development and forum
194 Annual learning portfolio, up to date nursing practice	PDR ? portfolio	Standard portfolio Support to complete Launch
196 KSF linked to commitment, dignity and respect, leadership skills		Review KSF with HR
197 Leadership training at every level	L&D strategy	Continue
198 Cultural **Health** of front line staff	MSB work	Explore cultural barometer Staff net promoter to be introduced 2014
199 Key Nurses for the shift		Implement from 1st April 2014
Information		
244 Common Information	IMT project IMT investment	IMT project to cross reference to recommendations

practices, shared data and electronic records		
245 Board accountability for Information	Board member responsible	clear governance structure prior to and on appointment of the Chief Information Officer
247 Accountability for quality accounts	Board members sign off quality account	Confirm position is relevant and appropriate with new Board members
252 Access to data	ROH comply with the 2 standards for anonymised data (ISB 1523 and IG toolkit criteria 324). Mandated annual IG training	Information asset review Research and Training provide confirmation regarding publication of case studies. Information Governance Privacy Impact Assessment in Q1 14/15
253 Access to quality and risk profile	Board papers ROH website	Patient and Public Services Team and in line with the Trust Marketing Strategy, to ensure ROH quality and risk information is easily accessed, with clear explanation written in plain English.
255 Using patient feedback	FFT, complaints and compliments monthly Board reports. Patients & public website option Access to NHS Choices website Face book and twitter account	Closer to real time availability. Plan to implement greater accessibility, transparency and responsive feedback. Extend use of social media
256 Follow up of patients	Post discharge follow up in some parts of the organisation	Implement across all wards Link to nursing establishment review
262/263/264 Enhancing the use, analysis and dissemination of	PROMS, delayed reporting Ad hoc outcomes reporting	IT Strategy data warehouse linked for all clinical systems In line with R252 Findings from Information Asset review that is

healthcare information	Deputy Medical Director lead for outcomes	being undertaken in R and T are adopted by the trust
269 Improving and assuring accuracy	Varying approaches, lack robust approach	Identify specific accountable positions to work with CIO to provide this assurance.
247/248 Accountability for quality accounts	Lodged with Commissioners, principle Birmingham Cross City CCG sharing the QA with all other commissioners. ROH QA is audited by an external auditor with assurance provide to Audit Committee as part of the Trusts Annual Report and Accounts in line with national guidance. Internal audit also undertake independent reviews of certain quality criteria.	Continue with current process
268 Resources	Information team data to central registries.	Developing IT and informatics infrastructure to improve access to and reporting of healthcare information.
Complaints		
109-122 Complaints handled as such, identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning;	Complaints Team action plan addresses recommendations Local resolution prioritised with request for supernumerary time at ward level to allow this to occur more readily. Publication of complaint letter content on website	Delivery of action plan In proposed staff mix changes for 2014/15

and proper and effective communication of the complaint to those responsible for providing the care.	to be further considered but initially felt inappropriate and a potential breach of confidentiality.	
Caring for the elderly		
236-243 Approaches applicable to all patients but requiring special attention for the elderly.	Physician care Care rounding Nutritional assessments Mental capacity assessments No late discharges home Discharge service	Older person ward champion Forward provision of Physician care Appropriate communication tools Communication with relatives/carers Recognise holistic care Observations accessible and actioned

Information SLWG- Advise that whilst it was not within ROH gift to deliver these recommendations, that the spirit of them should be adopted and that the Trust should work to best practice relating to public and patient access to and quality of information using the Health and Social Care Information Centre guidance.

246: Comparable quality accounts

251: Regulatory oversight of quality accounts

254: Access for public and patient comments

257/258/259: Role of the Health and Social Care Information Centre

260/261: Information standards

265/266/267 (in part): Enhancing the use, analysis and dissemination of healthcare information

270/271/272: Improving and assuring accuracy

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enclosure 1

Minutes of the Trust Board Meeting
held in public on Wednesday 26th March 2014 in the Boardroom

Present:
Trust Board
Mr Tim Pile, (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director
Mr Mike Flaxman, Interim Non-Executive Director

In attendance:
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development

Agenda No.	Agenda Item	ACTION
03/14/35	**Apologies and welcomes** There were apologies from Mr Andrew Pearson Welcome to Mike Flaxman as interim Chair of Audit Committee	
03/14/36	**Declarations of Interest** No other Declarations of Interest than those registered previously	
03/11/37	**Minutes of the Trust Board meeting held on 26th February 2014** The minutes were approved as a correct record subject to removal of Andy Meehan being recorded as having attended. Include standing item on board member visits to be added to agenda. AP to report on commercial tissue requests.	
03/14/38	**Action Points** The action notes were updated (see separate sheet). 07/13/1447 – Andrew Pearson was asked to provide an update at the next meeting.	
03/14/39	**Chairman's Report** Tim Pile deferred to the CEO.	

03/14/40	**<u>Chief Executive's Report</u>** JC introduced her report and outlined the forthcoming stakeholder strategy day. To support the Board in developing the 5 year strategy. Anne Cholmondeley underlined the importance of using April 25th as a means of staff engagement following on from the MSB work. MSB follow-on work had included communications such as two way core brief, greater visibility of staff, effective management of known under-performers. HR had introduced more electronic work and had simplified some of its transactional processes. Staff still welcomed and felt ongoing need for greater engagement and opportunities such as the stakeholder day were extremely valuable. JC confirmed that it was work in progress but the five year strategy would be really supported at this event. **EM commented that having made an investment of £40k to secure external support on staff engagement and felt that the Board should see a direct connection between the investment and the activity being undertaken. TP felt that the engagement strategy needed to be owned by the organisation. This should be one of the strategic themes brought to the board. It was agreed that there be a report to the board in April to consider how best to continue delivering leverage from that investment.** Jo Chambers drew attention to the EMT decision to bring an additional MRI scanner on site. Roger Tillman added that a new radiologist had been appointed this week. Tim Pile had been part of the appointment panel and felt the appointee had been extremely impressive. Monitor feedback confirmed the trust as having a green rating for governance (despite the trust's failure to meet targets, but because strong plans were in place) and a rating of 4 for finance (the highest rating). Jo Chambers confirmed that among senior NHS staff, there was concern that the real financial pressures would hit in the next financial year rather than in 2015/16. In comparison to many organisations, ROH had a relatively strong position because of its financial situation – having money to invest. Tauny Southwood asked if this was the right time to invest and it was agreed that it was, but that communication required careful handling.	**Anne Cholmondeley**

03/14/41	**<u>Medical Staff Committee Report</u>** Roger Tillman introduced the report. The issue of mobile phone usage in theatres was discussed. Helen Shoker advised that both she and Andrew Pearson had raised these issues with non-medical theatre staff (for whom mobile phone use was deemed inappropriate, having been witnessed by patients). Tim Pile felt that patient confidentiality was the key issue. Helen Shoker felt this was a matter of both common sense and professionalism. Anne Cholmondeley suggested reminding staff of the policy but also commented that staff still felt that not all were treated equally. Helen Shoker raised the issue of whether it remained appropriate for a single interest staff group to have direct access to the board on such issues. Frances Kirkham commented that this was a matter of managing staff within the existing policy. Tim Pile raised the issue of communication channels between MSC and the Trust Board. Anne Cholmondeley advised that in the past the Chair or CEO had given necessary feedback on matters. **It was agreed that feedback would be best given verbally to MSC and the CEO and Chair would meet the Chair of MSC.** Amanda Markall asked whether the MSC report to Board was circulated to MSC members and Roger Tillman said he thought not but that he would suggest this to the MSC Chair.	**Tim Pile/Jo Chambers**
03/14/42	**<u>Annual Plan</u>** Jo Chambers introduced the plan and asked the board to note that additional narrative was to be introduced on staff engagement. Tauny Southwood felt that it was lacking prioritisation but recognised that this was work in progress. It was agreed that the following dimensions be added: • Refreshing an existing strategy •Business as usual in contract for year one •The key strands we believe support our five year strategy -the agenda –right up front in the document It was noted that there remained a significant gap in terms of our definition of orthopaedic excellence in clinical terms. **The Board approved the plan for submission, subject to these amendments, but asked that it be circulated to the board prior to the submission.** The Board then considered the declaration it wished to make on governance – meeting the key national targets. Amanda Markall confirmed that, despite the failure to meet	

	targets in the last quarter, she felt that the trust was now in a good position to confirm that the trust would meet its targets. This was recognised as a challenge, mitigations such as appointing a lead to oversee the 18 week referral to treatment targets were being put in place. Cancer targets would always be hard to guarantee delivery on because numbers were variable and quite low. Frances Kirkham felt that recent experience did not give comfort. PA referred to the numbers in the corporate performance report which suggest the trust is moving forward and is, for example, reducing its backlog. Paul Athey raised the issue of the CDiff target which for 2014/15 was zero. **The Board discussed in detail the governance declaration required for the delivery of targets and on the basis that the plans, governance and engagement arrangements were in place and acknowledging the concerns about the as yet unknown requirements of year two, the Board felt it appropriate to confirm that it would meet all targets for the life of the plan.** It was suggested that Amanda Markall and Frances Kirkham raise the issue on behalf of the board, of consultant annual leave at an MSC meeting.	**Amanda Markall/Frances Kirkham**
03/14/43	**<u>Budget Approval 2014-16</u>** Paul Athey introduced the budget. Key issues were the establishment of a transformation fund. Contracts with Wes Midlands CCGs were signed and contracts agreed with specialist commissioners. The trust would need to deliver 3.8% growth. The CIP plans were not as robust as would have been liked and this resents a significant risk. Nonetheless, directorates were working hard on both cost-saving and growth elements of CIPs. The risk of contractual penalties was greater in 2014/15 and this had been provided for in the budget. The capital plan was for five years with room to amend as years progressed. The assumption that a second MRI scanner would be procured in year two. Elizabeth Mountford asked if staff found it difficult to think two years ahead rather than in the present. Paul Athey said this was a challenge and that they were now being asked to look at the gap analysis between now and the end of the period to allow them to think about the transition. Mike Flaxman noted that there were funds in reserve to mitigate CIPs and felt that some of that might be held back until the CIPs were being delivered.	

	Elizabeth Mountford noted that there was a saving allocated to sickness and she asked if the organisation was clear about how this would be delivered. Paul Athey advised that it was based on assumptions that existing initiatives would deliver these benefits. Helen Shoker gave an example of work being applied in ROH that HEFT had tried and found successful. Mike Flaxman commented that the first two years of the capital plan was well worked out. The deliverability of the subsequent three years had been questioned and he had received some assurances from Paul Athey. Tim Pile had expected to see a cashflow forecast and Paul Athey explained that there were spreadsheets from Monitor behind this and that in future cashflow would be reported. **The Board approved the 2014/15 revenue plan** **The Board approved the 5 year capital plan** **The Board supported the planned mitigations if a downside scenario occurs** **It was further agreed that more detailed on finance would be needed in the next year including on CIPs.**	
03/14/44	**<u>Corporate Performance report (inc. CIP & RTT Rectification Plan)</u>** Amanda Markall confirmed that performance in February had been very good and was ahead of plan and just below the rectification plan. Case mix had been reviewed and there had been a 3-5% shift in day case work on a monthly basis and this work will continue. Operations team and informatics are working together on an 18 week programme board. The trust had failed to meet its admitted target but the backlog had now reduced to a comfortable level. One patient had been identified as now having waited over 52 weeks for treatment. Over-performance across all areas had been achieved for the first time and theatre utilisation had been much improved. Elizabeth Mountford asked whether the position was now stabilised and Amanda Markall replied that it had not – the extra Saturdays would reduce to two a month and the review of capacity in week in theatres was underway. Average length of stay has risen and this is now being reviewed. Tim Pile asked that the detail of avoidable and unavoidable cancellations be included. Mike Flaxman felt that occupancy on paediatrics was extremely low. Amanda Markall advised that there had been underperformance	

	throughout the year and work with the Children's Hospital to develop a proper strategy was underway. **Frances Kirkham asked that a report on paediatrics be given to a future meeting.** Tauny Southwood confirmed that there were insufficient paediatric orthopaedic surgeons. Helen Shoker also advised that in future the Board would see a report on acuity which would show nursing levels. Paul Athey reported that the gap in surplus anticipated as a result of mid-year under-performance had been closed in February. Likely year-end outturn would be c £2million surplus. **Tim Pile asked that the outturn graphs of the previous year be added to offer a comparison**. Anne Cholmondeley advised that there had been some improvement in mandatory training and appraisal training. The commissioner targets in these areas have now been acknowledged as having been very high and this has been changed for next year. Frances Kirkham asked if we knew how we compared with other trusts for sickness and Anne Cholmondeley advised we were about 1% above for sickness.	**Amanda Markall** **Paul Athey**
03/14/45	**<u>The Patient Quality Report</u>** Helen Shoker introduced the report and overall the trust was very safe. The increase in falls was not associated with areas under undue pressure as a result of the rectification plan. The trust had met its CDIff target and there would be a major challenge in 2014/15 when the target dropped to zero. It was felt that the discrimination between avoid able and unavoidable would be useful. The infection prevention quality assessment and improvement tool will be implemented in place of the saving lives tool. ROH will trial this. WHO checklist compliance was good and this will be further developed. Friends and Family test had secured a higher number of responses. NJR compliance had risen but there had been some issues which were being addressed. Roger Tillman had attended a national meeting on NJR and felt ROH was in a good position.	
03/14/46	**<u>Board Assurance framework</u>** Helen Shoker circulated an updated BAF committee ownership list and explained that there was still work to do	

	on causes and consequences. The lead committee 'owns' the key impact of the risk and will refer to other committees as necessary. Tauny Southwood felt this was now much clearer. The risk on staff engagement was identified as something that may need further discussion. Tauny Southwood felt that EMT did not benefit from the challenge of non-executives and Jo Chambers felt that, as accountable officer, she was in a position to oversee and refer to the board as necessary. Tim Pile felt that any important matters should be raised at the Board. There remained concern that the staff engagement and workforce agenda be covered. **Staff engagement and organisational development should be the responsibility of EMT.** **Jo Chambers felt that the Board would need to see information on risk mitigation in more detail in future.**	**Helen Shoker**
03/14/47	**<u>Trust Annual Equality Report 2014</u>** **The Board received the updated report and, having included one word change suggested by Elizabeth Mountford, this was now approved for publication**.	**Anne Cholmondeley**
03/14/48	**<u>Trust Response to The Francis Report</u>** The Board would have a short workshop on the afternoon of the Board meeting. It was important to develop a local response to Francis which was a part of routine business, done because it **The Board noted the high level summary of actions to date and gaps**.	
03/14/49	**<u>Audit Committee Report</u>** Mike Flaxman introduced the report and explained that the internal audit report had been very good. The internal audit plan was also approved. In terms of the recommendations to improve process with regard to RTT, 8 of 10 recommendations had already been implemented. The BAF had been discussed. There had been some technical discussions among which the conclusion was that the trust was a single entity; the trust was a going concern with some concerns for the future – the middle option. Elizabeth Mountford complemented Mike Flaxman on holding the external auditors to account and explaining things easily. Tim Pile asked if it could be checked whether the CEO was not able to attend the Audit Committee as he felt they should be in attendance. Joy Street advised that recent best practice publications for NHS FT Boards confirmed that CEOs should not be members of Audit Committee but	

	might be invited from time to time as accountable officers.	
	Clinical Governance No meeting	
	Remuneration Committee No meeting	
	Charitable Funds committee Agreed to spend £80k on a playroom and some other ideas from the Director of Nursing. The chair had confirmed to members that , were funds not to be spent, thee option to transfer them might be exercised. Paul Athey had prepared a draft 5 year plan which has since been revised. Fund holders had been asked to give their ideas but had received a poor response. Ideas for suggested themes would be welcome. Tim Pile suggested that the pursuit of excellence within the strategy could guide the use of funds. Tim Pile felt the Trust should raise funds for specific projects.	
03/14/50	**Any Other Business** Frances Kirkham had heard a radio programme about a very nasty infection now prevalent in Europe. Helen Shoker advised that this had been discussed at Infection Control and this may then go up to CGC. Would like a presentation from doctors on the clever things they are doing Tauny Southwood felt that other staff should be encouraged to do this, may be at TBALD. Elizabeth Mountford asked what the expectations for attendance at governors' meetings and was advised that NED attendance at governor meeting was as available or as specifically invited.	
Date and Time of Next Trust Board Meeting April 30th 2014 at 8.30am 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 MEETING
TO BE HELD ON
WEDNESDAY 26TH MARCH 2014,
8.30AM – 12.00 NOON IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
03/14/34	**Apologies for Absence** Chairman	Andrew Pearson	To Note	
03/14/35	**Introductions & welcome** Chairman		To Note	
03/14/36	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
03/14/37	**Minutes of Public Board Meeting held on the February 26th 2014** Chairman		For Approval	Enc. 1
03/14/38	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
03/14/39	**Chairman's Report** Chairman		For Assurance	Verbal
03/14/40	**Chief Executive's Report** Chief Executive Officer		For Assurance	Enc. 3
03/14/41	**Medical Staff Committee Report** Deputy Medical Director			Enc. 4 – to follow
	Performance Management / Assurance Reports			
03/14/42	**Annual Plan 2014-16** Company Secretary			Enc. 5
03/14/43	**Budget Approval 2014-15** Director of Finance			Enc. 6
03/14/44	**Corporate Performance Report (inc CIP & RTT Rectification Plan)** Director of Finance			Enc. 7
03/14/45	**Patient Quality Report** Director of Nursing & Governance			Enc. 8
03/14/46	**Board Assurance Framework** Director of Nursing & Governance			Enc. 9

03/14/47	**Trust Annual Equality Report 2014** Director of Workforce and OD			Enc. 10
	Strategy			
03/14/48	**Trust Response to Francis Enquiry** Director of Nursing & Governance			Enc.11
	Board Committee Reports			
03/14/49	**Audit Committee Report** **Clinical Governance Committee** **Remuneration Committee** **Charitable Funds Committee**			Enc. 12 – to follow Nil Nil Verbal
03/14/50	**Any Other Business**			
	To be followed by a work shop			
	Date of Next Meeting: Wednesday 30th April 2014 8.30am – 1.00pm followed by work shop			

Enclosure 1

Minutes of the Trust Board Meeting
held in public on Wednesday 30th April 2014 in the Boardroom

Present:
Trust Board
Mr Tim Pile, (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director
Mr Mike Flaxman, Interim Non-Executive Director

In attendance:
Dame Yve Buckland, Chair designate
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development

Agenda No.	Agenda Item	ACTION
04/14/50	**Apologies and welcomes** There were no apologies. Welcome to Dame Yve Buckland, Chair Designate who takes up the role on May 1st.	
04/14/51	**Declarations of Interest** No other Declarations of Interest than those registered previously.	
04/14/52	**Minutes of the Trust Board meeting held on 26th March 2014** The minutes were approved. In response to a query from Frances Kirkham, Helen Shoker advised that the issue raised under AOB last time following a radio programme on new infections had been passed to CGC.	
04/14/53	**Action Points** The action notes were updated (see separate sheet). Tim Pile advised that MSC had sent three letters raising issues. The preferred stance was for the CEO to respond on behalf of the board, face to face wherever possible. .	

04/14/54	**Chairman and NEDs' Reports** Tim Pile advised that his pertinent issues were on the agenda. .	
04/14/55	**Chief Executive's Report** **1 Care Quality Commission Update – New Inspection Regime** **The Board noted** that the Trust would receive a new style inspection commencing on 2 June 2014 as one of two pilots for specialist orthopaedic hospitals, the other being the Royal National Orthopaedic Hospital in Stanmore. The inspection will provide a rating in each of five domains and an overall Trust rating of outstanding, good, requires improvement or inadequate. The five domains are: • Safe • Effective • Caring • Responsive • Well-led Jo Chambers updated the Board following her discussions with Sir Mike Richards to confirm that there would be a measured approach to the way in which the current acute hospital inspection model would be adjusted for specialist hospitals. A fewer number of inspectors would attend for fewer days reflecting that not all 8 service areas were applicable. It was also recognised that the CQC are still in a learning phase and the purpose of the pilot inspection sites is to test and develop the approaches; it is likely therefore that suggested changes might be made after this first round of inspections. The rating will be placed in the public domain and is an important judgement on the Trust, however, Mrs Chambers was reassured by the approach outlined by Sir Mike Richards. **2 Strategy Development – Stakeholder Engagement** As part of the Trust's strategy refresh a number of stakeholder engagement activities have been undertaken which culminated in a large scale event on 25 April involving over 100 participants comprising governors, staff, commissioners, partner organisations, patient groups and board members. This	

would be further reflected upon in the workshop to be held immediately after the Board. The evaluations had been majority positive.

Tim Pile felt it was a fantastic step forward in terms of eliciting opinions from a wide spectrum of people and the strategy will now be stronger as a result. Frances Kirkham concurred that it had been a good and positive day.

3 Executive Management Team – March 2014

The Board noted the key points to note from April's Executive Management Team meeting.

- Care Quality Commission meeting with the Specialist Orthopaedic Alliance
- The annual Quality Account draft was reviewed and discussed, noting the need for the 2014/15 quality improvement initiatives to be clearly embedded in normal working practice.
- A review and update on the corporate performance report, the patient quality report and workforce report. Updates from the Clinical and IM&T Programme Boards were also received.

The following decisions and approvals were made:

MRI Scanner – the business case to bring additional MRI scan capacity on-site, together with the quality enhancement of in-house reporting had been approved. It was highlighted that this was a case of listening to concerns from our clinicians about the variability of reporting through an external contract and taking action, albeit with a quality premium, but responding to ensure greater confidence and timeliness of reporting. The additional capacity will reduce waiting times for patients. This would be in place by Autumn following building the pad as its base and ensuring services are connected.

The **2014/15 business planning bids** that advanced from round 1 to round 2 were received as outline business cases.
Priority had been given to investment in:
- senior nurse capacity to support the implementation of the recommendations arising from the Robert Francis report into the failings at Stafford Hospital,

and making a 4th matron post substantive;
- oincreasing diagnostic and therapies capacity;
- oimplementing the Friends and Family Test, which is a national requirement;
- oinvestment to support staff involvement in creating change;
- oinvestment in a workforce analyst;
- oproject manager for IM&T in recognition of the considerable work involved in accelerating the Trust's ambition for improved systems and information.

- A number of other schemes were to be progressed where further work is required to identify the potential to be self-funding service improvements, or where there is a longer timeline for potential implementation.
- The Major Incident Plan, the Hospital Evacuation and Shelter Plan and the Road Fuel Shortage Plan were all approved.
- The Patient Access policy was approved.
- The Study Leave policy was approved.
- The Harassment and Bullying policy was approved.

Frances Kirkham asked if any board committees had scrutinised these and was advised that these had only been overseen by EMT as the committee of the Board with delegated authority for these particular policies. Mike Flaxman reminded colleagues that there was scrutiny of some policies by internal audit.

4 Monitor's Strategy 2014 - 2017

The Board noted that Monitor had recently published its own strategy for 2014 to 2017 which sets out the organisation's aims and priorities for the next three years. A central aim of the strategy is to "create a stable and coherent framework of incentives" to support innovation and sector redesign. ROH will need to pay more attention to service specifications. Paul Athey advised that he had attended a short notice meeting of specialist commissioners which had been called because NHS England had refuse to sign plans. The commissioners now had to work within resources and there was a national gap. National quality improvement schemes had been identified - using national benchmarking. The pressures will be greater for ROH in the longer term as most of the QIPP schemes relate to areas

	in which ROH does not operate. Block contracts may not be favourably viewed in the future and the situation means our specialist services will be under pressure for the future. **5 Specialist Orthopaedic Alliance** The Board noted that Royal Orthopaedic Hospital would host the next board meeting of the Specialist Orthopaedic Alliance (SOA), due to take place on 16 May 2014. There have been discussions about amending the governance arrangements of the SOA to reflect the changing membership and also the fact that some of the founder members are no longer stand-alone organisations but have become part of larger organisation. The CEO, MD and FD usually attend. Andrew Pearson and Paul Athey were unable to attend and **it was asked that the Deputy MD attend if at all possible.** Jo Chambers added that she was continuing to develop the Trust's external network and had met again with the CEO of Birmingham Children's Hospital which is a key strategic partner of the ROH and had an introductory meeting with the CEO of Heart of England Foundation Trust as well as the new chair of the Academic Health Science Network. These meetings would continue.	
04/14/56	**<u>Medical Director's Report</u>** Andrew Pearson introduced his report and gave more detail on the issues of clinical concern and work undertaken by the bone infection unit. The review noted some failures to adhere to all best practice standards – an example being that instrument trays were being kept in areas outside the laminar flow within the theatre. Work was underway to ensure greater and sustained levels of compliance. The issues in arthroplasty had given cause for concern but there did not appear to be an immediate need to use Bioquell, rather to again improve adherence to standards of best practice. Tim Pile urged speedy response to these issues (which were confirmed as a blip, rather than sustained lower performance). The work on ROH performance prepared by Professor Sir Tim Briggs had been well received (and challenged) by Trust executives and clinicians.	

	Tauny Southwood felt that the first items would have benefited from data – e.g. how many CDs were falling behind the desired standard and an indication of the numbers involved in having yet to sign off job plans. Frances Kirkham hoped to discuss the management role of CDs in more detail. She would also like to know what special and clever work was being done by clinicians and also what research activity. Elizabeth Mountford asked if Andrew Pearson needed support for gaining the data necessary to support quality enhancement. Andrew Pearson advised that data was more robust, but although some triangulation takes place (for example when a patient post-operatively goes to their GP with an infection issue) more could still be done. Helen Shoker commented that it was a real sign of a healthy team that clinicians themselves had spotted the issues and opened themselves to review. This is good news for the CQC. **The Board noted the report** which gave updates on clinical leadership, medical staffing resource, issues of clinical concern and external policy.	
04/14/57	**Medical Staff Committee Report** None received from meeting on April 25th although the Interim Chairman was in receipt of three letters.	
04/14/58	**Corporate Performance report (inc. CIP & RTT Rectification Plan)** PA reported a positive end to the year – not quite good enough to bring the Trust back to its plan , but only £200k short. The impairment in the accounts as a result of revaluation of the Day Care Unit was £2.6million (the building having already been in use for healthcare). CIP was short by £500K and this was indicative of the difficulties the Trust faces in taking out cash from services. There had been an over-performance on CCG contracts but an under performance on specialist contracts in outturn. Capital spend had been £1.4million under budget due to using space for additional ward capacity that would otherwise have been subject to investment. Mike Flaxman commented that it was a good, solid outturn. AM presented the data for March, which showed the Trust having done more work than since March 2011 (when the additional capacity of ward and theatre was available at BMI). Looking forward, as the pattern of work seemed to have changed, so the pattern of the organisation must change. Amanda Markall heralded lower performance in April due to bank holidays and planned theatre maintenance. Tim Pile	

	echoed the thanks and recognised that the quantum of sustained efforts and the challenge of maintaining such efforts. Mike Flaxman noted that the numbers for paediatric bed occupancy had changed and Paul Athey explained that the calculation methodology had been reviewed following comments at the last Board meeting. HS commented that the temporary environment was much better than the ward from which children had been decanted and that occupancy at the highest level would not be commended as best practice in a temporary environment. Amanda Markall made special note that the food satisfaction rate was now 98.20% in March and 89.08% for the year. **Tauny Southwood suggested that the feedback from oncology patients should be considered as their response to taste is altered**. This could be possible using the Friends and Family test data from the oncology ward. Amanda Markall noted that the activity target for admitted referral to treatment had not been achieved for the fifth month, but she felt that this would be met in April 2014as the backlog was now within the accepted tolerance. **Tim Pile asked that all board members give feedback on what they would like to change or add to in the CPR for next year.** .	**JS**
04/14/59	**<u>The Patient Quality Report</u>** Helen Shoker introduced the report and asked for comment. Tauny Southwood felt that the change in reporting was welcomed. Mike Flaxman felt that the legal development work was a really good initiative. Elizabeth Mountford felt it was a good example of us learning from an issue after having transparently discussed something and having subsequently identified a future solution. Frances Kirkham asked how the Trust intended tackling the lower than hoped for PROMs score on knees would be dealt with. Andy Pearson advised that Nikki Mason was working with the knee surgeons to offer enhanced physiotherapy and they were also considering changing length of stay as possible support mechanisms for improved outcomes.	
04/14/60	**<u>Staff Engagement</u>** Anne Cholmondeley gave a presentation to the Board which augmented the paper which had been circulated. She used the presentation to highlight issues of engagement, development, valuing people and alignment of skills and capabilities to business needs. There was significant support for the ideas presented, with concern expressed about singling out individual staff groups for special treatment. Discussion followed regarding the need to treat everyone with consistency, the need for active listening (without which engagement is hard)	

	and the need to define the parameters of empowerment because the organisation needs to remain compliant with the regulatory framework. It was also recognised that engagement approaches would benefit from being tailored to the different staff groups that existed within the Trust. Tim Pile felt that there was a debate to be had about values where he felt that it has to start at the Board which must develop the values and demonstrate the delivery of them. Tauny Southwood felt it would be really helpful to find a way of identifying the visionaries within the organisation – although he did not have a concrete idea of how the Trust could do that .Anne Cholmondeley felt that it was equally good to see everyday staff deliver small items of individual change.	
04/14/	**<u>Quarterly Workforce report</u>** Anne Cholmondeley presented her report and advised that the development funding from charitable funds for bands 1-4 was being used already. Appraisal and Mandatory training being linked to pay progression has improved take up of training. Unite and Unison will be considering industrial action following the pay review. Elizabeth Mountford asked if the Trust was working with union representatives to mitigate impact and Anne Cholmondeley advised that this was underway. The staff friends and family test will be run by an external provider. Frances Kirkham welcomed the forward looking quarter one priorities and commended this as an approach.	
04/14/61	**<u>Board Assurance framework</u>** Helen Shoker presented the BAF. Appendix 2 gives additional information on risks and offers an update on the previous position, providing a greater level of detail for the Board to receive assurance about how risks are being managed. The executive team is undertaking work to develop the detail still further. The board agreed that Board committees could take risks off rather than them stay on the BAF. Jo Chambers felt that the next stage of development for the BAF was to consider the big external risks and strategic risks, which may be encapsulated in the eight high level themes, but may also include others. Further work is necessary to identify and scope these risks for inclusion in the next BAF. **BAF to come back to the Board in two months' time.**	**HS**
04/14/62	**<u>Quarterly Governance Declaration</u>** The Board approved the following submissions to Monitor:	

	For Finance that: The Board anticipates that the Trust will continue to maintain a Continuity of Services risk rating of at least 3 over the next 12 months. *For Governance that:* **"The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.**	
04/14/63	**<u>Review of Compliance with Monitor's Code of Governance</u>** The Board noted the new NHS Foundation Trust Code of Governance (the Code) which applies from 1January 2014. It was further noted that the provisions of the Code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of NHS Foundation Trust Condition 4 of the NHS provider licence (also known as the Governance condition). However, statutory requirements are highlighted within the Code, disclosure requirements are imposed and FTs are strongly encouraged to take full account of the provisions. It was noted that the Strategic Report and Director's Report within the Trust's Annual Report confirm compliance with the provisions of the Code. **The Board supported the actions:** **1.A1.6 Development of a Clinical Governance Strategy by September 2014** **2.A 4.2 New Chair and Interim Chair to devise a new process for regular meetings of NEDs without executives present.** **3.A5.10 NED appraisals to be considered and process agreed with governors by June 2014** **4.B4.1 Governor and Director Induction Pack to be reviewed** **5.B4.2 Director development needs to be reviewed by new Chair as appropriate** **6.B6.1 New Chair to identify how evaluation of the Board, committees and Directors should be**	**HS/JS** **YB/TP** **YB/JS/Alan Last** **JS** **YB** **YB**

	undertaken ready for 2015 Annual report **7.B6.2 Commission an external governance review by end October 2014** **8.E1.1 In addition to the development of a public. Patient and stakeholder policy, the Board should consider its role in engagement (in support of Trust strategy) by September 2014**	**YB/JC** **YB/JC**
04/14/64	**<u>Ward Review - Safe Staffing</u>** The board noted the summary of the Trust's range of considerations in order to provide assurance that its wards were properly staffed and its patients safe. All wards are gathering data from April, reviewing day to day and then reporting, in arrears, through EMT. Reports will come to the Board from May. **Trust Board members agreed to:** • **familiarise themselves with the national agenda drivers and the purpose of this ongoing work.** • **note the existing and planned work being undertaken across our ward teams and Nursing project group** •**support the work of the Matrons and Director of Nursing/Deputy Director of Nursing.** **Board members were encouraged to meet with Helen Shoker or Lisa Pim to discuss things.** Helen Shoker expressed thanks for the investment in nursing which allows substantive appointment to the fourth matron; support for supervisory time for senior sisters to be with their teams and patients, offering leadership support, resolving complaints as and when and talking to families; a supernumerary bleep holder for weekends offering senior clinical leadership (this was previously a role allocated to an on duty staff member with on-ward duties). This investment of over £300k will help support delivery of the recommendations arising from the Robert Francis report recommendations and the investment exceeds the uplift included within the tariff for 2014/15 to deliver Francis recommendations.	**All**
04/14/65	**<u>Audit Committee Report</u>** Mike Flaxman introduced the report of the meeting held on 17th April 2014. • The early draft annual accounts were presented, and the main themes were discussed including impairments and the changes required by the 2013/14 Annual Reporting Manual.	

	The Trust's very strong liquidity position was noted. Progress in drafting the Annual Report was also noted. • The draft quality account was presented, and the main themes were discussed. The Quality Improvement priorities for 2014/15 were noted. • Internal Audit progress was noted, with only 1 planned audit report on Best Practice Tariffs for 13/14 outstanding. • Progress against previous Internal Audit and Counter Fraud recommendations were reviewed. The committee asked for particular assurance that CQC audit actions were being reviewed more rapidly than suggested in light of the forthcoming inspection. • Audit Committee were updated on progress against the 18 week audit recommendations, and were satisfied that appropriate steps were being taken to address the concerns raised. • The updated Board Assurance Framework and process was presented to the Audit Committee prior to report to the Board. After some debate around the supporting or lead committee structure, the committee agreed that the process was well structured, clear and should be adopted by the Trust Board subject to Board comment and regular review. **It was agreed that draft accounts would be circulated as soon as possible to all board members who should respond to Paul Athey as appropriate.** **The Board noted the Audit Committee report.**	**All/PA**
04/14/66	**Clinical Governance Committee** No meeting held but Helen Shoker and Tauny Southwood had developed a workplan and circulated it.	
04/14/67	**Remuneration Committee** No meeting	
04/14/68	**Charitable Funds committee** No meeting.	
04/14/69	**Any Other Business** Frances Kirkham asked for an update on IT and Paul Athey advised that many meetings had taken place and the draft strategy would come to the Board in June.	
Date and Time of Next Trust Board Meeting May 23rd 2014 at 12.30pm 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 MEETING
TO BE HELD ON
WEDNESDAY 30TH APRIL 2014,
8.30AM – 12.00 NOON IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
04/14/51	**Apologies & Welcomes** Chairman		To Note	
04/14/52	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
04/14/53	**Minutes of Public Board Meeting held on the March 26th 2014** Chairman		For Approval	Enc. 1
04/14/54	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
04/14/55	**Chairman & NED update** Chairman		For Assurance	Verbal
04/14/56	**Chief Executive's Report** Chief Executive Officer		For Assurance	Enc. 3
04/14/57	**Medical Director's Report** Medical Director		For Assurance	Enc. 4
	Performance Management / Assurance Reports			
04/14/58	**Corporate Performance Report (inc CIP & clinical Programme Board)** Director of Finance		For Assurance	Enc. 5
04/14/59	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 6
04/14/60	**Staff Engagement** Director of Workforce & OD		For Assurance	Enc. 7
04/14/61	**Quarterly Workforce** Director of Workforce & OD		For Assurance	Enc. 8
04/14/62	**Board Assurance framework** Director of Nursing & Governance		For Assurance	Enc. 9
04/14/63	**Quarterly Governance Declaration** Company Secretary		For Assurance	Enc.10
	Strategy			
04/14/64	**To be discussed at workshop**		For Assurance	

	Board Committees			
04/14/65	**Audit Committee report** Director of Finance		For Assurance	Enc. 11(to be tabled)
04/14/66	**Remuneration Committee**	No Meeting held		
04/14/67	**Charitable Funds Committee**	No Meeting held		
04/14/68	**Clinical Governance Committee** Director of Nursing & Governance		For assurance	verbal
04/14/69	**Any Other Business**			
04/14/70	**Review of Compliance with Monitors – Code of Governance** Company Secretary			Enc. 12
04/14/71	**Ward review – Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 13
	Date of Next Meeting: **Friday 23rd May 12.30pm – 4.30pm Joint Trust Board & Council Of Governors**			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enclosure 1

Minutes of the Trust Board Meeting
held in public on Wednesday 26th March 2014 in the Boardroom

Present:
Trust Board
Mr Tim Pile, (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director
Mr Mike Flaxman, Interim Non-Executive Director

In attendance:
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development

Agenda No.	Agenda Item	ACTION
03/14/35	**Apologies and welcomes** There were apologies from Mr Andrew Pearson Welcome to Mike Flaxman as interim Chair of Audit Committee	
03/14/36	**Declarations of Interest** No other Declarations of Interest than those registered previously	
03/11/37	**Minutes of the Trust Board meeting held on 26th February 2014** The minutes were approved as a correct record subject to removal of Andy Meehan being recorded as having attended. Include standing item on board member visits to be added to agenda. AP to report on commercial tissue requests.	
03/14/38	**Action Points** The action notes were updated (see separate sheet). 07/13/1447 – Andrew Pearson was asked to provide an update at the next meeting.	
03/14/39	**Chairman's Report** Tim Pile deferred to the CEO.	

03/14/40	**<u>Chief Executive's Report</u>** JC introduced her report and outlined the forthcoming stakeholder strategy day. To support the Board in developing the 5 year strategy. Anne Cholmondeley underlined the importance of using April 25th as a means of staff engagement following on from the MSB work. MSB follow-on work had included communications such as two way core brief, greater visibility of staff, effective management of known under-performers. HR had introduced more electronic work and had simplified some of its transactional processes. Staff still welcomed and felt ongoing need for greater engagement and opportunities such as the stakeholder day were extremely valuable. JC confirmed that it was work in progress but the five year strategy would be really supported at this event. **EM commented that having made an investment of £40k to secure external support on staff engagement and felt that the Board should see a direct connection between the investment and the activity being undertaken. TP felt that the engagement strategy needed to be owned by the organisation. This should be one of the strategic themes brought to the board. It was agreed that there be a report to the board in April to consider how best to continue delivering leverage from that investment.** Jo Chambers drew attention to the EMT decision to bring an additional MRI scanner on site. Roger Tillman added that a new radiologist had been appointed this week. Tim Pile had been part of the appointment panel and felt the appointee had been extremely impressive. Monitor feedback confirmed the trust as having a green rating for governance (despite the trust's failure to meet targets, but because strong plans were in place) and a rating of 4 for finance (the highest rating). Jo Chambers confirmed that among senior NHS staff, there was concern that the real financial pressures would hit in the next financial year rather than in 2015/16. In comparison to many organisations, ROH had a relatively strong position because of its financial situation – having money to invest. Tauny Southwood asked if this was the right time to invest and it was agreed that it was, but that communication required careful handling.	**Anne Cholmondeley**

03/14/41	**<u>Medical Staff Committee Report</u>** Roger Tillman introduced the report. The issue of mobile phone usage in theatres was discussed. Helen Shoker advised that both she and Andrew Pearson had raised these issues with non-medical theatre staff (for whom mobile phone use was deemed inappropriate, having been witnessed by patients). Tim Pile felt that patient confidentiality was the key issue. Helen Shoker felt this was a matter of both common sense and professionalism. Anne Cholmondeley suggested reminding staff of the policy but also commented that staff still felt that not all were treated equally. Helen Shoker raised the issue of whether it remained appropriate for a single interest staff group to have direct access to the board on such issues. Frances Kirkham commented that this was a matter of managing staff within the existing policy. Tim Pile raised the issue of communication channels between MSC and the Trust Board. Anne Cholmondeley advised that in the past the Chair or CEO had given necessary feedback on matters. **It was agreed that feedback would be best given verbally to MSC and the CEO and Chair would meet the Chair of MSC.** Amanda Markall asked whether the MSC report to Board was circulated to MSC members and Roger Tillman said he thought not but that he would suggest this to the MSC Chair.	**Tim Pile/Jo Chambers**
03/14/42	**<u>Annual Plan</u>** Jo Chambers introduced the plan and asked the board to note that additional narrative was to be introduced on staff engagement. Tauny Southwood felt that it was lacking prioritisation but recognised that this was work in progress. It was agreed that the following dimensions be added: • Refreshing an existing strategy •Business as usual in contract for year one •The key strands we believe support our five year strategy -the agenda –right up front in the document It was noted that there remained a significant gap in terms of our definition of orthopaedic excellence in clinical terms. **The Board approved the plan for submission, subject to these amendments, but asked that it be circulated to the board prior to the submission.** The Board then considered the declaration it wished to make on governance – meeting the key national targets. Amanda Markall confirmed that, despite the failure to meet	

	targets in the last quarter, she felt that the trust was now in a good position to confirm that the trust would meet its targets. This was recognised as a challenge, mitigations such as appointing a lead to oversee the 18 week referral to treatment targets were being put in place. Cancer targets would always be hard to guarantee delivery on because numbers were variable and quite low. Frances Kirkham felt that recent experience did not give comfort. PA referred to the numbers in the corporate performance report which suggest the trust is moving forward and is, for example, reducing its backlog. Paul Athey raised the issue of the CDiff target which for 2014/15 was zero. **The Board discussed in detail the governance declaration required for the delivery of targets and on the basis that the plans, governance and engagement arrangements were in place and acknowledging the concerns about the as yet unknown requirements of year two, the Board felt it appropriate to confirm that it would meet all targets for the life of the plan.** It was suggested that Amanda Markall and Frances Kirkham raise the issue on behalf of the board, of consultant annual leave at an MSC meeting.	**Amanda Markall/Frances Kirkham**
03/14/43	**<u>Budget Approval 2014-16</u>** Paul Athey introduced the budget. Key issues were the establishment of a transformation fund. Contracts with Wes Midlands CCGs were signed and contracts agreed with specialist commissioners. The trust would need to deliver 3.8% growth. The CIP plans were not as robust as would have been liked and this resents a significant risk. Nonetheless, directorates were working hard on both cost-saving and growth elements of CIPs. The risk of contractual penalties was greater in 2014/15 and this had been provided for in the budget. The capital plan was for five years with room to amend as years progressed. The assumption that a second MRI scanner would be procured in year two. Elizabeth Mountford asked if staff found it difficult to think two years ahead rather than in the present. Paul Athey said this was a challenge and that they were now being asked to look at the gap analysis between now and the end of the period to allow them to think about the transition. Mike Flaxman noted that there were funds in reserve to mitigate CIPs and felt that some of that might be held back until the CIPs were being delivered.	

	Elizabeth Mountford noted that there was a saving allocated to sickness and she asked if the organisation was clear about how this would be delivered. Paul Athey advised that it was based on assumptions that existing initiatives would deliver these benefits. Helen Shoker gave an example of work being applied in ROH that HEFT had tried and found successful. Mike Flaxman commented that the first two years of the capital plan was well worked out. The deliverability of the subsequent three years had been questioned and he had received some assurances from Paul Athey. Tim Pile had expected to see a cashflow forecast and Paul Athey explained that there were spreadsheets from Monitor behind this and that in future cashflow would be reported. **The Board approved the 2014/15 revenue plan** **The Board approved the 5 year capital plan** **The Board supported the planned mitigations if a downside scenario occurs** **It was further agreed that more detailed on finance would be needed in the next year including on CIPs.**	
03/14/44	**<u>Corporate Performance report (inc. CIP & RTT Rectification Plan)</u>** Amanda Markall confirmed that performance in February had been very good and was ahead of plan and just below the rectification plan. Case mix had been reviewed and there had been a 3-5% shift in day case work on a monthly basis and this work will continue. Operations team and informatics are working together on an 18 week programme board. The trust had failed to meet its admitted target but the backlog had now reduced to a comfortable level. One patient had been identified as now having waited over 52 weeks for treatment. Over-performance across all areas had been achieved for the first time and theatre utilisation had been much improved. Elizabeth Mountford asked whether the position was now stabilised and Amanda Markall replied that it had not – the extra Saturdays would reduce to two a month and the review of capacity in week in theatres was underway. Average length of stay has risen and this is now being reviewed. Tim Pile asked that the detail of avoidable and unavoidable cancellations be included. Mike Flaxman felt that occupancy on paediatrics was extremely low. Amanda Markall advised that there had been underperformance	

	throughout the year and work with the Children's Hospital to develop a proper strategy was underway. **Frances Kirkham asked that a report on paediatrics be given to a future meeting.** Tauny Southwood confirmed that there were insufficient paediatric orthopaedic surgeons. Helen Shoker also advised that in future the Board would see a report on acuity which would show nursing levels. Paul Athey reported that the gap in surplus anticipated as a result of mid-year under-performance had been closed in February. Likely year-end outturn would be c £2million surplus. **Tim Pile asked that the outturn graphs of the previous year be added to offer a comparison**. Anne Cholmondeley advised that there had been some improvement in mandatory training and appraisal training. The commissioner targets in these areas have now been acknowledged as having been very high and this has been changed for next year. Frances Kirkham asked if we knew how we compared with other trusts for sickness and Anne Cholmondeley advised we were about 1% above for sickness.	**Amanda Markall** **Paul Athey**
03/14/45	**<u>The Patient Quality Report</u>** Helen Shoker introduced the report and overall the trust was very safe. The increase in falls was not associated with areas under undue pressure as a result of the rectification plan. The trust had met its CDIff target and there would be a major challenge in 2014/15 when the target dropped to zero. It was felt that the discrimination between avoid able and unavoidable would be useful. The infection prevention quality assessment and improvement tool will be implemented in place of the saving lives tool. ROH will trial this. WHO checklist compliance was good and this will be further developed. Friends and Family test had secured a higher number of responses. NJR compliance had risen but there had been some issues which were being addressed. Roger Tillman had attended a national meeting on NJR and felt ROH was in a good position.	
03/14/46	**<u>Board Assurance framework</u>** Helen Shoker circulated an updated BAF committee ownership list and explained that there was still work to do	

	on causes and consequences. The lead committee 'owns' the key impact of the risk and will refer to other committees as necessary. Tauny Southwood felt this was now much clearer. The risk on staff engagement was identified as something that may need further discussion. Tauny Southwood felt that EMT did not benefit from the challenge of non-executives and Jo Chambers felt that, as accountable officer, she was in a position to oversee and refer to the board as necessary. Tim Pile felt that any important matters should be raised at the Board. There remained concern that the staff engagement and workforce agenda be covered. **Staff engagement and organisational development should be the responsibility of EMT.** **Jo Chambers felt that the Board would need to see information on risk mitigation in more detail in future.**	**Helen Shoker**
03/14/47	**<u>Trust Annual Equality Report 2014</u>** **The Board received the updated report and, having included one word change suggested by Elizabeth Mountford, this was now approved for publication**.	**Anne Cholmondeley**
03/14/48	**<u>Trust Response to The Francis Report</u>** The Board would have a short workshop on the afternoon of the Board meeting. It was important to develop a local response to Francis which was a part of routine business, done because it **The Board noted the high level summary of actions to date and gaps**.	
03/14/49	**<u>Audit Committee Report</u>** Mike Flaxman introduced the report and explained that the internal audit report had been very good. The internal audit plan was also approved. In terms of the recommendations to improve process with regard to RTT, 8 of 10 recommendations had already been implemented. The BAF had been discussed. There had been some technical discussions among which the conclusion was that the trust was a single entity; the trust was a going concern with some concerns for the future – the middle option. Elizabeth Mountford complemented Mike Flaxman on holding the external auditors to account and explaining things easily. Tim Pile asked if it could be checked whether the CEO was not able to attend the Audit Committee as he felt they should be in attendance. Joy Street advised that recent best practice publications for NHS FT Boards confirmed that CEOs should not be members of Audit Committee but	

	might be invited from time to time as accountable officers.	
	Clinical Governance No meeting	
	Remuneration Committee No meeting	
	Charitable Funds committee Agreed to spend £80k on a playroom and some other ideas from the Director of Nursing. The chair had confirmed to members that , were funds not to be spent, thee option to transfer them might be exercised. Paul Athey had prepared a draft 5 year plan which has since been revised. Fund holders had been asked to give their ideas but had received a poor response. Ideas for suggested themes would be welcome. Tim Pile suggested that the pursuit of excellence within the strategy could guide the use of funds. Tim Pile felt the Trust should raise funds for specific projects.	
03/14/50	**Any Other Business** Frances Kirkham had heard a radio programme about a very nasty infection now prevalent in Europe. Helen Shoker advised that this had been discussed at Infection Control and this may then go up to CGC. Would like a presentation from doctors on the clever things they are doing Tauny Southwood felt that other staff should be encouraged to do this, may be at TBALD. Elizabeth Mountford asked what the expectations for attendance at governors' meetings and was advised that NED attendance at governor meeting was as available or as specifically invited.	
Date and Time of Next Trust Board Meeting April 30th 2014 at 8.30am 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

Enclosure 2

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 26th March 2014

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
07/13/1447	Proposal for Option Appraisal Commercial Tissue Requests Process to be fully explained to theatre staff.	ED	Sep 2013		Outstanding. AP to contact ED and update in April 2014.
01/14/07	Corporate Performance Report & Programme Board Update EM asked that the compliance with annual leave policy be reviewed to identify the extent of breaching	AM/AC	April 2014 We agreed at last Trust Board this would be May given project won't be completed till April		
02/14/23 Chief Executive's Update (26.02.14)	The new Director of the West Midlands Academic Health Sciences Network (AHSN), Chris Parker, had presented an update on the establishment of this new entity**. It was agreed that TS, AP and Ed Davis meet with David Adams to revitalise the Trust's academic strategy.**	TS / AP/ Ed Davis	April / May 2014		
02/14/24 (26.02.14) Medical Directors Report	TS asked that AP consider preparing a more issues based report rather than listing meetings attended. FK asked for a more detailed	AP / AM	April 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	report on clinical directors**. It was agreed that AP and AM prepare something**				
03/14/40 Chief Executives Report (26.03.14)	EM commented that having made an investment of £40k to secure external support on staff engagement and felt that the Board should see a direct connection between the investment and the activity being undertaken. TP felt that the engagement strategy needed to be owned by the organisation. This should be one of the strategic themes brought to the board. It was agreed that there be a report to the board in April and a subsequent workshop to consider how best to continue delivering leverage from that investment.	AC			
03/14/41 Medical Staff Committee Report (26.03.14)	It was agreed that feedback would be best given verbally to MSC and the CEO and Chair would meet the Chair of MSC.	TP/JC	April 2014		
03/14/44 Corporate	FK asked that a report on	AM	April 2014		To be handled as part of Strategy Development

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
Performance Report (26.03.14)	paediatrics be given to a future meeting.				
03/14/46 Board Assurance Framework (26.03/14)	Staff engagement should be EMT and it was considered that Monitor License be with Monitor. JC felt that the Board needed to see information on risk mitigation in more detail.	HS	April 2014		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 April 2014 **Enclosure Number: 4**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Chief Executive's Report**

SUMMARY

To update the Board on national and local issues.

IMPLICATIONS

To ensure Board members are aware of the context and policy framework in which the Trust is operating, to support and inform the development of strategy and Board oversight of performance.

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update the Board on national and local issues.
Recommendation	The Board is asked to note the contents of the report and discuss items as appropriate.

This report provides Board members with an overview of key issues in relation to the Trust.

1 Care Quality Commission Update – New Inspection Regime

The Trust has been notified that it will receive a new style inspection commencing on 2 June 2014 as one of two pilots for specialist orthopaedic hospital, the other being the Royal National Orthopaedic Hospital in Stanmore.

The Care Quality Commission (CQC) has been testing its general approach to inspections with a number of acute hospitals and is in the process of adapting this for specialist organisations. On 8 March there was a collaborative event held between members of the Specialist Orthopaedic Alliance (SOA) and the CQC to discuss which criteria might apply to specialist orthopaedic hospitals to enable a more comprehensive assessment than can be applied across a range of specialities in a general acute hospital.

A follow up discussion is being arranged between the two CEOs and the Chief Inspector of Hospitals to discuss how these 'deep dive' assessments will be calibrated to ensure consistency of the ratings applied if the methodology is different.

The inspection will provide a rating in each of five domains and an overall trust rating of outstanding, good, requires improvement or inadequate. The five domains are:

- Safe
- Effective
- Caring
- Responsive
- Well-led

2 Strategy Development – Stakeholder Engagement

As part of the Trust's strategy refresh a number of stakeholder engagement activities have been undertaken which culminates in a large scale event on 25 April involving over 100 participants comprising governors, staff, commissioners, partner organisations, patient groups and board members. This interactive event will provide a range of perspectives that the board will be able to consider, alongside the policy context, in determining the final shape of the strategic direction over the next 5

years. The feedback from the event will be considered in workshop session to enable final assessment of strategic goals and priorities going forward. The final submission to Monitor is due on 30 June.

In support of this work and the development of our staff engagement approaches a number of initiatives have been introduced into the Trust. On 5 April a group of senior consultants and the executive team attended a workshop on 'developing a collaborative culture'. Additionally, three reference groups (consultant, clinical and non-clinical) have been established to enable staff to participate in the development of our strategic themes and priorities, which has helped to shape the strategic themes and priorities going into the stakeholder engagement event. The Clinical Directors have also had an opportunity to contribute to the discussion about service developments going forward, which will help to define our clinical strategy.

3 Executive Management Team – March 2014

Key points to note from this month's Executive Management Team meeting, held on 23 April, are:

- Chief Executive's update including feedback on the Care Quality Commission meeting with the Specialist Orthopaedic Alliance on the forthcoming pilot inspection of specialist trusts, and an update on the strategy development work.
- The annual Quality Account draft was reviewed and discussed, noting the need for the 2014/15 quality improvement initiatives to be clearly embedded in normal working practice.
- A review and update on the corporate performance report, the patient quality report and workforce report. Updates from the Clinical and IM&T Programme Boards were also received.

The following decisions and approvals were made:

- **MRI Scanner** – the business case to bring additional MRI scan capacity on-site, together with in-house reporting was approved. There is an additional cost of £49,000 to achieve this improvement which will provide greater assurance regarding the quality and consistency of reporting, ease of transferring records into the ROH patient records and increase capacity to meet demand and reduce waiting times for patients.
- The **2014/15 business planning bids** that advanced from round 1 to round 2 were received as outline business cases. The costs of all bids exceeded the development reserve available and were prioritised and approved to the level set aside for this purpose. There were two pre-commitments against the reserve for a consultant radiologist (succession planning overlap) and marketing. Additionally, priority has been given to investment in:
    - senior nurse capacity to support the implementation of the recommendations arising from the Robert Francis report into the failings at Stafford Hospital, and making a 4th matron post substantive;
    - increasing diagnostic and therapies capacity;
    - implementing the Friends and Family Test, which is a national requirement;

    - investment to support staff involvement in creating change;
    - investment in a workforce analyst;
    - project manager for IM&T in recognition of the considerable work involved in accelerating the Trust's ambition for improved systems and information.

- A number of other schemes will be progressed where further work is required to identify the potential to be self-funding service improvements, or where there is a longer timeline for potential implementation.
- The Major Incident Plan, the Hospital Evacuation and Shelter Plan and the Road Fuel Shortage Plan were all approved.
- The Patient Access policy was approved.
- The Study Leave policy was approved.
- The Harassment and Bullying policy was approved.

4 Monitor's Strategy 2014 - 2017

Monitor has recently published its strategy for 2014 to 2017 which sets out the organisation's aims and priorities for the next three years. A central aim of the strategy is to "create a stable and coherent framework of incentives" to support innovation and sector redesign.

Some of the main commitments in the strategy are:

- Truly reflect the efficient costs of delivering good quality care
- Improve incentives for controlling activity growth
- Encourage commissioners to make effective use of the flexibilities available in the current national tariff
- Pursue a step change in the quality and use of data on cost, activity and outcomes that underpin the payments system
- Facilitate the debate about what changes to the provider landscape will meet changing patients' needs.

It is clear that in its extended role as system regulator Monitor will be looking to use its new powers to create strategic changes within the NHS. The Board will want to consider the national picture in its strategic discussions to ensure alignment of our strategy within a changing national context.

5 Specialist Orthopaedic Alliance

The Royal Orthopaedic Hospital is due to host the next board meeting of the Specialist Orthopaedic Alliance (SOA), due to take place on 16 May 2014. There have been discussions about amending the governance arrangements of the SOA to reflect the changing membership and also the fact that some of the founder members are no longer stand-alone organisations but have become part of larger organisation.

6 Conclusion

This paper provides a high level overview of the range of significant activities going on at a national and local level which will impact on how the Trust moves forward and develops its own strategic response.

It is clear that the NHS continues to be under pressure with demand and costs growing at a faster rate than growth in funding. Commissioners are significantly challenged financially and are looking for transformation and service redesign as a means of addressing the disparity; this will apply to locally commissioned services and specialist services.

The Trust must take account of this context when developing its strategy and seeking to continually improve its day to day activities.

7 Recommendation

The Board is asked to note the contents of this report and discuss as appropriate.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: 30th April 2014 **Enclosure Number: 4**

Medical Director's Report to Board
March-April 2014

This report gives an insight into a range of issues which are the current focus of my work as Medical Director.

1 Medical and Clinical Leadership within the Trust

The Trust has an established group of clinical directors leading the seven directorates. Although this system is functioning and, with the support of Matrons and Directorate Managers, business performance is now well monitored, I believe that we still have some way to go. There is still variation in engagement in corporate meetings and sometimes individuals show reluctance to hold a robust management line. I am working with the Director of Operations to ensure that we offer support when tough action is necessary and we are also making available leadership training. Nonetheless, for several postholders, their priority remains clinical practice and I am working with executive colleagues to identify ways in which we might better engage those who wish to have blended clinical and medical leadership roles. This may crystallise at the point when the trust makes any significant structural changes.

2 Maximising the use of medical staffing resource

In order to understand the capacity of the medical workforce and to drive the flexible allocation of that capacity, it is necessary to undertake robust job planning (this reviews fixed and floating sessions of clinical and non-clinical activity).
The process of job planning for all consultants, through the directorates, has been slow and arduous resulting in 'slippage' in getting signed off job plans. I believe much of this delay is due to the fact that this is the first time this has ever been done at the ROH and hence the engagement has been variable, coupled with equally variable leadership support from some CDs. I remain optimistic that this level of pain will be a one-off and that as this becomes routine and familiar, there will be much less resistance.

3 Clinical issues of concern and under investigation

Post-operative Spinal Deformity Infections
During March and April there have been 5 post-operative spinal deformity infections. This rate is highly unusual and sparked concern among spinal deformity surgeons. The issue is still under investigation, but so far the pattern suggests that infections have occurred when using theatres 1 and 5. All instances were the first case on a list; all were complex 'front & back' cases.

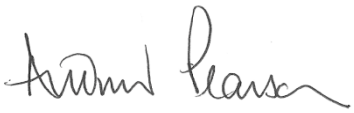
There is no pattern as regards surgeon and organism and no noted recent change in practice. Investigations will continue to try to identify a causal thread.

Readmissions in Arthroplasty as a result of Infection

6 joint replacement cases have been readmitted since early March 2013 with early deep infections. All initial operations took place within theatres 2, 6 and.9. Again an investigation is underway, together with reinforcement of infection control best practice. Consideration may be given to cleaning the affected theatres with Bioquell.

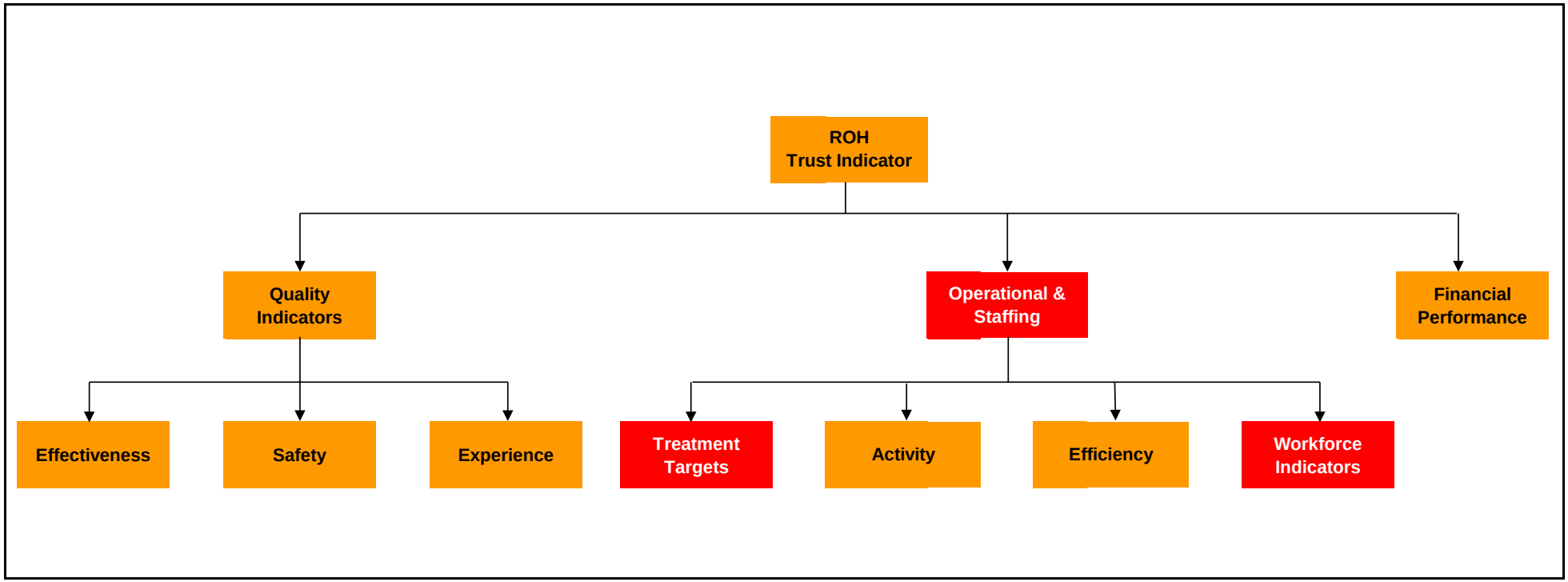
4 External policy

On Thursday April 24th, Professor Tim Briggs from the Royal National Orthopaedic Hospital gave a presentation to clinicians and executives on the results of his DOH commissioned work 'Getting it right first time'. This is a national study looking at performance data from all orthopaedic hospitals and departments and he presented the results for ROH - which were generally very good. There was discussion of the potential for hub and spoke networks of provision, standardisation of procedure and the development of additional doctors specializing in orthopaedics. It is hoped that, after his report is published in June, he might return to speak to a wider audience including the Board. The Executive Team will consider his ideas as part of their strategy development.



Andrew Pearson
23rd April 2014

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending March 2014



Monthly Report

Executive Summary as at March 2014

Headlines

For the month of March the Trust made a surplus before impairments of £524,000 compared to a planned surplus of £358,000. The Trust therefore has a year end surplus before impairments of £2,166,000, being £262,000 behind plan. Net impairments to I&E of £2.6m reduce the result reported to a deficit of £493k.

Backlog has decreased from 452 to 353 in month, and is it's lowest since June 2013

The Trust have met the non-admitted and incomplete RTT targets, but the admitted has been missed in month, and remains relatively static on prior month

Monitor Compliance Framework Targets	March 2014 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.01%	95.05%	0	6
Referral to treatment time - Admitted %	90%	88.37%	86.90%	1	6
Referral to treatment time - Incomplete Pathways %	92%	94.63%	93.52%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	100%*	95%	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%	1	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating					

* 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 Continuity of Service Rating	**4**

Key Trust Targets		March 2014 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	1		3
	Complaints	<=12	13		4
	CQUINS	100%	90%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<400	353		6
	Incomplete 14 - 18 Week Waiters	<450	413		6
	Total Discharged Elective Patients vs Plan	100%	92%		7
	Unused Theatre Sessions	<44	25		8
	Sickness	4.1%	4.7%		9
Financial	Surplus	£2,429	£2,149		10
	CIP	£2,831k	£2,504		10
	Agency Expenditure	£91k	£207k		11
	Locum Doctor Expenditure	£46k	£53k		11

Trust Summary

For the month of March the Trust made a surplus before impairments of £524,000 compared to a planned surplus of £358,000. The Trust therefore has a year end surplus before impairments of £2,166,000, being £262,000 behind plan. Net impairments to I&E of £2.6m reduce the result reported to a deficit of £493k.

Elective and non-elective activity has been lower than plan, after achieving plan in February, although overall activity levels were higher than both original and rectification plan.

Backlog has decreased from 452 to 353 in month, and is it's lowest since June 2013.

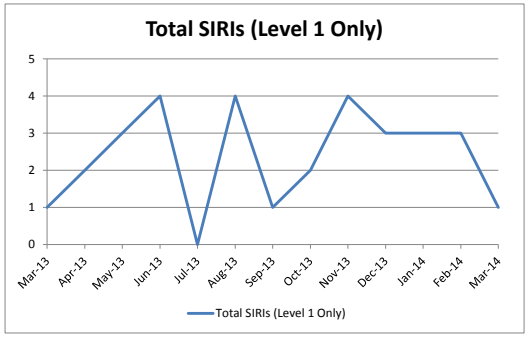
The Trust have met the non-admitted and incomplete RTT targets, but the admitted has been missed in month, and remains relatively static on prior month. Daily monitoring is taking place throughout April to ensure that all 3 RTT are achieved due to risks associated with this month (Easter, theatre maintenance and TBALD).

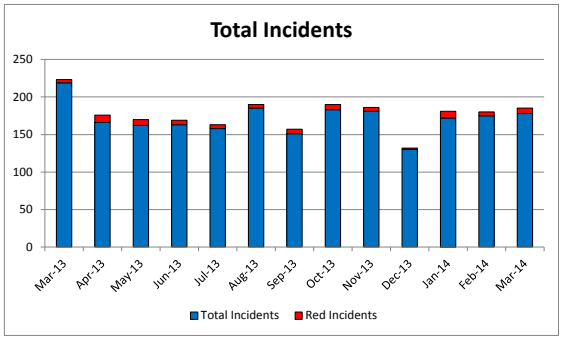
Quarterly Detailed Report
Safety Indicators as at March 2014

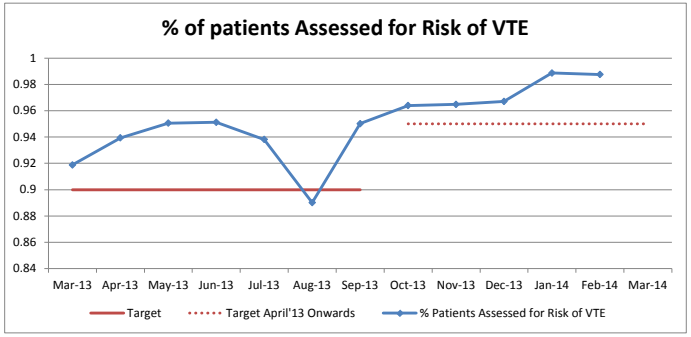
Headlines

- There has been a reduction in SIRIs from 3 in February to 1 in March.
- Falls have also reduced from 3 in February to 0 in March.
- The number of red incidents has increased from 5 to 7.

	Monitor	National	CQC Standard		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	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)	1	2	3	4	0	4	1	2	4	3	3	3	1	30
			4,16	SIRI per 1000 bed days	0.34	0.62	1.12	1.32	0.00	1.27	0.36	0.62	1.39	1.01	0.90	0.85	0.25	9.37
			4,16	Total Incidents	219	166	162	163	158	185	151	183	181	130	172	175	178	2004
			4,16	Incidents per 1000 bed days	74.19	51.83	60.23	53.95	47.07	58.96	54.12	56.82	62.70	43.61	51.71	49.30	43.65	625.76
			4,16	Red Incidents	4	10	8	6	5	5	6	7	5	2	9	5	7	75
			9,16	Total Drug Errors	66	31	21	15	15	23	18	21	16	8	11	18	18	215
			9,16	Drug Errors per 1000 bed days	22.36	9.68	7.81	4.96	4.47	7.33	6.45	6.52	5.54	2.68	3.31	5.07	4.41	67.14
		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	91.88%	93.94%	95.06%	95.13%	93.82%	89.02%	95.02%	96.40%	96.48%	96.71%	98.87%	98.76%		95.51%
			9	Incidence of Hospital Related VTE	1	0	0	1	1	0	1	1	0	1	1	1	1	8
			4	Patient Falls - Inpatients	7	4	7	6	4	9	2	4	8	6	3	6	0	59
			4	Patient Falls per 1000 bed days	2.37	1.25	2.60	1.99	1.19	2.87	0.72	1.24	2.77	2.01	0.90	1.69	0.00	18.42
			4,16	% Harm Free Care	93.26%	97.89%	96.19%	97.94%	98.90%	97.85%	98.70%	97.00%	98.90%	97.50%	97.41%	100.00%	97.71%	97.69%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

There has been 1 SIRI reported in month, compared to 3 in Feb.

There has been an increase in incidents reported in month to 178, although this is still largely in line with the usual pattern of incidents.

Patient falls have reduceed from 6 last month to 0 this month.

There have been 7 red incidents in month, compared to 5 in Feb.

Drug errors have remained static at 18, although this represents a lower rate of drug errors per 1000 bed days.

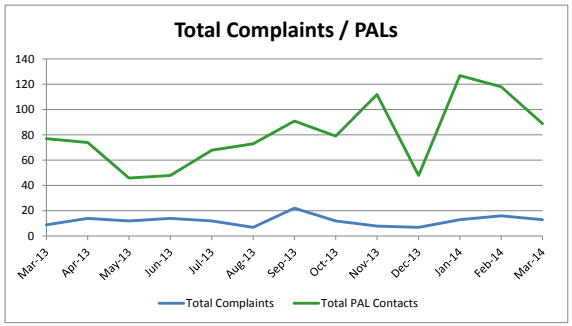
Additional information on all of the above is included in the Quality Report.

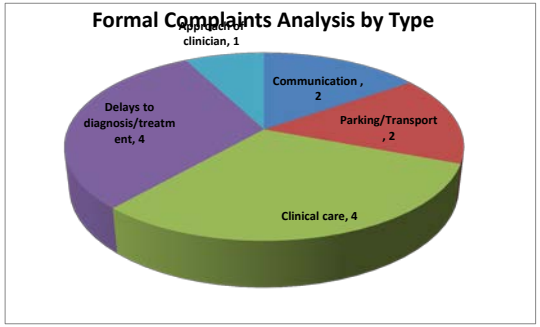
Quarterly Detailed Report
Experience Indicators as at March 2014

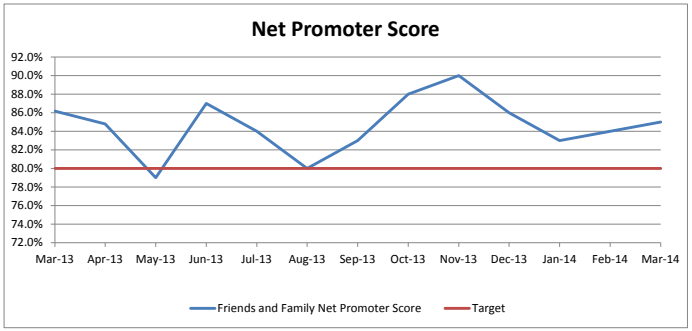
Headlines

- The number of complaints has reduced from 16 in February to 13 in March. All complaints received were formal. PALS contacts have also reduced from 118 to 89, a drop of 25%.
- 98.2% of patients liked their food, which is the highest rating the Trust have ever received on this metric.
- Compliments have increased from 439 in February to 552 in March (26% increase).

	Monitor	National	CQC Standard		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Full Year Position
Experience			17	Complaints to Complements Ratio	1:46	1:25	1:25	1:29	1:32	1:46	1:14	1:34	1:16	1:63	1:37	1:27	1:42	1:30
			17	Total Complaints	9	14	12	14	12	7	22	12	8	7	13	16	13	150
			17	Complaints reverted to informal <48 hrs	0	1	0	1	1	3	3	0	1	0	0	0	0	10
			17	Formal	9	13	12	13	11	4	19	12	7	7	13	16	13	140
			17	Complaints per 1000 bed days	3.05	4.37	4.46	4.63	3.57	2.23	7.89	3.73	2.77	2.35	3.91	4.51	3.19	46.84
			17	Total PAL Contacts	77	74	46	48	68	73	91	79	112	48	127	118	89	973
			17	PALS Contacts per 1000 bed days	26.08	23.11	17.10	15.89	20.26	23.27	32.62	24.53	38.80	16.10	38.18	33.24	21.82	303.83
			17	Total Compliments	414	347	295	404	386	320	298	409	124	440	481	439	552	4495
			17	Compliments per 1000 bed days	140.24	108.35	109.69	133.72	114.99	101.99	106.81	127.00	42.96	147.61	144.62	123.66	135.36	1403.60
				Food - Real Time Patient Survey	77.54%	77.50%	85.43%	86.67%	90.48%	92.40%	90.00%	90.60%	92.00%	96.60%	95.00%	93.00%	98.20%	89.08%
			17	Friends and Family Net Promoter Score	86.18%	84.8%	79.00%	87.0%	84.0%	80.0%	83.0%	88.0%	90.0%	86.0%	83.0%	84.0%	85.0%	80.00%







Experience Commentary

COMPLAINTS

13 complaints received (all formal) down from 16 last month. Most concerning was that most of the complaints were in relation to delays to diagnosis/treatment and clinical care.

PALS:

Number of contacts this month was 89, down from 118 in Feb.

COMPLIMENTS:

Number of compliments received this month is 552, up 26% on last month.
98.2% of patients liked their food, which is the highest rating the Trust have ever received on this metric.

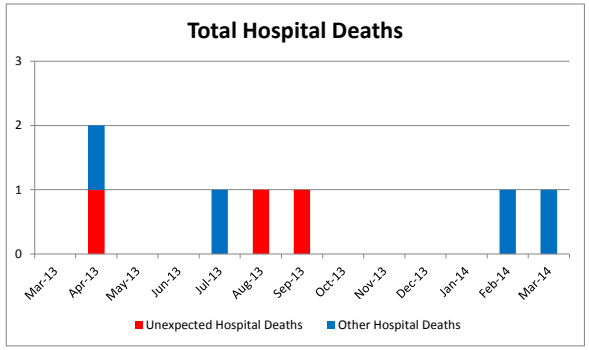
All of the above is discussed in further detail in the Quality Report.

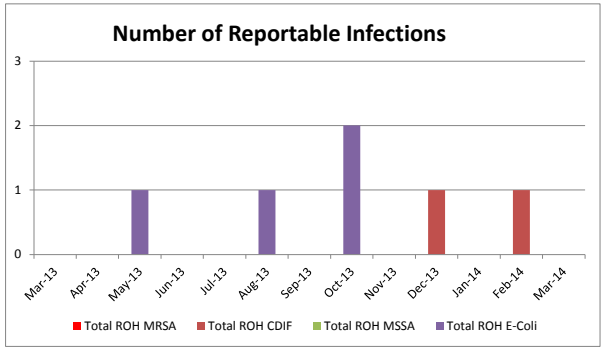
Quarterly Detailed Report
Effectiveness Indicators as at March 2014

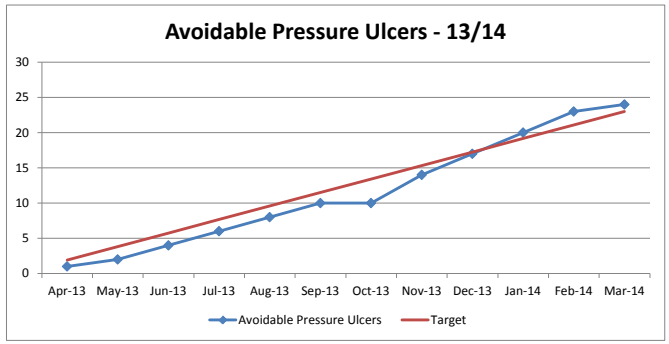
Headlines

- There were no reportable hospital acquired infections in month.
- There was a drop in grade 1 & 2 avoidable pressure ulcers (from 3 to 1).
- There was one expected death in month.

	Monitor	National	CQC Standard		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	2	0	0	1	1	1	0	0	0	0	1	1	7
			4,18	Hospital Deaths per 1000 bed days	0.00	0.62	0.00	0.00	0.30	0.32	0.36	0.00	0.00	0.00	0.00	0.28	0.25	0.18
			4,18	Unexpected Hospital Deaths	0	1	0	0	0	1	1	0	0	0	0	0	0	3
				Other Hospital Deaths	0	1	0	0	1	0	0	0	0	0	0	1	1	4
			8	MRSA % Screened	114.3%	129.56%	129.13%	140.59%	145.53%	127.51%	146.00%	132.00%	114.30%	100.10%	135.40%	102.00%	109.00%	124.14%
	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	1	0	1	0	2
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	1	0	0	1	0	2	0	0	0	0	0	4
			8	HCAIs not attributable to ROH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	1	1	0	2	1	0	0	0	5
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	5	1	1	2	2	1	1	0	2	2	3	3	1	24
			4	Avoidable Pressure Ulcers per 1000 bed days	1.60	0.31	0.37	0.66	0.60	0.64	2.51	0.00	1.39	1.01	0.90	0.85	0.25	0.79







Effectiveness Commentary

There was one death in month; this was an expected death of a patient.

There was 1 avoidable pressure ulcers of grade 1 or 2, down from 3 in the previous month. There were no grade 3 or 4 avoidable pressure ulcers in month. This is consistent with prior month.

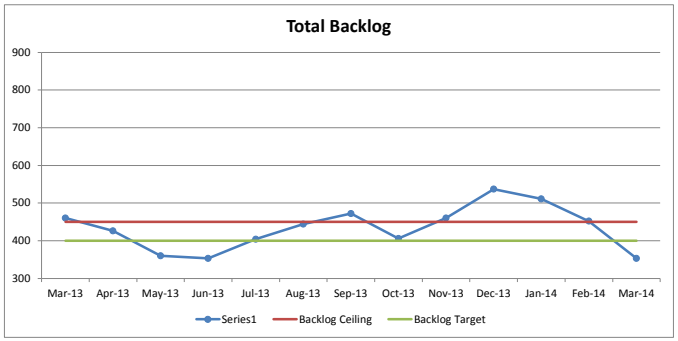
Further information on effectiveness is included in the Quality Report.

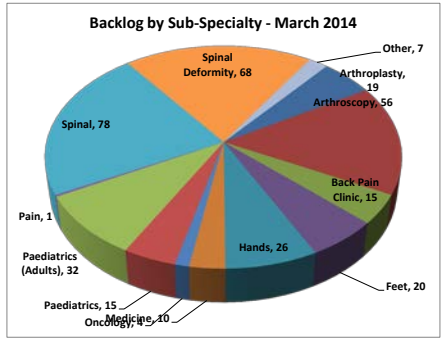
Quarterly Detailed Report
Treatment Targets as at March 2014

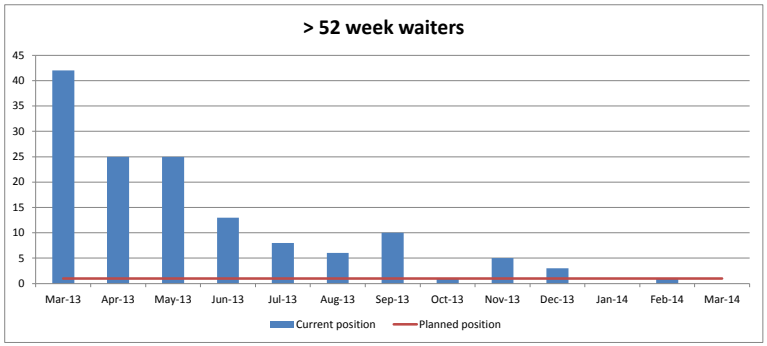
Headlines

- Backlog has decreased from 452 to 353 in month
- The Trust have met the non-admitted and incomplete RTT targets, but the admitted has been missed in month, and remains relatively static on prior month
- Draft cancer target results remain high.

	Monitor	National	CQC Standard		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	42	25	25	13	8	6	10	1	5	3	0	1	0	1
	M	N	4	Referral to treatment time - Non Admitted %	95.18%	95.24%	95.08%	95.35%	95.29%	95.78%	95.42%	95.24%	95.13%	95.12%	95.13%	95.00%	95.01%	95.24%
	M	N	4	Referral to treatment time - Admitted %	90.00%	90.22%	90.39%	91.37%	92.05%	90.33%	90.19%	90.09%	88.12%	83.25%	83.57%	88.76%	88.37%	89.05%
	M	N	4	Referral to treatment time - Incomplete Pathways %	92.01%	92.77%	94.36%	94.77%	94.18%	93.71%	93.34%	94.01%	93.33%	87.49%	92.71%	93.21%	94.63%	93.50%
			4	Non admitted Backlog - Pathways waiting >18 wks	187	155	121	110	131	159	163	160	167	259	260	199	151	149
			4	Admitted Backlog - Pathways waiting >18 wks	273	271	239	243	273	285	309	246	293	278	251	253	202	204
			4	Total Backlog - 18 week pathways waiting >18 wks	460	426	360	353	404	444	472	406	460	537	511	452	353	353
			4	Incomplete 14 -18 Week Waiters	535	388	411	504	477	630	654	565	640	721	721	520	413	475
	M	N	4	Cancer 2 week (all cancers)	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.0%	93.33%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	99.21%
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.0%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.0%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.0%	90.00%	100.00%	66.67%	80.00%	100%*	83.30%	100.00%	85.70%	66.70%	85.70%	100.00%	100.00%	88.75%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	100.00%	99.24%	100.00%	99.52%	99.20%	99.09%	99.70%	99.43%	99.36%	99.37%	98.90%	99.82%	99.57%	99.39%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	1	0	0	0	1
			1,21	Data Quality on Ethnic Group - Inpatients	91.99%	97.64%	95.29%	96.43%	94.86%	95.22%	98.35%	95.65%	95.70%	95.47%	96.19%	96.16%	95.48%	95.96%







Treatment Targets Commentary

The number of patients waiting over 52 weeks for March is 0, down from 1 in February.

18 week incomplete and non-admitted targets have been met, but the admitted target has been missed failed, in line with Montior and CCG discussions. Daily monitoring is taking place throughout April to ensure that all 3 RTT are achieved due to risks associated with this month (Easter, theatre maintenance and TBALD). Backlog has reduced significantly by 99 patients and is at its lowest since June 2013 at 353. This performance gives a potential trajectory of a backlog of c.300 by July.

Cancer, all targets achieved in month with quarterly position also achieved

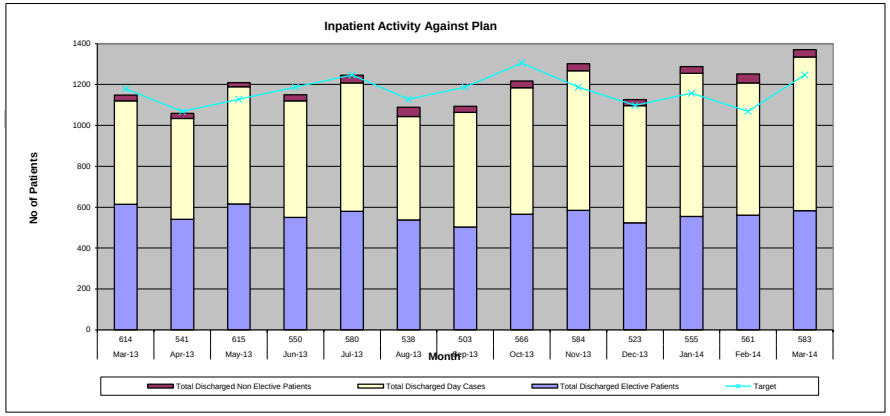
Over 99% of patients having their imaging within 6 weeks despite ongoing outsourcing of MRI.

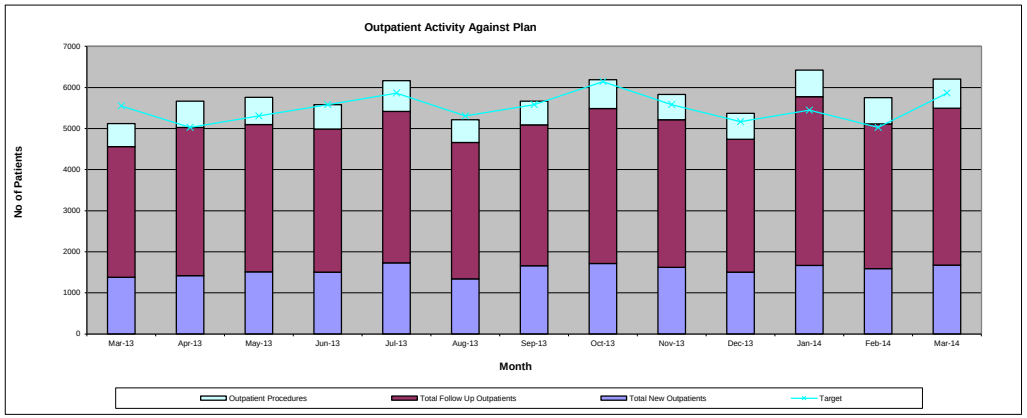
Quarterly Detailed Report
Activity Targets as at March 2014

Headlines

- Elective and non-elective activity has been lower than plan, after achieving plan in February.
- Overall admitted patient care activity was high and exceeded both original and rectification plan, as a result of strong Day Case performance. The Trust treated the highest number of patients in March since March 2011.
- Outpatient activity remains above plan.

	Monitor	National	CQC Standard		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Full Year Position
Activity			4	Total Discharged Elective Patients	614	541	615	550	580	538	503	566	584	523	555	561	583	6699
			4	Total Discharged Non Elective Patients	29	25	20	30	38	44	30	33	35	31	32	43	36	397
			4	Total Discharged Day Cases	506	493	574	570	627	506	560	618	683	573	700	647	752	7303
			4	Total New Outpatients	1381	1416	1513	1508	1728	1343	1659	1713	1619	1509	1672	1593	1678	18951
			4	Total Follow Up Outpatients	3179	3611	3583	3481	3691	3314	3428	3774	3595	3231	4101	3519	3819	43147
			4	Outpatient Procedures	562	635	662	594	743	560	575	697	618	627	652	643	703	7709
			4	Elective as % Against Plan	108.3%	99.43%	107.1%	91.0%	91.4%	93.7%	83.2%	85.1%	96.6%	93.5%	94.2%	103.1%	91.8%	93.90%
			4	Non Elective as % Against Plan	75.8%	72.4%	54.8%	78.1%	94.3%	120.6%	78.1%	78.1%	91.2%	87.3%	85.5%	124.5%	89.3%	87.64%
			4	Day Cases as % Against Plan	96.9%	100.7%	111.1%	104.8%	109.8%	97.9%	103.0%	103.3%	125.6%	113.9%	132.0%	132.2%	131.7%	113.79%
			4	% New Outpatients Against Plan	101.5%	111.1%	112.5%	106.5%	116.2%	99.8%	117.2%	110.0%	114.3%	115.2%	121.1%	125.0%	112.9%	113.43%
			4	% Follow Up Outpatients Against Plan	97.8%	114.2%	107.4%	99.1%	100.1%	99.3%	97.6%	97.7%	102.3%	99.4%	119.7%	111.3%	103.5%	104.10%
			4	% Outpatient Procedures Against Plan	80.6%	107.6%	106.3%	90.6%	108.0%	89.9%	87.7%	96.7%	94.3%	103.4%	102.0%	109.0%	102.2%	99.68%





Activity Commentary

The elective/DC case mix trend continued in March with 31% over achievement against day case and an 8% underperformance against electives.

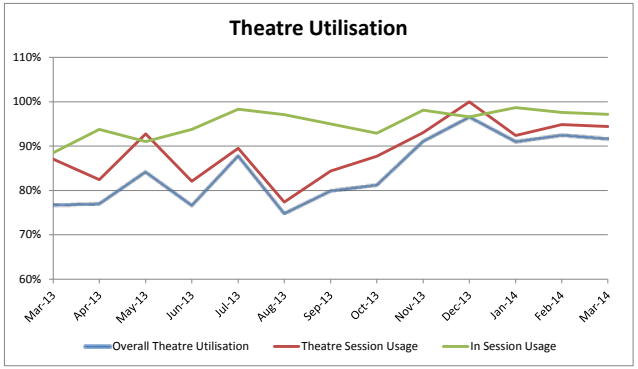
New OP continue to exceed plan with a 13% increase against plan in 13/14 and an additional 866 patients being seen (of which approximately 30-40% will convert to treatment).

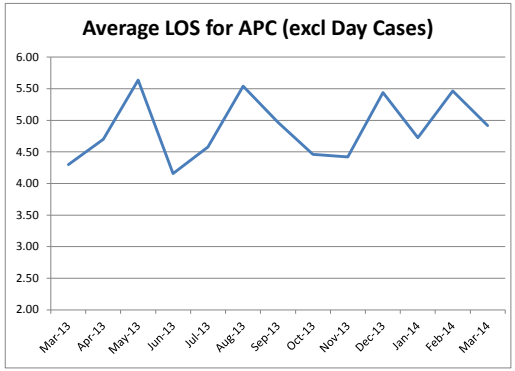
Quarterly Detailed Report
Efficiency Indicators as at March 2014

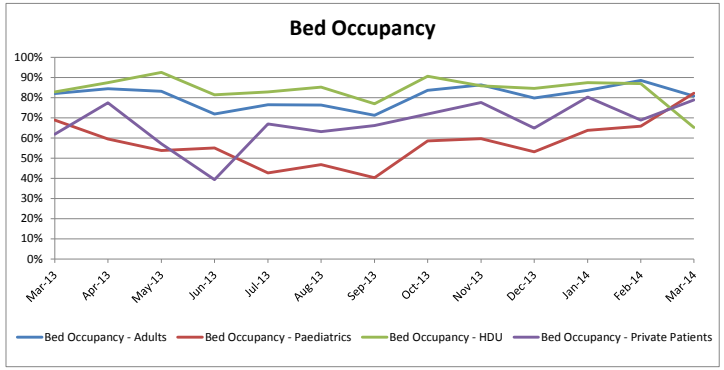
Headlines

- Total cancelled patients on the day and day before surgery totalled 58, a reduction for the fourth consecutive month.
- Total patients cancelled by the hospital on the day have increased from 3 in February to 5.
- Theatre utilisation, session usage and in session usage remain high.

	Monitor	National	CQC Standard		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Full Year Position
Efficiency			4	Overall Theatre Utilisation	77.0%	77.30%	84.41%	76.95%	87.98%	75.15%	80.19%	81.51%	91.23%	96.58%	91.13%	92.59%	91.74%	83.60%
			4	Theatre Session Usage	87.07%	82.45%	92.72%	82.09%	89.50%	77.38%	84.42%	87.73%	93.02%	100.00%	92.37%	94.88%	94.44%	87.27%
			4	In Session Usage	88.5%	93.76%	91.04%	93.73%	98.31%	97.11%	94.99%	92.92%	98.07%	96.58%	98.66%	97.59%	97.14%	94.60%
			4	Unused Theatre Sessions	53	76	30	77	50	102	67	61	30	0	36	21	25	575
			4	Number of Cases per Theatre Session	3.11	2.82	3.01	3.08	2.79	2.95	2.91	2.67	3.09	2.97	2.83	3.10	3.08	2.94
			4	Total Cancelled Operations (On Day or Day Before)	52	91	72	63	88	58	62	82	120	84	78	71	58	927
			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)	2	4	5	5	11	14	4	2	11	10	9	3	5	83
			4	% Cancelled Operations by Hospital	0.18%	0.40%	0.43%	0.46%	0.93%	1.36%	0.38%	0.17%	0.89%	0.94%	0.73%	0.25%	0.38%	0.60%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.59	2.78	2.45	2.55	2.25	2.54	2.36	2.32	2.34	2.29	2.58	2.44	2.48	2.48
			4	Pain Review-To-New Ratio	2.99	3.53	4.65	2.90	4.02	4.24	1.89	3.59	2.70	3.38	3.72	3.85	3.53	3.69
			4	Outpatient DNAs	10.52%	7.70%	8.79%	9.23%	8.70%	9.33%	8.49%	8.46%	8.51%	8.61%	9.59%	8.18%	8.21%	8.63%
			4	Bed Occupancy - Adults	81.96%	84.37%	83.16%	71.91%	76.53%	76.26%	71.19%	83.58%	86.36%	79.80%	83.60%	88.61%	80.72%	80.43%
			4	Bed Occupancy - Paediatrics	68.89%	59.44%	53.76%	55.00%	42.71%	46.77%	40.28%	58.60%	59.72%	53.18%	63.80%	65.87%	82.20%	55.90%
			4	Bed Occupancy - HDU	82.89%	87.36%	92.53%	81.44%	82.76%	85.15%	77.01%	90.67%	85.92%	84.62%	87.45%	86.89%	65.16%	84.28%
			4	Bed Occupancy - Private Patients	61.91%	77.47%	57.14%	39.29%	66.96%	63.13%	66.19%	71.89%	77.62%	64.94%	80.28%	68.88%	78.80%	68.52%
			4	Admissions on the Day of Surgery	457	381	433	403	418	374	371	417	405	386	421	415	441	1635
			4	AVLOS for APC (excl day cases)	4.30	4.70	5.63	4.16	4.58	5.54	4.97	4.46	4.42	5.44	4.72	5.47	4.92	4.75







Efficiency Commentary

Total cancelled patients on the day and day before surgery totalled 58, a reduction for the fourth consecutive month. The OTDC cancellation avoidance project continues to achieve the KPI's set and is ahead of target to reduce cancellations. To note: the OTDC cancellations numbers reduced against a high activity month of March. Hospital cancellations are still within project targets and the total reflects the ROH team accommodating emergency procedures.

LOS although reduced by 0.57 day, remains high and work is ongoing to analyse the cause for this.

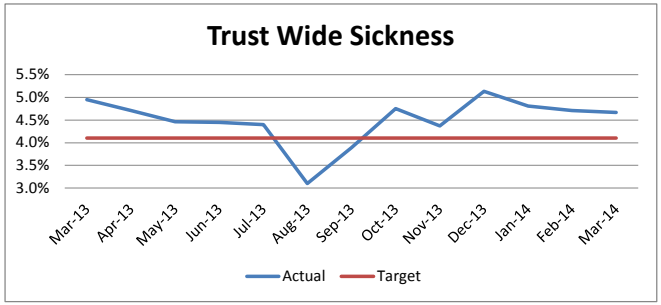
Theatre utilisation, session useage and in session useage remain high.

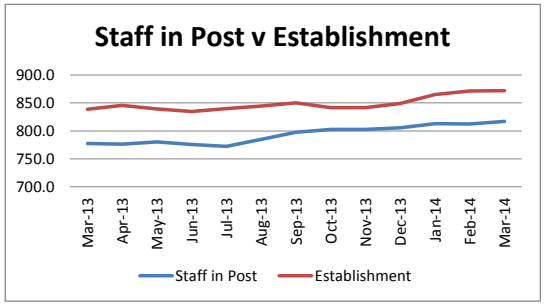
Monthly Report
Workforce Indicators as at February 14

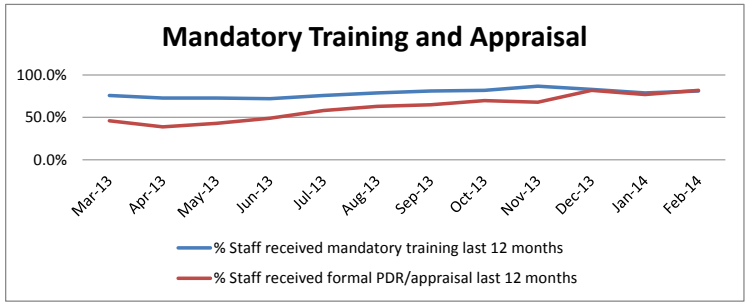
Headlines

- The WTE staff employed continues to rise.
- Staff turnover has reduced.
- Agency spend as a % of staff costs has increased in month.

	Monitor	National	CQC Standard		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Full Year Position
Workforce			13	Total WTE Employed	777.5	776.5	780.5	775.8	772.5	784.9	797.7	802.6	802.9	805.3	813.0	812.5	817.1	798.9
			13	Total WTE Employed as % of Establishment	92.7%	91.8%	93.0%	92.9%	92.0%	92.9%	93.8%	95.3%	95.4%	94.8%	94.0%	93.3%	93.7%	93.9%
			13	Staff Turnover (%)	12.7%	11.6%	12.0%	12.6%	12.5%	12.5%	12.7%	12.8%	12.9%	13.1%	12.2%	11.8%	11.3%	12.6%
			13	% of Sickness - Trust wide	5.0%	4.7%	4.5%	4.5%	4.4%	3.1%	3.9%	4.8%	4.4%	5.1%	4.8%	4.7%	4.7%	4.4%
			13	Agency % of Staff Cost	8.7%	6.1%	8.0%	8.4%	6.1%	6.5%	6.4%	6.2%	5.6%	5.8%	6.9%	9.7%	9.9%	6.7%
			13	Temporary staffing hours as a % of establishment														
			13	% Staff received mandatory training last 12 months	76%	73%	73%	72%	76%	79%	81%	82%	87%	83%	79%	81%	80%	81%
			13	% Staff received formal PDR/appraisal last 12 months	46%	39%	43%	49%	58%	63%	65%	70%	68%	82%	77%	82%	82%	71%
			13	% of required staff receiving safeguarding training		33%	30%	21%	51%	51%	54%	60%	58%	66%	66%	68%	68%	59%
			13	Qualified Nurse / Bed ratio														
			13	Staff Net Promoter score														







Workforce Commentary

The number of staff employed has increased by 40 WTE or 5% during the year. Levels of recruitment continue to be high.

Sickness levels in month have remained unchanged. Large joints, paediatrics and medical secretaries with the largest in month increases. A review of data has suggested that a number of staff who breached the policy triggers for short term absence between January and April 2014 may not have been managed and the HR Manager will be completing validation of this during May.

Turnover is steadily reducing and is 1.4% lower than March 2013.

Agency useage continues to be high and is linked to additional clinical activity.

Mandatory training compliance with the 'stretch' target of 95% continues to be a challenge but attendance during April has been significantly higher, possibly linked to implementation of the new pay agreement.
Appraisal has improved by 43% in year and the staff opinion survey results indicate appraisal levels are above average compared to other acute specialist providers.

Quarterly Detailed Report
Financial Performance as at March 2014

Headlines

For the month of March the Trust made a surplus before impairments of £524,000 compared to a planned surplus of £358,000.

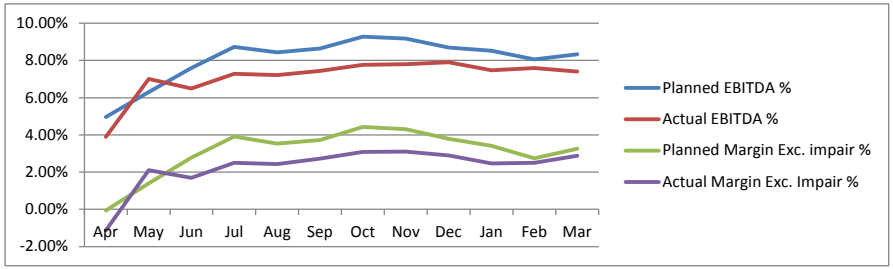
The Trust therefore has a year end surplus before impairments of £2,166,000, being £262,000 behind plan. Net impairments to I&E of £2.6m reduce the result reported to a deficit of £493k.

The Trust achieved annual CIP savings of £2,504k of which 95% is recurrent. This is £478,000 behind the target for the year.

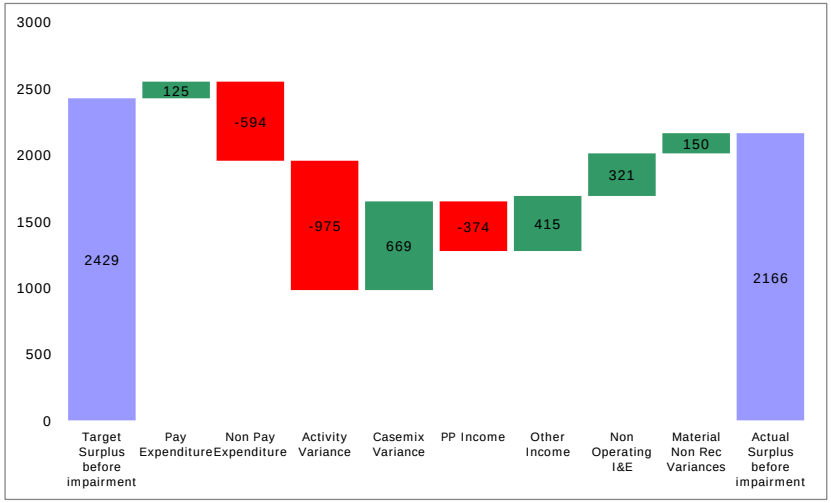
Trust Financial Metrics

	Year to Date		
	Actual	Plan	Risk
Capital Servicing Capacity	4.6	4.6	4
Liquidity Ratio	79.0	66.0	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 March the Trust made a surplus before impairments of £524,000 compared to a planned surplus of £358,000. The Trust therefore has a year end surplus before impairments of £2,166,000, being £262,000 behind plan.
Net impairments to I&E of £2.6m reduce the result reported to a deficit of £493k. 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

Overall activity was higher than both rectification and original plan, resulting in higher than average income for the month. Elective activity was 583 (against an average for the year of 558), non-elective 36 (average 33) and Day Cases 752 (average 609). As a result income was nearly 20% higher in month than the average income across the year.

Note: Provisions against disputed income have been netted against income in the bridge. However, in the financial statements it is necessary for these to be shown against non-pay expenditure.

Pay

The total paybill has increased in March. The paybill this month is the highest for this financial year. Bank usage also at its highest for current year and agency usage is at its highest for this financial year. Agency spend is highest in large joints and theatres, with spends of £87k and £64k respectively. Substantive pay is high in month as it contains adjustments for locum time included within agency in Months 1-8 which should have been included in substantive pay (£53k) and an accrual for backdated PA pay for a consultant (£31k). In addition, there is an additional weeks pay for those individuals paid on a weekly basis in comparison to February.

Non Pay

Non pay spend was relatively high for the month. This was driven primarily by additional costs in relation to attempting to deliver the rectification plan, such as continuing to run the extra capacity ward, and funding drugs costs for the extra theatre useage. In addition, there has been expenditure incurred for IT licenses, and higher than average MRI costs in light of the continued outstourcing to Alliance Medical to meet demand, with the monthly cost pressure in March totalling £38,000.

Impairment

The Trust has an impairment of £2.6m on its estate, which is based on the valuation provided by the Trust's valuation experts (an additional £0.2m has been offset against the revaluation reserve). The main factors influencing the impairment were the opening of the new Admissions and Day Care Unit and the planned demolition of Wards 5 and 7 in 2014/15.

CIP

CIP achievement currently sits at £2,504k of which 95% is recurrent. This is £478,000 behind the target for the year.

Quarterly Detailed Report
Financial Efficiency Indicators as at March 14

Headlines

- The paybill has been the highest in this financial year and has been going up consistently over the last four months.
- Agency pay has been highest for this financial year.
- Both the Trust surplus before impairments and CIP performance remain below planned levels

		Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Cost of Staffing	Total Paybill	£3,388,000	£3,216,996	£3,313,000	£3,259,000	£3,324,000	£3,252,000	£3,233,418	£3,279,000	£3,311,000	£3,274,000	£3,315,000	£3,471,000	£3,649,000
	Substantive Pay	£2,841,000	£2,809,592	£2,852,000	£2,822,000	£2,864,000	£2,806,000	£2,805,483	£2,861,500	£2,919,000	£2,877,100	£2,893,700	£2,949,000	£3,086,400
	Bank Pay	£246,000	£203,441	£187,000	£197,000	£252,000	£230,000	£213,956	£208,000	£195,000	£201,000	£187,000	£226,000	£234,000
	Overtime Pay	£5,000	£9,915	£4,000	£4,000	£4,000	£5,000	£7,612	£5,500	£4,000	£4,900	£6,300	£5,500	£5,600
	Agency Pay (excluding Medical Locums)	£234,000	£139,565	£241,000	£191,000	£150,000	£144,000	£138,048	£177,000	£133,000	£109,000	£148,000	£173,000	£223,000
	Medical Locum Pay	£62,000	£54,484	£28,000	£81,000	£54,000	£67,000	£68,319	£52,000	£60,000	£82,000	£80,000	£117,000	£100,000
	ADH Payments - Surgical	£40,000	£26,000	£38,000	£20,000	£17,000	£26,000	£23,000	£22,000	£31,000	£22,000	£38,000	£45,000	£62,000
	ADH Payments - Clinics	£17,000	£11,000	£14,000	£7,000	£17,000	£9,000	£13,000	£15,000	£19,000	£17,000	£18,000	£28,000	£17,000
	ADH Payments - Anaesthetics	£84,000	£46,000	£47,000	£48,000	£63,000	£46,000	£53,000	£48,000	£53,000	£62,000	£71,000	£76,000	£80,200
	ADH Payments - Spot Work & Strategy	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Income & Efficiency	Trust Surplus	£2,203,000	-£66,000	£250,000	£305,000	£602,000	£729,000	£978,000	£1,305,000	£1,509,000	£1,599,000	£1,503,000	£1,598,000	-£493,000
	Normalised Surplus	£1,853,000	-£66,000	£250,000	£443,000	£891,000	£912,000	£977,000	£1,228,000	£1,431,000	£1,587,000	£1,491,000	£1,586,000	-£493,000
	Total Income	£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	£6,436,000	£5,849,000	£6,371,188	£7,438,839
	CIP	£3,820,000	-	£339,000	£561,000	£869,000	£1,125,000	£1,378,000	£1,537,000	£1,787,000	£2,039,000	£2,161,000	£2,351,000	£2,500,000

Summary

The paybill this month is the highest for this financial year. Bank usage also at its highest for current year and agency usage is at its highest for this financial year. Agency spend is highest in large joints and theatres, with spends of £87k and £64k respectively. Substantive pay is high in month as it contains adjustments for locum time included within agency in Months 1-8 which should have been included in substantive pay (£53k) and an accrual for backdated PA pay for a consultant (£31k). In addition, there is an additional weeks pay for those individuals paid on a weekly basis in comparison to February.

CIP achievement currently sits at £2,504k of which 95% is recurrent. This is £478,000 behind the annual target.

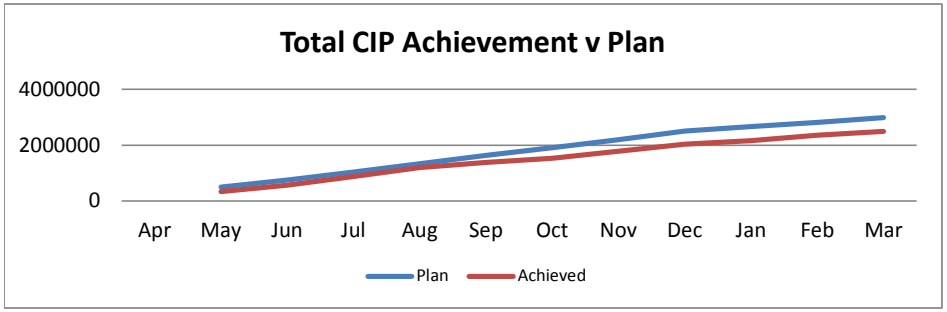
Monthly Report
Cost Improvement Programme Indicators as at March 14

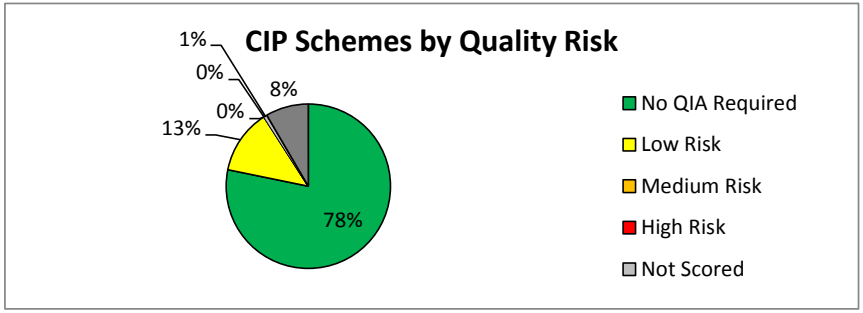
Headlines

CIP achievement for the year was £2,504k. This represents a £478,000 underachievement on CIP for the year.

95% of the CIP achieved in the year is recurrent.

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	862	0	0	246	1,108	78%	246
Corporate Areas	774	677	0	0	97	774	87%	97
Income	1,100	965	0	0	136	1,100	88%	135
Total	**2,982**	**2,504**	**0**	**0**	**478**	**2,982**	**84%**	**478**





Significant Exceptions

Theatres & Anaesthetics. Only 52% of the £473k target was implemented.

Income. 88% of the £1.1m plan was implemented.

Management. 69% of the target was achieved

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Quarterly Detailed Report
Statement of Position as at March 14

Headlines

The Trust finished Q3 with a Statement of Position £2.9m behind plan which reflects £2.7m of technical adjustments in respect of impairments on the Trust's estate, in addition to underperformance against planned surplus targets.

Cash is ahead of plan, with a final balance of £19.4m.

The Trust finished Q4 with a Statement of Position £2.9m behind plan which is as a result of £2.7m impairment identified during the revaluation of the Trust's land and buildings, in addition to underperformance against planned surplus targets for the year.

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 the end of Q1.

The fixed assets are c.£5m behind plan at year end. However, the actual balance reflects the downward revaluation of the assets by c.£3m (including the element taken to the revaluation reserve). The capital report later in the pack shows capital expenditure performance against the revised plan and this is showing the Trust as being £1.2m behind target.

A stocktake took place within Theatres during March and all adjustments have been reflected in the closing figure for Q4. Stock levels have increased steadily over the year, partly to ensure appropriate levels to meet the needs of the Trust's rectification plan and partly as a result of various changes in theatre suppliers which has seen a gradual move from consignment to ROH owned stock. Total stock, largely made up of implants, theatre consumables and drugs stands at £3.9m at the end of the financial year, with theatres stock accounting for 94% of the overall figure.

The creditors balance is largely in line with plan, with PSPP performance standing at 96.15%.

The cash balance is ahead of plan by c.£1.4m, which is largely as a result of slippage in capital spend and an increase in the stock balance.

The £541,000 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 12 days, a reduction from 17 at Q3.
Creditor days: Creditor days currently stands at 23 days, a reduction from 30 at Q3.

Debtors > 90 days: Total debts over 90 days is £574k or 12.14% of the total debtor balance. A bad debt provision for high risk areas is included in the I&E position.

Creditors > 90 days: Total creditors over 90 days is £37k at a percentage of 0.35% of the total creditor balance. This is a significant reduction from Q3's balance of £718k, which largely related to one supplier where the contract was yet to be finalised and so the Trust was holding payment.

During Q3 the Trust received £91,000 from the Energy Efficiency Fund in the form of Public Dividend Capital to support the replacement roof capital programme, explaining the movement in PDC reserve against plan.

STATEMENT OF POSITION	Actual £000	Plan £000
FIXED ASSETS:		
Intangible assets	438	0
Tangible assets	40,122	45,572
Investments	0	0
TOTAL FIXED ASSETS	**40,560**	**45,572**
CURRENT ASSETS:		
Stocks and work in progress	3,922	2,721
Debtors	4,597	4,960
Investments	0	0
Cash at bank and in hand	19,357	17,963
TOTAL CURRENT ASSETS	**27,876**	**25,644**
CREDITORS:		
Creditors falling due within one year	(10,564)	(10,540)
NET CURRENT ASSETS/(LIABILITIES)	**17,312**	**15,104**
TOTAL ASSETS LESS CURRENT LIABILITIES	**57,872**	**60,676**
CREDITORS:		
Creditors falling due after more than one year	(541)	(545)
PROVISIONS FOR LIABILITIES AND CHARGES	(285)	(246)
TOTAL ASSETS EMPLOYED	**57,046**	**59,885**
FINANCED BY		
TAXPAYER'S EQUITY		
Public dividend capital	38,996	38,905
Revaluation reserve	2,416	2,712
Donated asset reserve	0	0
Available for sale investments reserve	0	0
Other reserves	0	0
Income and expenditure reserve	15,634	18,268
TOTAL TAXPAYERS' EQUITY	**57,046**	**59,885**

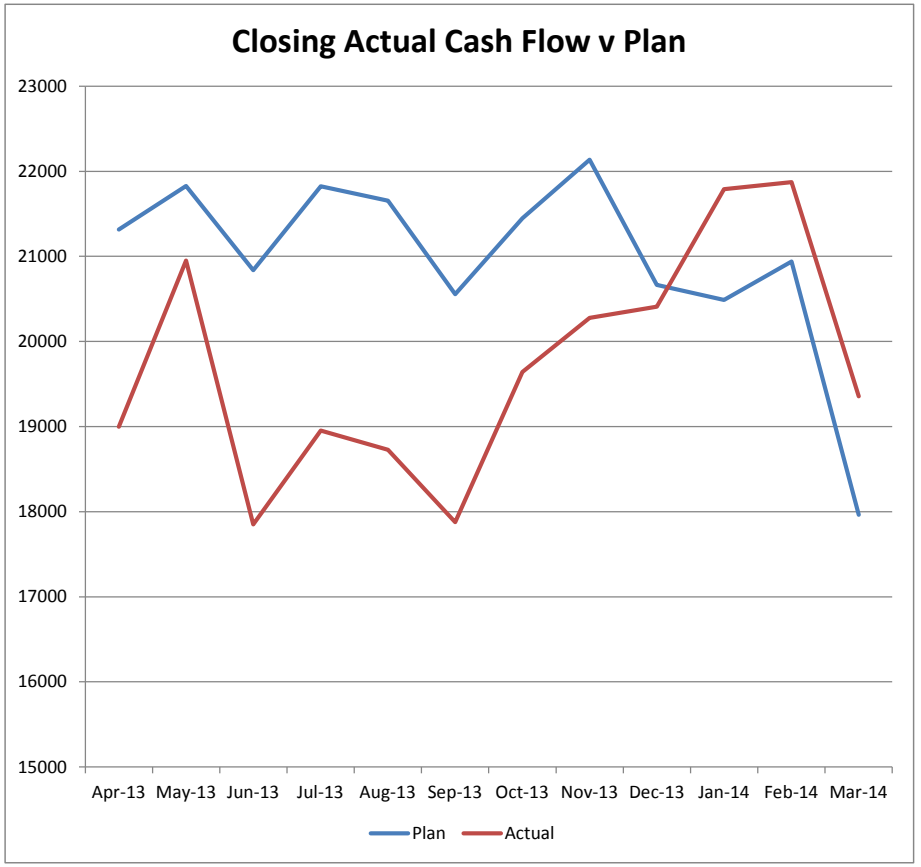
Quarterly Detailed Report
Financial Cash Flow as at Mar 14

Headlines

The Trust closed Q4 with a higher than expected cash balance of £19.4m against a plan of £18.0m. This is largely as a result of slippage in the capital plan. More detailed analysis of the variances is provided in the balance sheet report.

CASHFLOW STATEMENT
As at 31st March 2014

	Actual £'000	Plan £'000	Variance £'000
Earnings Before Interest Taxation & Depreciation	5,472	6,282	(810)
Movement in Working Capital			
(Increase) / Decrease in Stock	(1,081)	120	(1,201)
(Increase) / Decrease in Debtors	(1,058)	(1,444)	386
Increase / (Decrease) in Creditors	(1,327)	612	(1,939)
Increase / (Decrease) in Provisions and Liabilities	59	(336)	395
Total Movement in Working Capital	**(3,407)**	**(1,048)**	**(2,359)**
Cash flow from Operations			
Capital Payments	(2,883)	(7,367)	4,484
Cash flow before Financing	**(2,883)**	**(7,367)**	**4,484**
Financing			
Interest Received	73	0	73
Interest Paid	(24)	(29)	5
Capital element of finance lease rental payments	0	0	0
Public Dividend Capital Received	91	0	91
Public Dividend Capital Repaid	(1,413)	(1,323)	(90)
Dividend Paid	0	0	0
Loans Received	0	0	0
Loans Paid	0	0	0
Grants Received	0	0	0
Grants Paid	0	0	0
Total Financing	**(1,273)**	**(1,352)**	**79**
Net Cash Inflow / (Outflow)	(2,091)	(3,485)	1,394
Opening Cash Balance	21,448	21,560	(112)
Closing Cash Balance	**19,357**	**18,075**	**1,282**

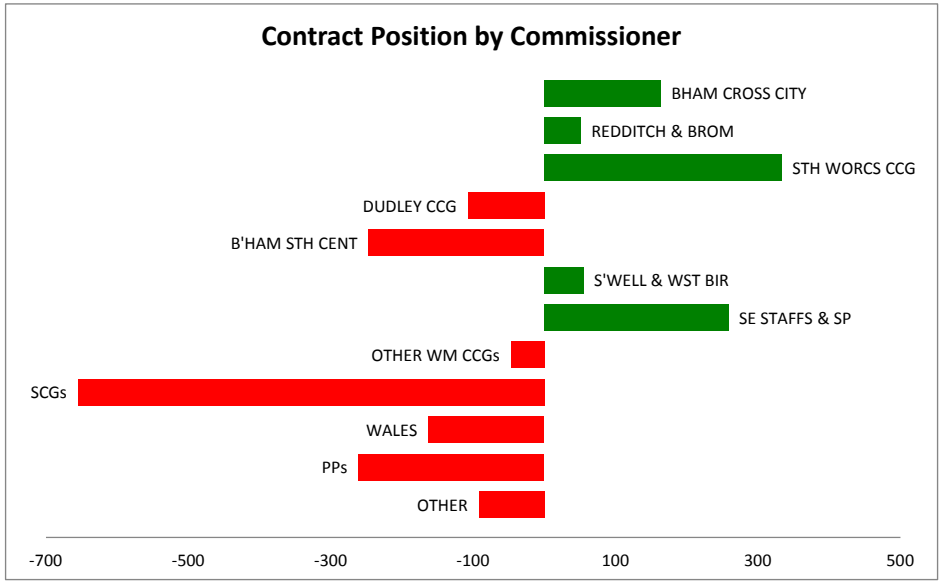


Quarterly Detailed Report
Income and Expenditure Statement as at December 13

Headlines

- The Trust has failed to meet its surplus target before impairments of £2.4m.
- EBITDA margin is 1.27% behind plan at Quarter 4.
- The Trust has overperformed on income in Quarter 4 due to the rectification plan which enabled the Trust to improve on Quarter 3 underperformance.

	Current Quarter			YTD			FY
	Act	Plan	Var	Act	Plan	Var	Plan
Income	19,682	18,526	1,156	74,534	74,621	(87)	74,621
Pay Costs	(10,673)	(10,216)	(457)	(40,133)	(40,204)	71	(40,204)
Drug Costs	(855)	(688)	(167)	(1,714)	(1,537)	(177)	(1,537)
Other Costs	(7,016)	(6,030)	(986)	(27,170)	(26,409)	(761)	(26,409)
EBITDA	**1,138**	**1,592**	**(454)**	**5,517**	**6,471**	**(954)**	**6,471**
Depreciation	(547)	(949)	402	(2,170)	(2,740)	570	(2,740)
Net interest	32	12	20	74	49	25	49
Other	(55)	(351)	296	(1,254)	(1,351)	97	(1,351)
	568	**304**	**264**	**2,167**	**2,429**	**(262)**	**2,429**
Impairment	(2,660)	(300)	(2,360)	(2,660)	(300)	(2,360)	(300)
Net surplus / (Deficit)	**(2,092)**	**4**	**(2,096)**	**(493)**	**2,129**	**(2,622)**	**2,129**
EBITDA %	5.78%	8.59%		7.40%	8.67%		8.67%
CIP	465	482	(17)	2,504	2,983	(479)	2,993



Finance Commentary

The Trust has failed to meet its target of £2.4m before impairment compared to being behind plan at Q3 by £0.1m. Overall Q4 the surplus before impairments is £568k compared to a Q3 surplus of £621k.

The biggest area of contract underperformance in the year to date (which excludes CIP growth assumptions) has been against contracts with Specialist Commissioning Groups, equating to nearly £655k to the end of Q4. The private patients income is £261k behind plan for this financial year.

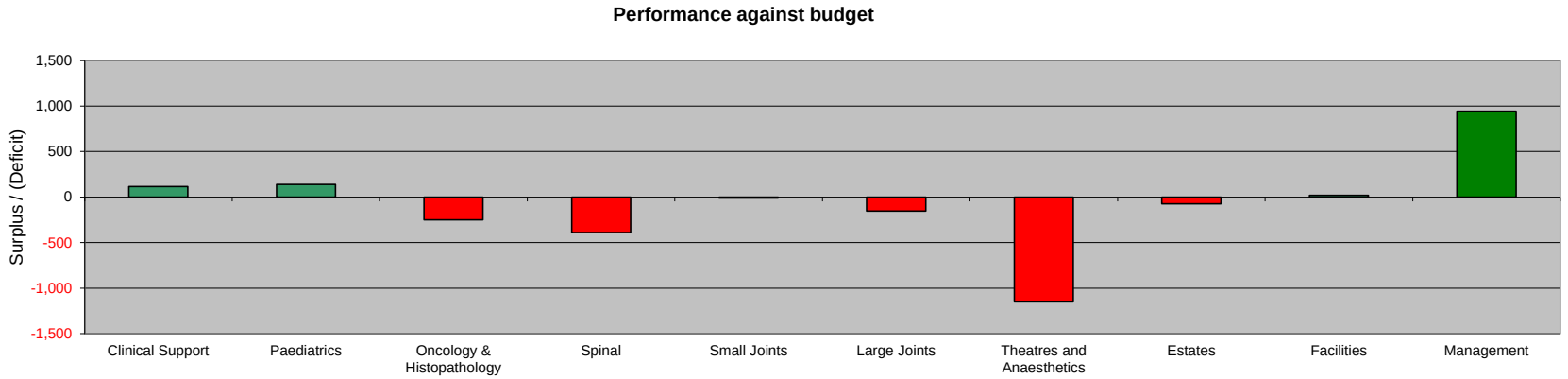
Performance against our local contracts is variable, with underperformances against Birmingham South Central, Dudley and Wales offset by over performance in South Worcester, South East Staffordshire and Birmingham Cross City. Overall the local contract's income is overperforming against the plan by £461,000.

Compared to the plan we have overspent on non pay, this has been the short term investment towards the rectification plan on implants and consumables including Theatres and the extra capacity ward. This has been discussed further on the financial performance tab.

Quarterly Detailed Report
Finance Performance by Directorate as at March 14

Headlines

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



Theatres & Anaesthetics - £1,152,000 overspent
Pay- Theatres are overspent by £409,000 at month 12 on staffing as a result of year to date agency cost (£774,000 to date on nursing and technical cover) for substantive vacancies, although the on-going recruitment programme has seen reductions in agency use. The consultant temporary hours for this financial year are overspent by £351,000.
Non Pay - Theatres are £795,000 overspent on non pay medical supplies, equipment & consumables. There has been increase in Implants and prosthesis in Q4, overall overspend on clinical and general supplies and services, and an underachievement of CIP for the financial year.
Income - The remaining variance is as a result of £52k overperformance on directorate income.

Management - £944,000 underspent
Pay is overspent by £47,000 mainly on locums on Trust funded junior doctors.
Non pay is underspent by £875k mainly because of reserves and year end financial adjustments.

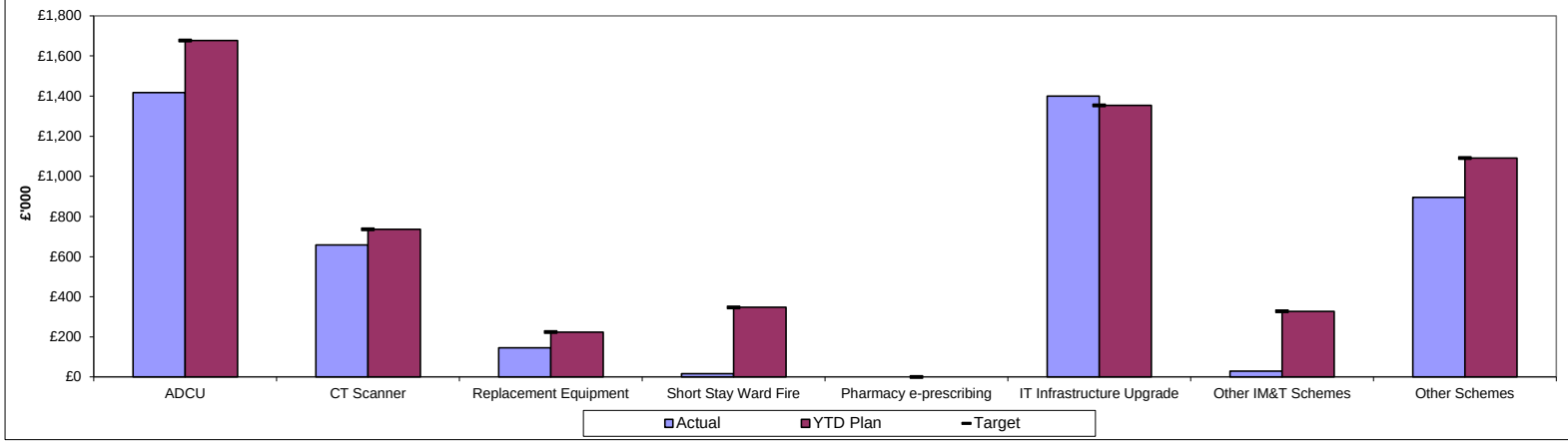
Spinal - £391,000 overspent.
Pay is overspent by £34,000 which mainly on consultant temporary hours.
Non pay is overspent by £358,000 which mainly relates to the treatment of patients in the private sector ,BCH and EEG /radiology contracts with external providers.

Quarterly Detailed Report
Capital Programme Update as at Mar 14

Headlines

The capital plan is £1.2m behind plan at Q4 based on the revised capital plan submitted to Monitor.

Scheme Analysis



Capital Commentary
At the end of March the capital plan was £1.2m behind plan.

ADCU
The new ADCU facility opened in July 2013 however some work continues to finalise this.

CT Scanner
There has been £659k of spend against the budget of £736k.

Replacement Equipment
£146k has been spent of the £224k budget. The main spend has been in Theatres in relation to an Allen Frame and theatre lights.

Short Stay Ward Fire
Work has been delayed due to bed shortages, but will occur in 2014/15.

Pharmacy e-prescribing
This project has now be moved to 2014/15.

IM&T
Since the tender in Q3, a supplier was selected, and the spend has taken place largely in line with plan.

Overall
Cash spent on capital at the year end (as shown on the Cash tab) is £2,883k. This differs from the amounts shown above due to the purchase of assets at the year end which had not been paid for at this point.

Quarterly Detailed Report
Business Intelligence as at March 14

Headlines

- Significant increase in Admitted Patient Care and Outpatient Activity between financial years
- Significant increase in Referrals between financial years
- 2014-15 Contract Activity and Finance agreed
- CQUIN performance in Q4 - all targets expected to be acheived in Q4 with exception of Pressure Ulcers

Benchmarking - DOH Hospital Activity Statistics Quarter 4
The following tables illustrate the change in activity between 2012/13 and 2013/14 reported
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 the most recent Quarter

Table 1 - Comparison of Elective Admissions

	Quarter 4			
Admission Type	**12/13**	**13/14**	**Variance**	**%**
Elective Admissions	1,728	1,699	-29	-1.678%
Day Case	1,499	2,099	+600	+40.027%
Grand Total	**3,227**	**3,798**	**+571**	**+17.694%**

Table 2 - Comparison of GP Referrals

	Q4			
GP Referrals	**2012-13**	**2013-14**	**Variance**	**%**
No of GP Referrals	4,361	4,686	+325	+7.452%

Table 3 - Comparison of Outpatient Attendances

	Quarter 4			
Outpatient Type	**12/13**	**13/14**	**Variance**	**%**
New	4,346	4,943	+597	+13.737%
Follow-Up	9,970	11,439	+1,469	+14.734%
Grand Total	**14,316**	**16,382**	**+2,066**	**+14.431%**

Table 4 - Market Share Analysis

The table below shows the 'Top 10' GP Practices referring to the Trusts' Services in Quarter 4

		2012-13	2013-14				
Rank	**GP Practice**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Grand Total**
1	LORDSWOOD HOUSE GROUP MEDICAL PRACTICE	126	157	164	139	135	721
2	M M P SOUTH BIRMINGHAM	98	102	119	97	75	491
3	HOLLYMOOR MEDICAL CENTRE	73	91	87	95	88	434
4	NORTHFIELD HEALTH CENTRE F	70	97	80	78	61	386
5	HALL GREEN HEALTH	81	77	84	67	67	376
6	WYCHALL LANE SURGERY	65	89	85	66	51	356
7	LEACH HEATH MEDICAL CENTRE	50	81	71	93	77	372
8	MILLENNIUM MEDICAL CENTRE	63	63	69	68	62	325
9	KINGSFIELD MEDICAL CENTRE	74	74	62	46	63	319
10	JIGGINS LANE SURGERY	73	60	67	65	55	320

Business Opportunities

Waiting List Initiatives for Local Trusts
Despite requests from other Trusts there has been very little waiting list initiative patients transferred from other Providers. The Trust has done some work for WHAT, and SWBH. The Trust has recently been contacted again by WHAT and is awaiting confirmation of the scope of any potential initiative in terms of type of patients and quantity
.

2013-14 Commissioning Issues
With the exception of the Grade 3&4 Pressure Ulcers, the Trust expects to achieve CQUIN milestones in Q4. The yearend threshold for Pressure Ulcers was breached in Q2. The Trust is working with Commissioners to determine the year-end financial impact of non-achievement of this CQUN and the VTE CQUIN that was failed in Q1 and Q2. The Trust has made excellent progress in reducing the number of patients waiting over 52 weeks and as a consequence the financial penalties imposed by Commissioners have been minimal in Q4.
The draft contractual performance for the year-end indicates that the Trust over-performed against its contracted activity income targets for Contracts with CCGs but under-performed at a similar level for Specialised Commissioners.

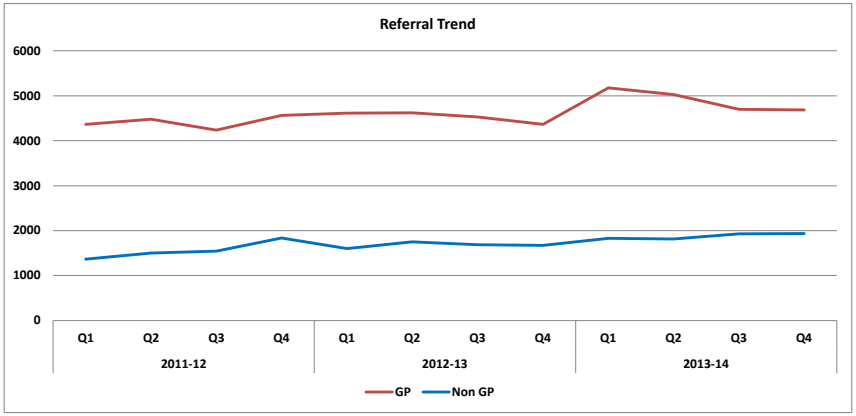
2014-15 Contracts
The Trust has agreed Contract values with both CCG and Specialised Commissioners, with activity plans broadly in line with those proposed by the Trust. The West Midlands CCG's Contract has been signed, however the Specialised Services have not yet provide a Contract for signature.

CQUIN Schemes have been agreed with the CCGs, however discussions are ongoing with the Specialised Commissioner regarding the CQUIN detail.

The Trust Team presented to a panel of Commissioners, Public Health and Patient representatives from the 3 Worcestershire CCGs regarding the future commissioning arrangements for Electro-Acupuncture treatments. The CCG have confirmed that they will not be commissioning this specific treatment in 2014-15. The Trust has responded to the Commissioners intention and will be offering their patients alternative treatments. This is the first time the Trust has experienced a service that has been "decommissioned" by its Commissioners and although it is not a major financial risk, it illustrates the

Referrals

The number of referrals in the most recent Quarter 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 EMT: 30th April 2014 **Enclosure Number: 6**

SUMMARY OF REPORT TO TRUST BOARD

DIRECTOR LEAD:	Helen Shoker, Director of Nursing & Governance
LEAD AUTHOR:	Alison Braham, Governance Manager
SUBJECT:	**Patient Quality Report – Annual Summary 2013-14**

SUMMARY

This paper will provide Trust Board with an overview of patient safety, experience and effectiveness activity during the period April 2013 to March 2014. Areas of good practice and for further development are highlighted within this summary.

The quality of our patient care must remain a high priority for the organisation. This report aims to assist Trust Board in bringing together key quality issues.

Throughout quarter 4 the development of a comprehensive Patient Quality Report to Trust Board has resulted in visibility and awareness of the component parts of high quality care. Moving into 2014/15 there will be a greater focus on triangulation of the data, understanding what this means for our patients and our services and how we are learning from this.

Patient Safety – Areas of Good Practice

Incident reporting has increased for the third consecutive year
Reduction in avoidable pressure ulcers
RCA for all hospital acquired pressure ulcers
One grade 4 ulcer in year, unavoidable
Nutritional risk assessment completed on admission, with appropriate care planning
'At risk' stamps at Pre Op for Pressure Ulcers and Nutritional risks
Better understanding of falls risks and causes

Patient Safety – Areas of Further Development

Incident review at Directorate level, confirmation of learning
Promotion of open, fair and transparent approach
Organisational culture- staff survey new CQuIN Scheme
Grade 3/2 pressure ulcer reduction of hospital acquired avoidable
'The Throne Project' to reduce falls in bathrooms
Slipper Exchange and safe footwear
Sustained completion of falls risk assessment on admission
Patient and carer awareness of falls risks post operatively
Shared Directorate learning of WHO compliance and steps to safer surgery principles for avoidance of harm

Patient Experience- Areas of Good Practice

Trust real-time patient survey by volunteers
Friends and Family Test, net promoter score and response rate
Sharing of litigation cases at Clinical Audit, EMT and Trust Board
No single sex breaches

Patient Experience – Areas of Further Development
Directorate management of complaints
Directorate and team learning from complaints, PALS concerns and Friends and Family Test
Development of 'in house' medico-legal group to provide expert advice
Ensure all incidents are investigated at the time of occurrence
Improve PROMS primary knee replacement
National Joint Registry compliance to be robustly maintained throughout the year

Effectiveness of Care – Areas of Good Practice
Achieved Safety Thermometer standards

Effectiveness of Care – Areas of Further Development
Explore integration of additional patient outcome measures with the Medical Director, Clinical Directors, Clinical Leads and R&D/R&T departments

RECOMMENDATIONS

The Trust Board is asked to:

- **Receive** the annual Patient Quality Safety and Experience report 2013/14
- **Recognise** achievements and **support** further development
- **Identify** areas of risk requiring further assurance
- **identify** any other patient safety and experience issues for inclusion in future reports

1. PATIENT SAFETY

1.1 Serious Incidents requiring investigation (SIRI) (March 2014)

There was 1 SIRI reported in March which related to the delayed diagnosis of an Oncology patient. (See Appendix 1 for full SIRI details – new and ongoing.)

1.2 All other incidents requiring an investigation

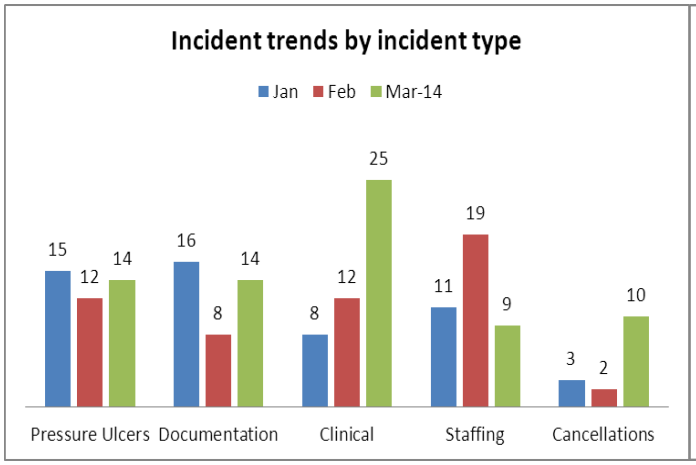
7 additional incidents were reported that subsequently required an RCA investigation to be undertaken (See Appendix 2).

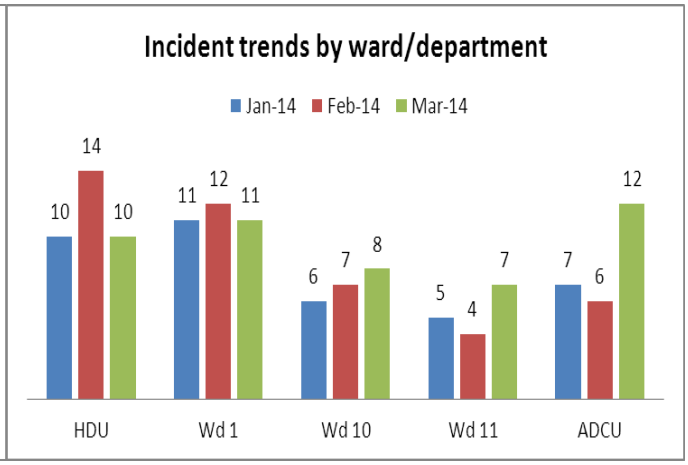
1.3 Deaths

There has been 1 in-hospital expected death reported during March 2014. This patient had been unwell for 5 days and the family and patient agreed a DNR order.

1.4 Incident trends

There were 178 incidents reported during March, compared to 175 incidents reported during February.



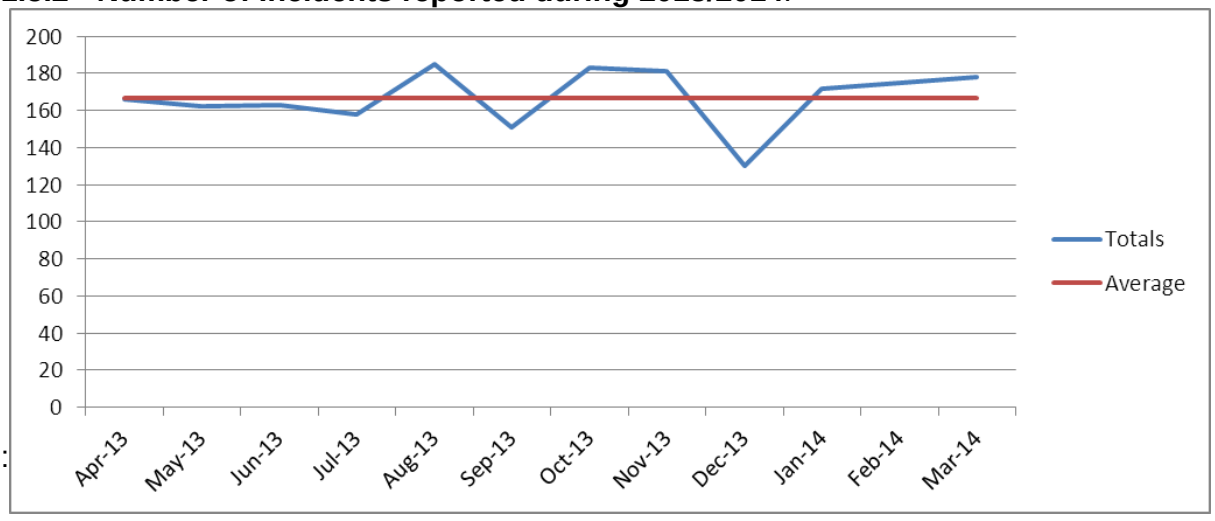


1.5 ANNUAL OVERVIEW

1.5 .1 Notable achievements of 2013/14:

Incident numbers have risen during the financial year from 166 in April 13 to 178 in March 2014.

1.5.2 Number of Incidents reported during 2013/2014:

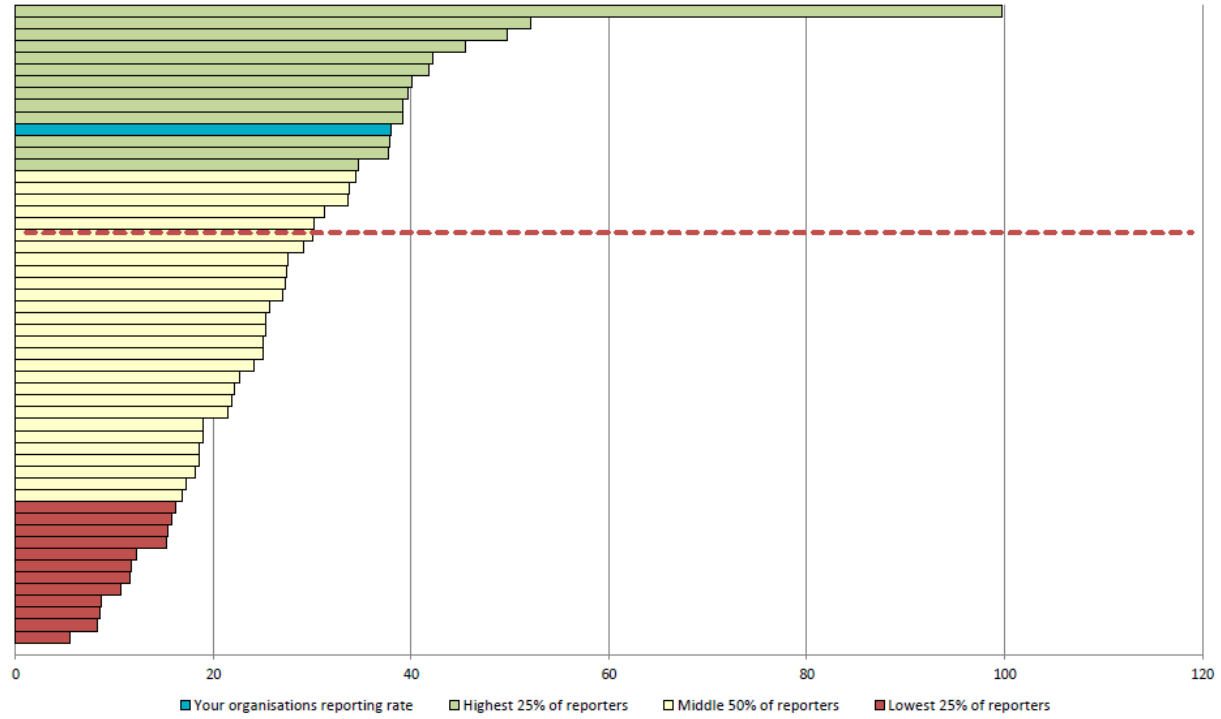


Reporting to the National Reporting and Learning System has improved. The last report, (covering incidents reported during October 2012-March 2013) showed a reporting rate of 6.3 incidents per 100 admissions, which puts the organisation within the upper half of the cluster reporting rate comparison graph (see below graph).

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 01 October 2012 and 31 March 2013. 456 (rate of 6.3) incidents were reported by this organisation during this period.

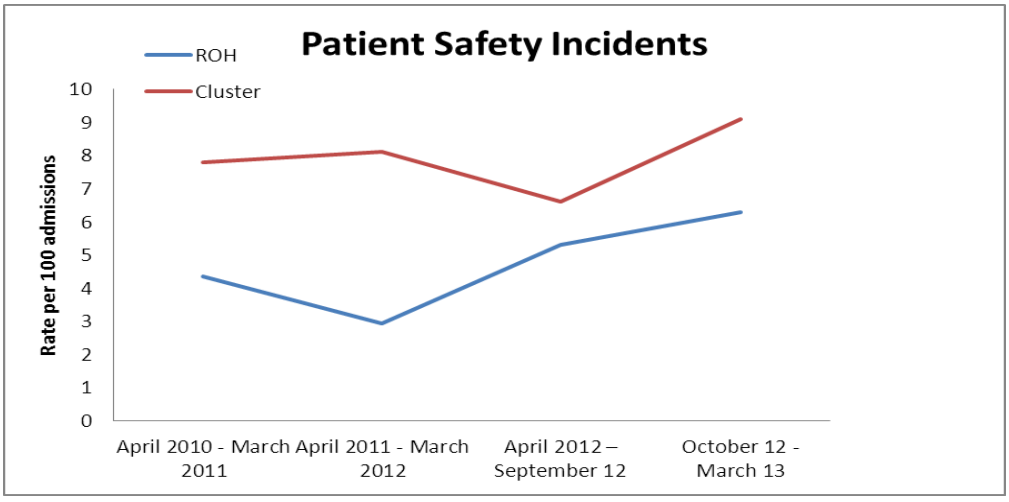
Figure 1: Comparative reporting rate per 100 admissions for 20 ACUTE SPECIALIST organisations.



The median reporting rate for this cluster is 7.3 reporting rate per 100 admissions

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

The graph below shows how our rate has risen over the past couple of years, with the cluster group as comparison:



This improvement demonstrates the work put in by the Trust to improve patient safety incident reporting. One example of the improvement in quality generally has been the drop in serious harm incidents being reported to the NRLS from 1.8% to 0.9% (cluster group average: 0.3%).

1.5.3 Other activities of note:

There has been an enhanced and varied training schedule delivered by the Governance team between April 2013 and March 2014. This has included incident reporting, incident management, use of the RCA module on Ulysses, Policy management. Risk assessments and Management of Stress training has also been provided by the Trust Health and Safety Officer.

Bespoke and ad hoc training also takes place on a regular basis and has included:

- Creating SMART action plans
- Witness statement training
- Overview of CQC compliance
- New litigation/public liability requirements

The Governance team also delivered mandatory training at every session arranged by the Learning and Development Department including attendance at Trust Induction Day and Junior Doctor Induction sessions.

Governance representatives continue to work closely and provide ongoing support to their allocated directorates. This year there has been progress made with chasing up a number of outstanding action plans.

With designated support from the Governance Department, the Theatres & Anaesthetics Directorate commenced a large piece of work that involved closing down 2011-12 outstanding action plans.

The appointment of a new permanent Deputy Director of Nursing and Governance in 2014 and the earlier appointment of a Governance manager during 2013, as well as other additions to the team in terms of Governance facilitators, has enabled more support and training to be developed to enable quality and safety to driven forward in the organisation.

Quality and Safety reports have also been streamlined to enable a single Patient Quality report to be submitted for review and discussion to EMT and the Board on a monthly basis.

1.5.4 Key opportunities for the forthcoming year:

- To continue with the delivery of Governance training, particularly incident reporting and management for new and existing staff.
- Bespoke incident training aimed at specific staff groups within the organisation such as the development of a Governance training programme for Consultant Anaesthetists commencing in April 2014
- The continued promotion of an open, fair and transparent incident reporting process to support the upward trend in patient safety incident reporting.
- Governance will continue working with directorates to ensure that the Ulysses system can be used to meet the individual reporting requirements of directorate teams.
- Working collaboratively with the Birmingham & Solihull Mental Health Trust to gain and share ideas to improve the functionality of the RCA tool on Ulysses.
- A Patient Safety Organisational Culture CQUIN will be launched in April 2014. This involves collecting and analysing the findings from a staff questionnaire designed to assess the safety culture within the organisation.
- The Deputy Director of Nursing and Governance and the Governance manager will increase their participation in external learning opportunities, such as Learning Events promoted by NHS England Local Area Team, Reviewer training for the West Midlands Quality Review Service and visits to share and gain ideas from other Trusts both locally and nationally.

1.5.5 Specific areas for the Board/EMT to note:

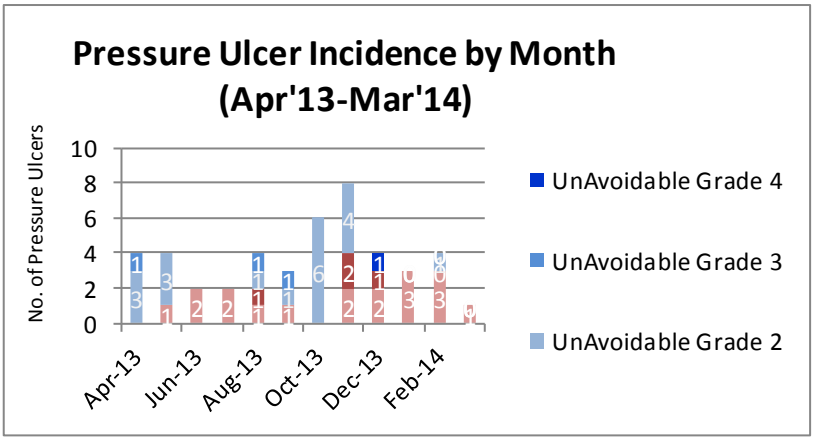
Additional funding to cover the extension of 2 fixed term posts within the Governance team was not successful at Business Planning stage.
In order to mitigate for the potential impact of this to the Governance Team and wider organisation the Governance team will need to review and modify the level of support currently offered to ensure an effective and robust service continues to be delivered to the wider organisation

1.5.6 End of year summary

Enhanced training and greater awareness of incident reporting has resulted in a significant increase in Incident reporting throughout the organisation.
The appointment of several new staff to the Governance team has ensured the continued delivery of quality and safety training and support to directorates in the provision of key quality and safety reports.
Work continues to ensure the Ulysses incident reporting system is as user-friendly and efficient as possible to support robust incident reporting, development of risk registers and the production of RCA investigation reports.

1.6 PRESSURE ULCERS

During the year a total of 22 avoidable pressure ulcers occurred and 23 unavoidable pressure ulcers, due to either the general poor condition of the patient and/or non-compliance with preventative strategies/equipment, or a pressure ulcer developing irrespective of all preventative strategies being put in place. It is recognised that as a specialist Trust we perform complex orthopaedic surgery which in some instances can lead to the patient being on a theatre table for 9hrs +. The single grade 4 pressure ulcer which occurred this year developed in a patient who was admitted with existing pressure damage, which deteriorated post operatively. This patient had undergone palliative surgery and the RCA findings indicate this was an unavoidable deterioration as all care and documentation was in place.

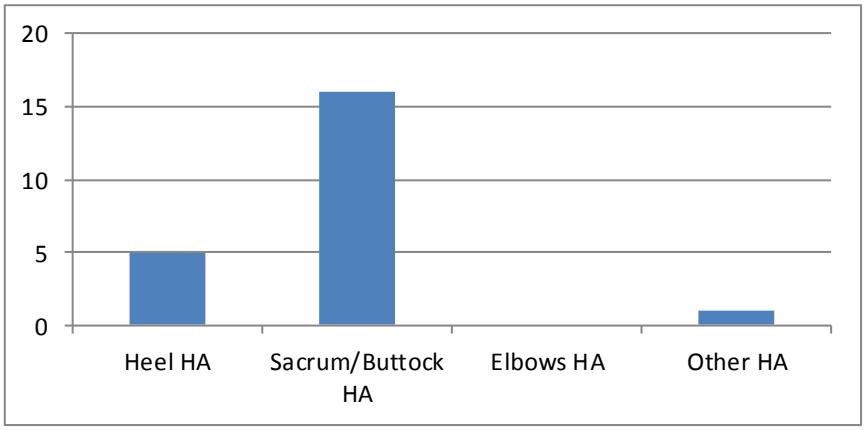


Patients have been admitted to the organisation with existing pressure damage and a total of 58 pressure ulcers were noted as present on admission, either from home or other Trusts. When patients are admitted with existing pressure ulcers this impacts upon resources Trust wide. All incidents that are hospital acquired grade 2 and above undergo a root cause analysis, the results are discussed with wards/areas and common themes shared with all nursing staff. These are also discussed at link nurse meetings. The patient stories / events are then shared on Mandatory training and clinical skill training days to highlight the groups at risk and actions needed.

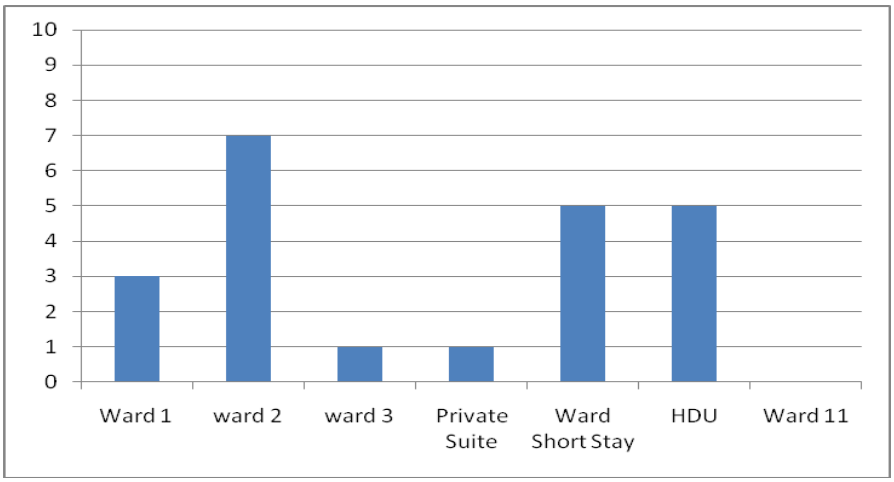
A total of 5 patients developed plaster/ removable splint pressure ulcers whilst an inpatient, 3 of which were deemed unavoidable. All of these cases were complex and ward staff inspected skin daily, completed risk assessments and reported and acted upon concerns. One patient had apparent vascular deficit, following the removal of the cast the damage developed further due to the vascular deficit. A further patient had a cast that was made removable due to their known high risk factors; this

was removed daily to inspect skin however unfortunately a dressing was placed over an area of early pressure damage, not removed to enable inspection and therefore this was classed as avoidable as the deterioration was not noticed. A further patient developed flexion deformity to their knee and was a complex case. With existing multiple risk factors, he developed pressure damage to his heel (grade 2) due to the flexion deformity and was subsequently placed in a plaster cast to help manage the deformity. The heel was incorporated into the cast which exacerbated the pressure damage, although the cast wasn't the initial cause.

The below graph demonstrate the areas of the body affected by pressure ulcers for inpatients, the data below includes avoidable pressure ulcers. This information can help determine how to reduce pressure ulcer incidence within the organisation.



Ward areas with avoidable pressure ulcers are shown on the graph below, some patients moved between two areas leading to multiple counting of ulcers. Themes include high risk patients sitting for longer periods than recommended or the pressure relieving aids not being in place. A factor specific to orthopaedic surgery is the receiving a block/epidural affecting sensation. Focusing on the key at risk areas can help in reducing incidence.



Mandatory training on pressure ulcer prevention is provided monthly for all staff. In addition to this all nursing staff groups receive in-depth training in the prevention and management of pressure ulcers. The HCA's also receive additional practical training on the prevention and management of pressure ulcers; this compliments the theory day. Attendance is monitored through the learning and development department. Sessions are provided for the student nurses, which is coordinated by the clinical placement coordinator.

All Nurses are encouraged to complete pressure ulcer competencies, with the aid of a pressure ulcer prevention and management ward based competency document. Assessment is provided by Tissue viability link nurses and the Tissue Viability Nurses. The competency documents are monitored by ward managers, and reported to matrons for their areas.

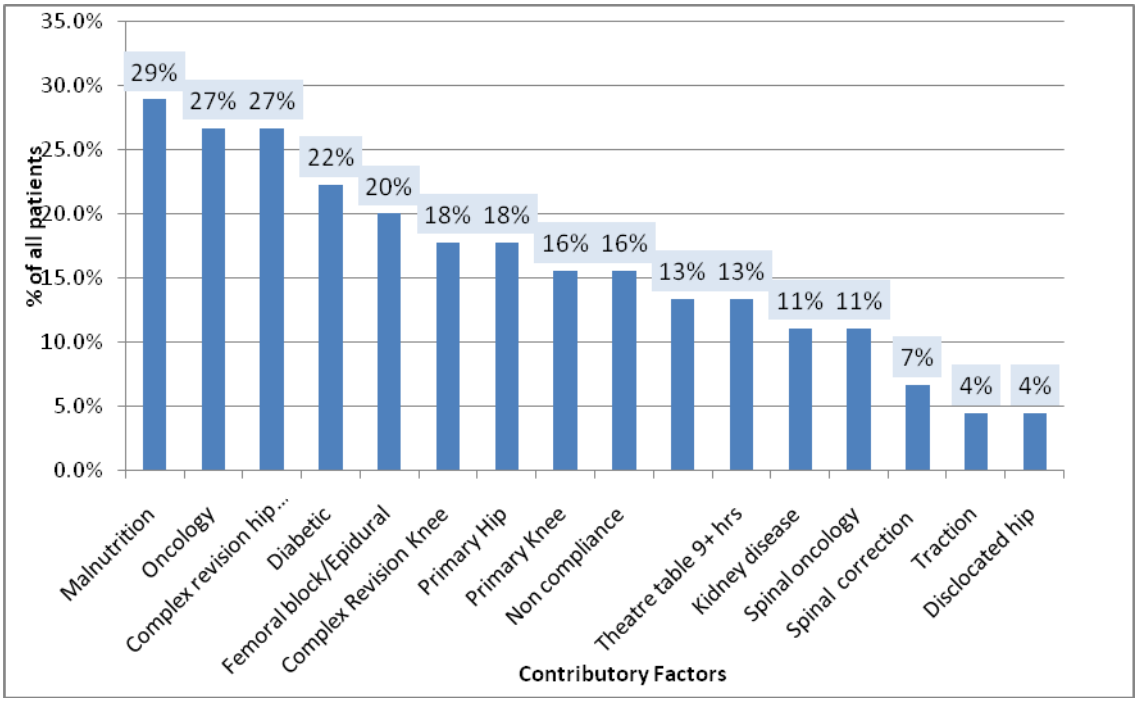
The Tissue viability link nurses audit their own ward area every quarter which helps identify areas they may need to improve upon. Audit findings has demonstrated that 96% of patients had a Waterlow risk score recorded within 6 hours of admission, and 96% had the appropriate care measures in place. Across the year this data is reasonably consistent. The Tissue viability team carry out independent documentation audits to ensure all wards are using the correct paperwork, this is fed back to ward managers and matrons. The findings demonstrate documentation is improving, supported by the ward link nurses.

An adapted version of the SKIN tool has been added to the pressure ulcer prevention care-plan to improve recognition of problems and help preventative care. Pressure ulcer prevention packs are now commenced in pre op assessment clinic and are available on admission to help improve standards. Patients at increased risk of developing pressure ulcers or those nutritionally at risk are now being identified with "AT RISK" stamped on their pre-operative documentation, this is to ensure wards and theatres are aware of their vulnerability for developing pressure ulcer.

Daily ward rounds Mon-Fri are carried out by the Tissue Viability/IPCT team and highlight patient concerns regarding skin integrity, wound issues, infection, nutritional concerns or deteriorating patients. These rounds ensure interventions are in place and offer additional assistance /advice for staff.

1.6.1 Review on trends and/or patient groups.

Common factors of both avoidable and unavoidable incidents are demonstrated in the graph below:



The data is insufficient to identify true trends at present and last year's data has been accounted for in our reduction strategy. Clinical judgment is of paramount importance in the drive to reduce pressure ulcers therefore raising awareness and knowledge amongst clinical staff is of extreme importance. Risk factors such as diabetes, malnutrition and multiple co morbidities are known to increase risk therefore these factors are to be expected in this data. A third of patients who developed pressure ulcers had malnutrition as a factor. This emphasizes the need to nutritionally optimise our patients throughout their whole journey of care at this organisation.

Complex 2 stage revisions, complex oncology bone and soft tissue tumours and subsequent surgery, all neurological deficits (from spinal injury/ tumour/ disease process or from anaesthetic intervention) increases the risks significantly. These areas need concentrated resources and direct interventions and through directing our attention to this complex group of patients we are experiencing a reduction in pressure ulcer incidence. The spinal and oncology wards have increased the amount of pressure

relieving equipment this year and accesses low air loss systems for complex cases. Such patients are referred to the dietician for review as malnutrition/poor wound healing can be an issue post operatively. Optimising these patients pre-operatively can be difficult due to their condition and the adjunctive treatment they may have required (e.g. chemotherapy).

Heel gel pads are put in place in theatre and recovery for patients with no pressure damage evident, to reduce the pressure to the heels of patients undergoing femoral blocks or epidurals.

The plaster practitioners have provided training sessions to staff on plaster care and management and importance of early escalation, as a result incidents are now reported more promptly and action taken appropriately.

For a small number of patients who find concordance with preventative plans difficult low air loss mattress systems are considered. Ongoing support and education is provided to these patients and their families with the aim of ensuring they understand how they can work with nursing teams to prevent themselves from developing ulcers.

1.7 ANNUAL NUTRITIONAL REPORT

Quarterly audits undertaken by the link nurses have continued in quarter 4.
Of 52 patients observed at mealtimes with 94% were allowed to enjoy their meal undisturbed.
Of 64 patients observed 94% had a MUST/STAMP completed within 6hrs of admission
94% of patients had a repeat MUST score completed of which 13% of patients had been referred to the dietician and 5% had a 'nutritionally at risk' care plan in place.
Other concerns noted included assistance needed with diet, dietary advice, or concerns regarding wound healing.

RGNs, HCA, and Student nurses attend training on the clinical skills days run every month. To enhance this there is a nutritional folder on each ward and staff competencies which ward link nurses facilitate. Mandatory training sessions are provided once a month for both clinical and non-clinical staff also covers fasting guidance and recent audit results.

Patients who are identified as being nutritionally "AT RISK" now have this stamped in red on their admission documentation, and also on their pre-operative checklist. This is commenced in pre op assessment clinic and followed through to admission.

1.8 ANNUAL FALLS REPORT

1.8.1 Falls Monthly update

The number of falls reported for March may be as a result of better reporting of incidents and are associated with a single long term patient who experienced multiple falls on Ward 2.
During March there has been improvement in the completion of falls risk assessments across inpatient areas. The key quality indicators have been achieved successfully, with 93% of all falls risk assessments being completed within 6 hours of admission and 96% of all high risk patients having a care plan in place.

Figure 2: Quarterly falls audit results 2013-14.

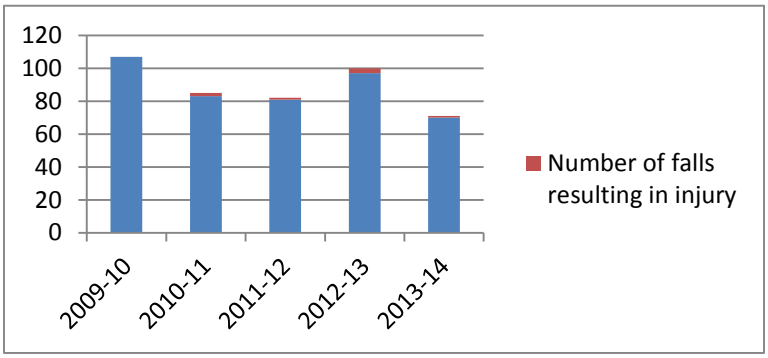
		Q1	Q2	Q4	Overall performance over 12 months
Q1	**Has the falls assessment been completed within 6 hours of admission?**	98%	97%	93%	95.2%
Q2	**If the patient is identified as high risk is a care plan in place?**	98%	91%	90%	91.2%

1.8.2 Notable Achievements of 2013-2014.

Over the year a large proportion of falls related to patients attempting to independently mobilise without asking for/waiting for assistance or against carer's advice. A lack of appropriate footwear being worn when patients mobilise causing slips, predominantly within the older adult population, has been identified. Confused and disorientated patients, those with spinal pathology, limb amputees and patients who have undergone spinal anaesthesia were amongst the highest rate of fallers, due to phantom limb pain, poor perception/understanding and lower limb dysfunction.

A collaborative approach to falls prevention has continued based on risk assessment, care planning and preventative measures. The number of inpatient falls in the year has decreased over the last year. During 2012-2013, 97 adult inpatients sustained a fall compared to 70 adult inpatients this year, a 28% reduction.

Figure 1: The total number of patient falls (blue) and those resulting in injury (red).



In supporting patients to regain independence and where early mobilisation is encouraged post operatively it is anticipated that this is likely to result in some patients sustaining a fall whilst in this hospital. It is therefore reassuring that only one patient sustained harm as a result of a fall, moderate harm. All falls with harm are fully investigated to identify care or service delivery issues, recommendations or actions and to learn to further assist preventative strategies.

Ongoing education, training and leadership is aimed at ensuring the risk of patient falls is acknowledged across all of our professional groups and that assessment, documentation and care standards remain high.

1.8.3 Key Opportunities for 2014-2015

This year will address many areas for development in falls awareness and prevention whilst further analysing the nature of patient falls across the organisation. Looking at areas of best-practice and continuing to network successfully with other trusts further motivates towards gaining our own innovative ideas to change/improve practice at ROHFT.

"The Throne Project" is one such project which has been approved for the next year by the falls working group and both Executive Director and Deputy Director of Nursing and Governance. From April 2013 to date, 64% of all reportable adult inpatient falls at ROHFT occurred in the hospital's toilets and bathrooms. Whilst these incidents did not give rise to any moderate or serious patient injuries (such as lacerations and fractures), minor harm was sustained by some. The consequences of these falls range from patient distress, loss of confidence and independence, pain and an increased length of stay. This provides the motivation for *"The Throne Project"*; an attempt to understand the nature of why patient falls occur in toilets and bathrooms and identifying any possible environmental risk factors which could be improved to protect patient safety and reduce harm.

Frequently falls have been associated with mobilisation of our patients and appropriate footwear has been identified as a causative or contributory factor. The slipper exchange scheme is planned to

provide appropriate footwear and wards are stocking anti-slip anti-embolic stockings. Funding will be sought from Charitable Funds Committee to establish the slipper exchange scheme and Directorate teams are encouraged to explore the cost pressure of moving to anti-slip anti embolic stockings for those patients deemed at greatest risk of a fall when mobilising around the bed and ward.

Further emphasis will be placed on communicating falls prevention messages to our patients pre-operatively and will be achieved by sharing information with our patients regarding their increased vulnerability to falls following surgery, how they can help us to help them stay safe and to raise awareness around falls generally. Links have been made with *Age UK* Birmingham and it is hoped that a series of staff and patient events will occur as a result; utilising these as a backdrop for developing falls programmes and strategies on an organisational level. Falls and Dementia leads have also linked in order to make special efforts to focus on this more vulnerable patient group who have the potential to be serial fallers in the acute hospital environment.

As an organisation, we have also been invited to link with the CCG on a joint programme with the local authority to develop an integrated strategy for falls in older people. This will formulate a strategic delivery and oversight group being established, with the first meeting taking place next month. This provides a great opportunity to raise the Trust profile; marketing and promoting the excellent ways in which we not only care for our patients but strive to keep them safe to our primary and (other) secondary care partners.

It is envisaged that funding to allow for supervisory Senior Sisters across the inpatient wards will enhance the work undertaken to date on falls prevention, for example, clinical and practical training at the patient bed side, and consistent achievement of the key quality indicators. The role of the falls lead will be reviewed should the funding bid for the fourth matron post be successful.

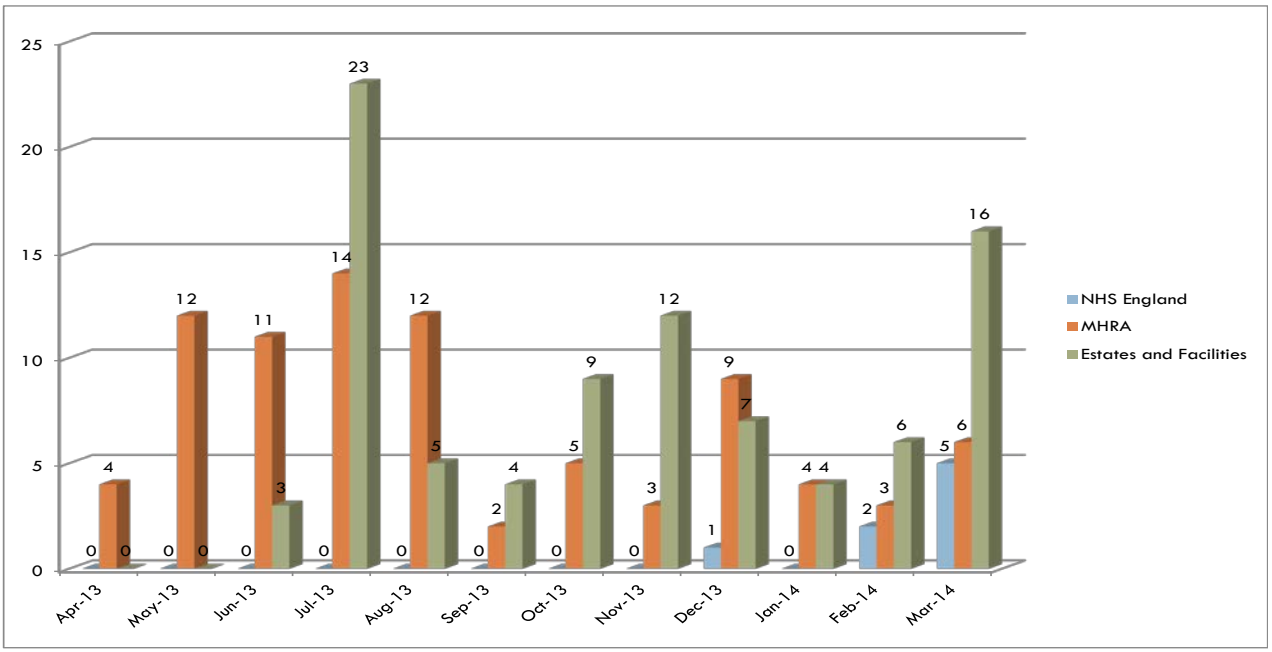
1.8.4 End of Year Summary

It is recognised that the numbers of patients who fall during their stay are low in comparison to neighbouring organisations and that any associated injury as a result, has not caused significant patient harm. The causes of falls and ways in which they are prevented will continue to be examined, appropriately considered and learning consequently applied. To support patient care disseminating and sharing best practice, ongoing education of both patient and staff groups and understanding and implementation of current guidelines for falls prevention and patient safety will continue.

1.9 PATIENT SAFETY ALERTS

During the past 12 months there have been 182 alerts issued to the trust through the Central Alerting System (CAS).

1.9.1 Breakdown of alerts by month/type:



1.10 WHO COMPLIANCE

Notable achievements of 2013/14
Concise completion of the WHO checklist has identified the prevention of clinical incidents in areas of Regional Anaesthesia, wrong limb surgery and adverse reactions to patients.

Key opportunities for 2014/15
It is planned to further improve data collection and the use of the robust data base. This detail will continue to be shared with operating teams and at Clinical Audit meetings.

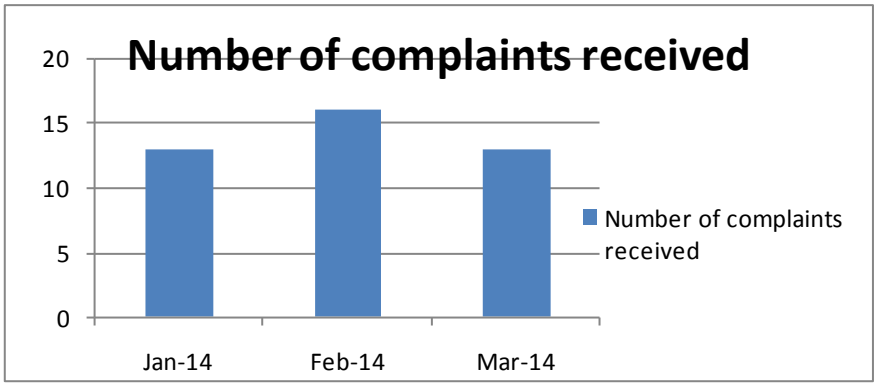
Specific areas considered important for EMT and Trust Board to note
Review of the audit process highlighted a need for improvements and the method of audit changed to reflect the compliance with WHO checklists within the operating environment.

End of year summary
During the handover process between Theatres and Recovery the WHO Checklists have continued to be examined per patient. Any non-compliance has been challenged at source and the checklist returned to Theatre.

2 PATIENT EXPERIENCE

2.1 Complaints received

Table 1 & 2: Numbers of Formal Complaints- January 2014 to March 2014 and Comparator



Q4 2013/14	Q3 2013/14	Q4 2012/13 (for comparison
42↑	26	37

Table 3: Complaints Handling Response Times

STANDARDS	ACHIEVEMENT Q4 2013/14
Acknowledged within the 3 day target	100% →
Responded to within agreed target period	80%↓
On-going but within the agreed target date	92%↑
On-going and are out of agreed target date	0↓
Completed over the agreed target date	9 ↑
Required consent to be gained	4 →
Informal Complaints resolved in this quarter	0↓

The department's compliance with KPI's has been met in this quarter although the figure has dropped from 87.5% to 80.4%. This is due to the complexity of some cases which have required multi-

disciplinary feedback across teams, and on occasions liaising with other acute providers. The Trust has several clinicians who work across several sites and/or abroad which makes gathering feedback in a timely way somewhat more challenging. This has been escalated to the relevant Directorates and Executive Directors.

The number of complaints in the quarter has increased in line with previous yearly trends. Areas with the largest volume of complaints received in the quarter can be broadly themed as follows:

- Poor organisation, administration and communication, particularly with regard to provision of information about progression of individual cases; numerous changes to outpatient appointments and letters sent cancelling appointments not received by patients and delays/perceived delays to have appointments and surgery dates confirmed
- Clinical outcome and clinical decision making (across all directorates)
- Approach of clinician/staff attitude (no patterns)
- Nursing Care provided/received (no patterns)

2.1.1 Healthcare Ombudsman update

2 cases have been referred to the Ombudsman in this quarter and it is not anticipated that they will investigate further.

2.1.2 Comeback complaints received and response times

In Q3, there were 6 comeback complaints which can be categorised as follows:

2 complainants were seeking financial redress

2 complainants had been to the PHSO and remained unhappy as their cases were not upheld and came back to the Trust to express further upset

1 complainant remains unhappy regarding explanation of waiting times being led by clinical need in the spinal service

1 complainant unhappy with clinical explanation given and would like to come and meet the clinical team to discuss further, this is being arranged

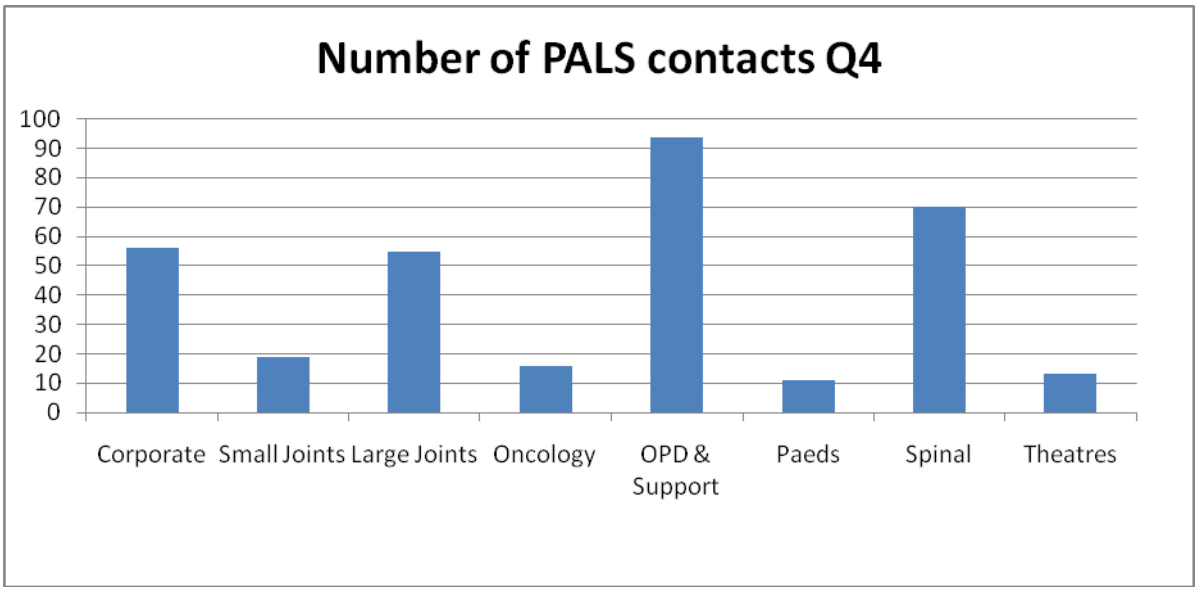
2.1.3 Actions being taken

- Regular minuted meetings with the Governance team linking incidents, pals, complaints and litigation continue to take place. All patient safety incidents are now automatically sent to Patient Relations Manager and the Public & Patient Services Manager.
- The Patient Relations Manager attended a course on complaint handling post Francis and Clywd/Hart reviews at which delegates from the DH, CQC, AvMA and the PHSO gave presentations and guidance as to best practice, likely changes to CQC visits and how complaints management will be part of each visit.
- The Public and Patient Services Manager and Patient Information Manager attended a Patient Experience event run by Nottinghamshire Healthcare NHS Trust who are exemplars in engaging patients and staff in driving forward the patient experience and embedding the culture internally.
- To enhance the standard of complaint responses to complainants the Public and Patient Services Manager was invited to attend SMT and review the processes in place and to discuss fully embedding complaint action plans trust wide and in directorates. A revised process is being developed for the start of 2014/15 year.
- Learning across teams and directorates

2.2 PATIENT ADVICE AND LIAISON SERVICE (PALS)

Q4 2013/14	Q3 2013/14	Q4 2012/13 (for comparison)
334↑	303	268

Graph 1: PALS Contacts by Area



Quarter 4 has seen a further increase in the numbers of PALS contacts received as compared with Quarter 3.Trends in PALS concerns received reflect a similar pattern as to that for Complaints for the two final quarters of the year. During quarter 4 there were 186 concerns which represents 56% of contacts and 148 general enquiries which represents 44% of contacts.

General enquiries include but are not limited to:

- Work experience requests
- Clinical placement requests
- Travel directions
- Parking arrangements
- Contact details for colleagues
- Difficulties getting through to departments
- Copy medical records
- Interpreter requests

Concerns raised in the quarter:

- "Rushed" or perceived rushed discharges
- Requests for care and treatment plans to be confirmed
- Appointments repeatedly cancelled/changed and patients not always informed
- Delays in clinic
- Long waits in ADCU – early arrival, surgery late in the day; lists not staggered
- Orthotics service provision

2.3 COMPLIMENTS

Table 1: Number of compliments recorded

Q4 2013/14	Q3 2013/14	Q4 2012/13
1472	989	1198

Compliment recording has continued at a steady rate through the quarter with support from Matrons and Directorate Managers to ensure feedback is collated.

2.4 PATIENT SURVEYS

2.4.1 National survey

The results of the 2013 National Inpatient Survey have been received and show clear improvement in several areas. The Trust is now significantly better than others in 72 of the 85 questions and significantly worse in none. Initial results have been distributed and a full report will be presented to the Board in Q1 14-15. Some of the results have been used to create areas for improvement in the Quality Plan and will form part of a new Patient Experience action plan. This will replace the National Inpatient Survey action plan to better reflect trends for improvement from all of our data.

2.4.2 Trust Real-Time Survey

The real-time patient survey continues to be tracked by the Public and Patient services Manager, with information being sent monthly to Senior Nurses and Departmental managers as appropriate.
A total of 405 patients were surveyed during this quarter. The number of surveys had increased in quarter 3 but reduced this quarter to a similar level collected over the first half of the year. Volunteers have been recruited to increase the number or real time surveys undertaken, however this has been affected this quarter by volunteer absence as a result of ill health, finding employment and holidays. The availability of a computer space to input the results is also an issue.

Trends from the questions are as follows:

- There has been a significant decrease in the number of patients reporting that the food is poor (3.95% this quarter compared to 7.5% last quarter) This indicates that the action taken by Public and Patient Services, Ward Managers and Facilities has impacted positively. Friends and Family comments will continue to be brought to the attention of the relevant staff to ensure that this responsiveness to patient opinion is maintained.
- It has now been confirmed that there has been a significant improvement on patients feeling that staff were available to talk to about worries or concerns on the National Survey. This would indicate that the monthly monitoring and reporting back to Ward Managers and Matrons is effective.

The three best performing areas this quarter:

- Privacy when discussing treatment or condition
- Privacy when being examined or treated
- Overall being treated with dignity and respect

Staff being available to talk about worries or concerns and information being provided continues to perform well

2.4.3 Areas requiring improvement:

- Knowing who to contact after leaving the hospital if there are any concerns (decrease to 38% this quarter from 39.8% of patients are still reporting that they don't know)
- Not having additional printed information other than appointment letter before coming to appointment: (increase to 16% this quarter from 14% are reporting that they have not received patient information)
- Hand washing of clinical staff (8% from 12% last quarter)
- Not being told about side effects of new medication still continues to be a concern

Actions taken:

- Information is continuing to be sent to departments and managers. This is impacting in certain areas more effectively than others.
- Public and Patient Services continues to work with departments to resolve areas of concern where appropriate
- Reduction in the % of people not knowing about side effects of new medication has been agreed as an improvement target with commissioners.

- The Public and Patient Service Manager will assess the 'knowing who to contact' question in light of the fact that all patients are asked this. Given that some patients have just been admitted or are 2 days post-op, the trust would not necessarily expect these patients to know this information. Further analysis of this result will show whether this is a genuine concern or the result of the survey design. Action will be taken according to the outcome.
- The 'your first appointment' information is not being sent out with first appointment letters currently as volunteers are unable to ascertain which letters they are required for. The Public and Patient Services Manager will liaise with the appointment department to attempt to resolve the issues.

2.5 PATIENT EXPERIENCE CQUIN

The composite patient experience score has been replaced by the Friends and Family net promoter score as the measure of patient experience nationally. This CQuIN scheme has been successfully achieved this year.

2.5.1 Friends and Family Surveys Net Promoter Score (CQuIN)

Jan-14	Feb-14	Mar-14
83	84	85

The average net promoter score for Q4 is 84 and remains in the top quartile nationally. The average completion rate for the quarter is 43%, whilst this is a reduction from the beginning of the year it remains much higher than the required 20% of inpatients and higher than the national average.

- The majority of patients remain very happy with the care that they have received and have confidence in their care providers
- Patients remain most concerned about process rather than care; particularly about being given appropriate and timely information regarding what's happening.
- Patients feel that discharges felt 'rushed' and confidence in their recovery has not had time to build.

Actions taken:

- Data is provided monthly to Ward Managers and Directorates, including positive and negative comments for each area. As these are anonymous surveys, this information is used for trend analysis rather than specific individual concerns.
- The discharges feeling 'rushed' are a possible consequence of increased activity and through-put. Information has been provided to individual areas where this has been identified to ensure that the process is reviewed.
- Notice Boards at the entry of each ward are being prepared to share patient experiences and ward staffing, under the working title of 'your care, our service'.

2.6 LITIGATION

2.6.1 March 2014 update

New Cases: 2 potential clinical negligence cases was notified in March 2014

Ref	Date of incident	Details	Directorate
T438	2006	Shoulder surgery	Large joints
T437	April 2012	Knee replacement surgery	Oncology

Existing Cases: Formal letters of claim were received in the following cases

Ref	Date of Incident	Details	Directorate
T361	2007 onwards	Failure to diagnose and treat juvenile arthritis	Paeds
T337	Jan/Feb 2011	Fractured leg whilst in hospital following hip replacement Jan/Feb 2011	Theatres/ Large Joints
T399	Oct 2010	Potential product liability claim and potential clinical negligence claim – hip prostheses.	Large Joints

Closed cases: none
Coroner's Inquests: none

2.6.2 Notable achievements of 2013/14

- Improved litigation reporting e.g. monthly Patient Quality Report, Clinical Audit Meetings and TBALD meetings.
- Consolidation of good practice relating to management of litigation cases e.g. data management.
- Use of the NHSLA 'fast track' electronic portal for the management of third party claims.
- Litigation assistant commenced study for professional law qualification Chartered Institute of Legal Executives Certificate).
- Training for staff on claims e.g. inclusion in mandatory training, and bespoke training sessions (e.g. witness statements, third party claims).

2.6.3 Key opportunities for 2014/15

- Formation of an 'in-house' medico-legal group to give expert clinical advice on claims against the Trust and assist with dissemination of learning from claims.
- Improve sharing of learning from claims across the Trust.
- Benchmarking claims against the Trust with other similar Trusts.
- Ensure <u>all</u> untoward incidents (including staff and visitor accidents) are investigated at the time of occurrence.

2.6.4 Specific areas considered important for EMT and Trust Board to note

- There has been a significant (29%) increase in the number proceeding clinical negligence claims in the last 12 months, although the total number of litigation cases being managed has only increased slightly.

2.6.5 Open Litigation files

	Number of files open 31.3.13	Number of files open 31.3.14
CNST proceeding claims	41	58
CNST cases at disclosure stage	71	65
LTPS proceeding claims (staff)	13	9
LTPS proceeding claims (Visitors/ Public)	5	3
Total open files	130	135

- The number of new cases has fallen with only 5 new cases received in Q4 (compared with 16 in Q2 and 11 in Q3). This may be owing to the changes in the payment of fees incurred by claimants which came into effect on 1st April 2013: from this date, claimants who enter into a Conditional Fee Agreement (CFA) with a solicitor must pay their solicitor's fees from their damages. Previously, the cost of legal fees was recoverable from the defendant if the claim was successful.
- As in previous years, common themes of clinical negligence claims include consent (e.g. failure to fully explain surgical outcome and alternative treatment); surgical outcome (e.g. nerve damage, leg length discrepancy); nursing care (e.g. pressure ulcers); and delay in diagnosis.

2.6.6 Coroner's Inquests annual overview:

A total of 4 inquests were held between 1st April 2013 and 31st March 2014 relating to patients treated at the ROH:

1. an oncology patient who was transferred to QEH owing to deteriorating condition where he died 6 days later;
2. a large joints patient who died at home 43 days post uneventful shoulder surgery;
3. an oncology patient who was ready for discharge but suddenly became unwell and was transferred to HDU where she died the same day;
4. An elderly patient with multiple co-morbidities who underwent emergency spinal surgery Christmas-Eve 2012. The patient deteriorated and was to Russell's Hall where he died 10 days later.

No concerns were raised at the inquests concerning the patients' treatment and care at the ROH.

2.6.7 End of year summary

The management of risks associated with claims against the Trust for clinical negligence and liability to third parties remains a key priority for the Governance Team. Significant improvements have already been made in linking and sharing the investigation of claims, serious incidents and complaints and the Team now aims to extend this to improving the sharing of learning from claims, SIRIs and complaints. The planned formation of an expert medico-legal forum should enable the Trust to give more robust challenge to unmeritorious claims and help to identify instances of poor or unsafe practice requiring remedial action. The Governance Team will endeavour to facilitate the implementation of required actions and improvements highlighted by the investigation of claims.

2.7 SINGLE SEX COMPLIANCE

There were no single sex compliance breaches between April 2013 and March 2014.

2.8 PATIENT REPORTED OUTCOME MEASURES (PROMS)

2.8.1 Notable achievements of 2013/14

The Trust has exceeded the PROMS target of 90% compliance in 2013/14 for both hip and knee replacement surgery.

2.8.2 Key opportunities for 2014/15

The process for monitoring compliance will be simplified by developing reports from ORMIS / PAS.

2.8.3 Specific areas considered important for EMT and Trust Board to note

Primary Knee Replacement - below the national average for EQ5D and Oxford Knee Score and although not considered an outlier at present the data is close to the lower limits for these measures. As a specialist provider this requires further attention and action.
The 2012/13 data is provisional, based on previous years the 2012/13 data will be finalised around August 2014. The position may change slightly as more data becomes available.

2.8.4 End of year summary

Further investigation of the factors that influence EQ5d and Oxford score in Primary knee replacements are ongoing and will be overseen by the Clinical Governance Committee.
PROMS scores have been monitored quarterly at COEG and each consultant is given the data for their Hip/Knee replacements with patients who show no improvement or a worsening score identified. COEG will be required to fully report to Clinical Governance Committee in 2014/15.

2.8.5 Data

Internal Monitoring of Compliance

OPERATION	No patients meeting PROMS criteria	Q's completed	% eligible patients completing Q's
Knees	1284	1224	95.3%
Hips	904	857	94.8%
ALL	2188	2081	95.1%

Latest available national data for Compliance

	Total HES Procedures	Total Pre-Op Qs completed	Participation rate
Knees	411	376	91.5%
Hips	614	584	95.1%
ALL	**1025**	**960**	**93.7%**

Provisional 2012/13 data

Adjusted average Health Gain				
	Oxford Hip Score	Hip EQ5d	Oxford Knee Score	Knee EQ5d
England	21.317	0.438	16.01	0.319
Royal Orthopaedic Hospital	21.719	0.452	15.658	0.299

2.9 NATIONAL JOINT REGISTRY (NJR) ANNUAL REPORT

2.9.1 Compliance progress 2013

For the period January to December 2013 with an end submission date of 28th February 2014: 2237 forms were submitted and include Hip, Knee, Shoulder, Ankle, Elbow replacements and revisions. Based on the number of NJR forms submitted, the Trust is above the 90% (overall) compliance rate for 2013. The provisional NJR Consent progress for January to December 2013 is approximately 88%. NJR Consent relates specifically to patients giving consent to their personal data being recorded on the NJR database.

The NJR will publish the Trust's compliance rate for 2013 in September 2014 as part of the NJR annual report.

2.9.2 Compliance Progress (January-March 2014):

Given the focus to ensure compliance with the 2013 NJR returns a backlog developed for data inputting of the 2014 NJR (covering January and February). There are plans in place to address this and specific details of progress will be outlined in future updates. The tables below demonstrate the 2014 position.

	Jan 14	Feb 14	March 14
% Compliance	88%	92%	90%

Consent Progress January-March 2014

	Jan 14	Feb 14	March 14
% Consent	29%	45%	51%

2.9.3 Notable achievements of 2013/14

- Achieving overall NJR compliance

2.9.4 Key opportunities for 2014/15

- Improving internal processes to ensure a backlog does not form again.

2.9.5 Specific areas for Board/EMT to note

- The consent compliance for 2013 is slightly under expected levels but this will not affect the Best Practice Tariff which is set to come into place in 2014/15. To achieve this tariff organisations are expected to have achieved over 75% consent compliance. The CQC inspection of specialist orthopaedic organisations will have increased scrutiny of NJR and the actions and improvements made as a result of the findings. COEG will lead this.

2.9.6 End of year summary

- Compliance with the NJR mandatory national audit has now been met through significant focus. HES figures set for release at the end of April should confirm this. Continued work will take place to improve internal processes to ensure a backlog does not form again, that robust reporting and escalation of results and concerns are shared in a timely manner. This has already started with the consent compliance process. There is a short-term plan in place for general compliance, and ideas have been put forward to improve the process further.

3 EFFECTIVENESS OF CARE

3.1 ANNUAL OVERVIEW OF SAFETY THERMOMETER

2013-2014	Targets	Jan 14	Feb 14	March 14	Quarter 4
Pressure Ulcers	2.1%	1.56% new 2.35% old	0%	0.76% new 0.77% old	0.77%
Falls	2.5%	0%	0%	0%	0%
Total Harm Free		96.09%	100%	97.7%	97.93%

Safety Thermometer Report Quarter 3

2013-2014	Targets	October 13	Nov 13	Dec 13	Quarter 3
Pressure Ulcers	2.1%	1% new 1% old	0%	0% new 5.32% old	1% new 2.1% old 2.44%total
Falls	2.5%	3%	1.15%	1.06%	1.7%
Total Harm Free		97%	98.85%	94.68%	96.8%

Safety Thermometer Report Quarter 2

2013-2014	Targets	July 2013	Aug 2013	Sept 2013	Quarter 2
Pressure Ulcers	2.1%	1.1	2.15%	1.3%	1.5%

Falls	2.5%	0%	0%	0%	0%
Total Harm Free		98.9%	97.85%	98.7%	98.5%

Safety Thermometer Report Quarter 1

2013-2014	Targets	April 2013	May 2013	June 2013	Quarter 1
Pressure Ulcers	2.1%	2.11%	1.9%	1.03%	1.68%
Falls	2.5%	0%	0.95%	0%	0.95%
Total Harm Free		97.89%	96.19%	97.94%	97.34%

4.0 Summary of Patient Quality Report

The development of the monthly report to EMT and Board has brought together many of the core components of quality. This has provided greater visibility and understanding of the all-round care experienced by the patient and carers who visit the organisation.

It is pleasing to note that improvements have continued to be made throughout the year in many aspects of quality.
Focused attention and enhancements to reporting and learning mechanisms will form the major drive for 2014/15.

APPENDIX 1

1.1 New SIRIs March 2013

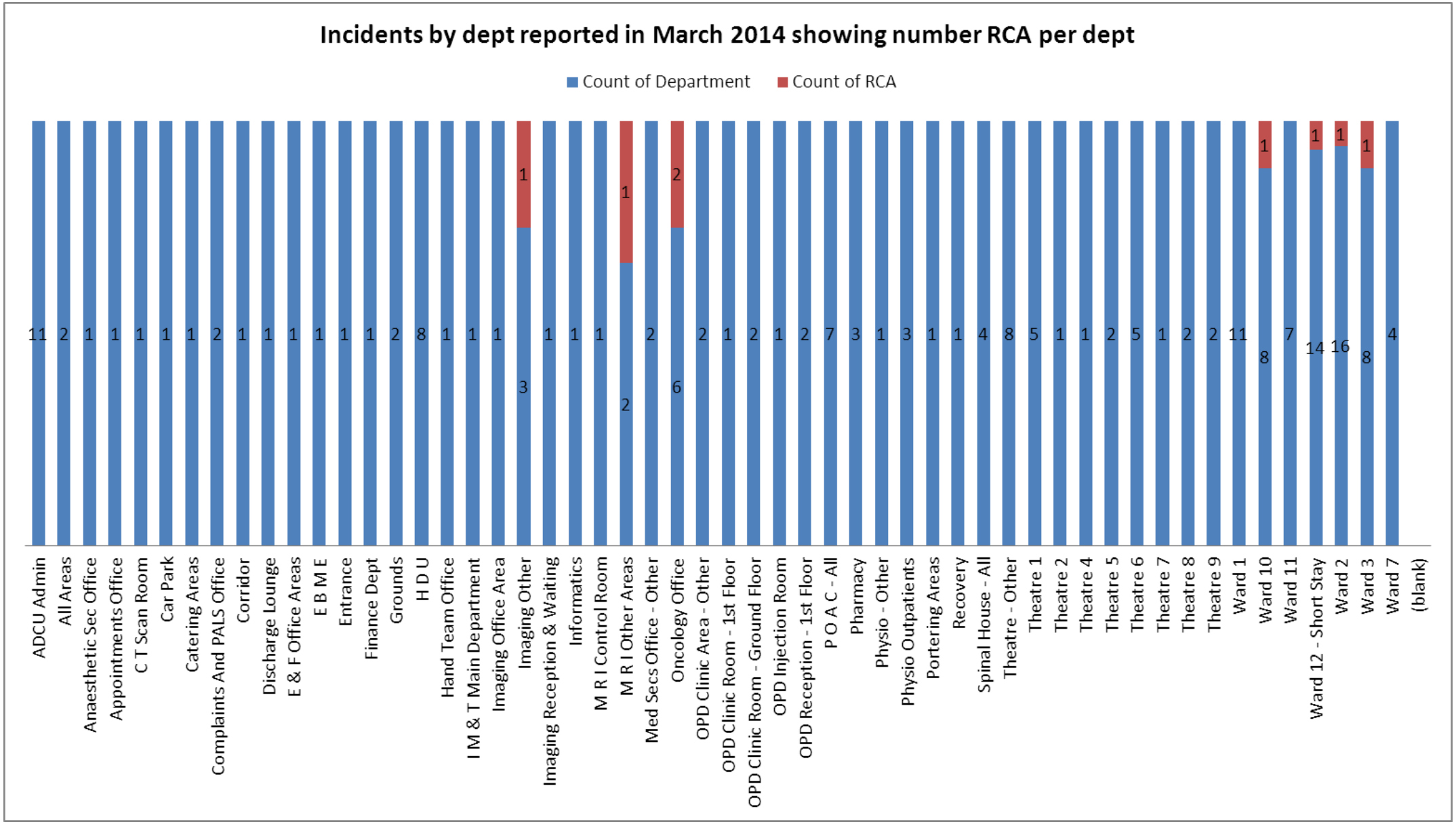
Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final report due
12532 STEIS 2014/8553	10/03/14	13/03/14	Delayed diagnosis	Near miss	Oncology	Investigation underway	20/05/14

1.2 Ongoing/Submitted SIRIs:

Ref	Incident date	Description	Directorate	Progress / date submitted	Date report due	Findings summary
11994 STEIS 2013/ 35356	25/11/13	Anaesthetic concerns	Theatres & Anaesthetics	Submitted 24/3/14.	19/02/14	***Lessons learned*** Staff to ensure they have a clear understanding of their professional responsibility to inform their line manager or clinical lead of any health or personal issues which may impact on their ability to be a safe practitioner. Staff members who are required to leave their clinical duties must ensure that patient care is unaffected and that their team members are fully aware of their absence in advance of leaving the clinical setting.
12189 STEIS 2014/ 2378	16/12/13	21/1/14	Diathermy burn	Submitted 25/3/14.	25/03/14	Patient has not suffered any lasting harm as a result of this incident but however will be left with a scar to his thigh. **Arrangements for sharing and learning:** Disseminate the S.O.P for safe use of diathermy and have all staff read, understand and sign so that this type of incident

						does not reoccur. Surgical team to be more vigilant when using the diathermy and to also manage the safe return of the diathermy finger switch back into the diathermy scabbard.
12278 2014/ 2878	23/01/14	27/01/14	Consent not done	Submitted 24/3/14.	31/03/14	**Lessons Learned:** To ensure patient verbally confirms the surgical procedure and the correct side to be operated on. ADCU staff to ensure patient documentation is correct and complete prior to collection from theatre staff. Surgeon to be present at the 'sign in' section of the WHO check. Student ODP's always need to be supervised by the senior theatre practitioner when checking in patients prior to surgical procedures. The senior theatre practitioner is responsible for the student's training and learning, therefore, should not expect the student to undertake specific safety checks autonomously. The importance of the WHO check list and implications of what can happen when processes are not adhered to.
12164/8 STEIS 2014/49 00	07/01/14	12/02/14	Anaestheti st absence	Downgrad ing request made.	Theatres & Anaesthetic s	Asked to downgrade this following initial investigation as original incident detail misleading.
12383 STEIS 2014/48 95	10/02/14	12/02/14	Confidentia lity breach	Investigati on underway	Corporate	Investigation underway
12412 STEIS 2014/58 69	11/02/14	19/02/14	Pt transfer	Investigati on underway	Theatres & Anaesthetic s	Investigation underway

APPENDIX 2


Incidents by dept reported in March 2014 showing number RCA per dept
Count of Department
Count of RCA
ADCU Admin 11
All Areas 2
Anaesthetic Sec Office 1
Appointments Office 1
C T Scan Room 1
Car Park 1
Catering Areas 1
Complaints And PALS Office 2
Corridor 1
Discharge Lounge 1
E & F Office Areas 1
E B M E 1
Entrance 1
Finance Dept 1
Grounds 2
H D U 8
Hand Team Office 1
I M & T Main Department 1
Imaging Office Area 1
Imaging Other 3 1
Imaging Reception & Waiting 1
Informatics 1
M R I Control Room 1
M R I Other Areas 2 1
Med Secs Office - Other 2
Oncology Office 6 2
OPD Clinic Area - Other 2
OPD Clinic Room - 1st Floor 1
OPD Clinic Room - Ground Floor 2
OPD Injection Room 1
OPD Reception - 1st Floor 2
P O A C - All 7
Pharmacy 3
Physio - Other 1
Physio Outpatients 3
Portering Areas 1
Recovery 1
Spinal House - All 4
Theatre - Other 8
Theatre 1 5
Theatre 2 1
Theatre 4 1
Theatre 5 1
Theatre 6 2
Theatre 7 5
Theatre 8 1
Theatre 9 2
Ward 1 2
Ward 10 11 1
Ward 11 8
Ward 12 - Short Stay 7
Ward 2 14 1
Ward 3 16 1
Ward 7 8
(blank) 4

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: 30th April 2014 **Enclosure Number: 7**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Anne Cholmondeley Director of Workforce & OD**
SUBJECT:	**Staff Engagement**

SUMMARY

This report is designed to brief Board members for a presentation and discussion on staff engagement. The paper explains what staff engagement is, the recent Trust context and the actions undertaken as a result. The paper also describes the current context. At the Board meeting I will present the aims of an engagement strategy and how this fits into a wider people strategy, for discussion and agreement at the Board.

RISK & IMPLICATIONS

Staff engagement is one of the key BAF risks and this paper together with the presentation explains how this risk has been and will continue to be addressed by the Board

RECOMMENDATIONS

Trust Board is asked to read this paper in preparation for a Board presentation and discussion on the proposed staff engagement approach.

Staff Engagement Briefing for Trust Board

What is staff engagement and why engage staff in delivering great patient care?

The Board, with stakeholders, is developing an organisational strategy that is ambitious and places the trust as a centre of excellence in the delivery of orthopaedic care. The people who work in the Trust will create the successful delivery of this strategy and our challenge as a Board is to determine approaches that enable staff to be the best at what they do in order that they consistently contribute to achieving the Trust's ambitions.

There is clear academic evidence in the NHS(1) that high staff engagement is linked to higher patient satisfaction, better patient experience and better financial performance. As individuals, engaged staff are motivated to provide solutions to challenges they experience, seek opportunities to improve patient care and act as advocates for their Trust, both as a place to work and a place to receive treatment.

Great staff engagement is sometimes described as whether staff " say,stay and strive" for the organisation or business they work for. Specifically:

- what staff say about their employer – is it a good place to work, do they feel valued etc;
- whether their intention is to stay with the organisation. This being a positive choice because of their positive experiences rather than a forced choice in the absence of a better alternative.
- whether they 'strive' for the organisation i.e. invest their personal energy, skills and passion for the benefit of the organisation and it's customers or in healthcare, patients.

Recent Trust Context

In late 2012, a series of votes of no confidence in individual members of the Trust Board were made by the Medical Staff Committee. In order to understand both the causes of this dissatisfaction amongst the medical workforce and understand whether this feeling was more widespread, several of the large consultancy firms were invited to work with the Trust to undertake some diagnostic work. None of the submissions were acceptable either due to the scope or cost of their work. An organisation called Managing the Service Business (MSB) were therefore commissioned by the Acting Chief Executive. MSB reported their work in August and September 2013 and a summary of their findings is detailed in appendix one of this report.

Action taken since the diagnostic work

The results of the diagnostic work were widely shared with staff and some immediate actions were taken pending the arrival of the new Chief Executive:

- Increasing executive and management visibility. Both Executive Directors and senior managers in directorates have been more visible to staff, both through informal walk-about and through structured conversations about future developments such as the move to seven day services.

- Reducing the prevalence of meetings. This feedback was from our senior managers and as a result the monthly performance meetings were made less frequent to enable them to focus on delivery of their services and personal visibility.

In addition the following actions have been taken by members of the executive team and senior managers since the arrival of the new Chief Executive:

a. Personal visibility of the new Chief Executive

b. Development of a strategy and specifically a strategic narrative that describes the future ambition of the Trust

c. Regular communication from the Chief Executive in the form of newsletters and blogs which is starting to 'wins hearts and minds' towards the Trust's future ambition and to develop a richer appreciation by staff of the external context in which the Trust provides healthcare. These are important enablers towards creating a workforce of people who are ready for change in the organisation.

d. From May 2014, the process for Core Brief will be more rigorous and require formal cascade briefing of staff and provide an opportunity for staff to feedback.

e. Important first steps have been taken to link individual staff reward, be that pay or support for personal development, to successful delivery of objectives and behaviours that are consistent with the Trust's values. This has been enabled through a new pay agreement for staff on Agenda for Change terms and through the allocation of Charitable funds for personal development.

f. There has been a marked increase in the number of staff whose performance is being reviewed through the capability processes. This is an early indicator that managers and leaders in the organisation are more readily tackling poor performance.

g. There has been an increase in resources in key areas identified by staff most notably IT, radiology/imaging and medical secretaries. These have been

further supported through the developments agreed in business plans for 2014/15.

h. Evolving the HR and OD function. Work continues to streamline transactional processes and invest time and capacity into the transformational agendas. The roll-out of ESR self service will be completed later this year and through new appointments, the Director of Workforce +OD and Head of Learning and OD have been able to focus on initial pieces of transformational work on values, leadership behaviours and development of the overall people strategy.

Current cultural context

Many of the interventions detailed above were implemented from November 2013 onwards and therefore it is early to assess their impact in a quantitative way. Early aneacdotal feedback from staff is mixed with some describing a noticeable change in climate and increased belief in the future, with others remaining to be persuaded that 'things will be different' in practice. There has been a willingness from a wide range of staff to actively participate in the development of the Trust's strategy, including a number of consultant medical staff. In addition the effort people have made to achieve the necessary improvements in activity levels in the last six months of 2013/14 should not be underestimated; it is a sign that staff will strive in the interests of patients and the organisation when there is a clear imperative.

Conclusion

Our ambition to improve staff engagement is only one part of a rounded people strategy that articulates the vital role that staff have in delivering great patient care and the future ambition for the Trust as a great place to work. It will be important that our work as leaders in the organisation focuses on all aspects of great people management, from education, learning and development to alignment of resources to achievement of goals, valuing staff through enabling them to contribute at work alongside their life responsibilities to effectively rewarding and recognising individuals who consistently achieve in their roles. At the Board meeting I will outline my initial thoughts on the component parts of a People Strategy and for the staff engagement aims within that and how the HR and OD function is changing to lead and support delivery of our ambitions.

References

(1) Employee Engagement and NHS Performance; Michael West and Jeremy Dawson 2012.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: 30th April 2014 **Enclosure Number: 8**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Anne Cholmondeley Director of Workforce & OD**
SUBJECT:	**Workforce Report**

SUMMARY

This is the quarterly workforce report to the Board and has a particular on workforce development that is underway. The workforce key performance indicators are reported separately in the Corporate Performance Report.

RISK & IMPLICATIONS

This report provides an update on a number of workstreams which will support achievement of the objective 'to be a great place to work' and in particular to address the BAF risk relating to staff engagement.

RECOMMENDATIONS

Trust Board is asked to note the content of this report in particular the work on-going to finalise Trust Values, leadership behaviours, linking pay to performance contribution and implementation of the new national requirement of the friends and family test for staff.

Quarter Four Workforce Report

1. **Workforce Development**

a. Development of Staff in Pay Bands 1-4

In late February 2014, the new Learning and Development Advisor started in post in this new role funded by the additional funding received by the Trust from the new Education Tariff. The postholder has a specific focus on staff in pay bands 1 – 4 and all staff in non-clinical roles whose learning needs have been supported intermittently in the recent past. The postholder also has responsibility for progressing utilisation of the Charitable Funds made available to address:

- National Vocational Qualifications
- Personal Development for high performing staff
- Customer Care training
- Technical learning to support career development

The process has commenced for the allocation of funds for personal development and technical learning. An update will be provided to Charitable Funds in May.

b. Diversity

During the quarter significant work has been undertaken to support delivery of the Trust's Public Sector Equality Duty and address some of the concerns highlighted in the staff opinion survey. The annual report on diversity was presented to the Board and a new Equalities policy has been agreed by EMT and will be communicated in May to improve understanding of this important agenda. In addition there has been a review of the role of Contact Officers who support staff who believe they have been bullied and/or harassed. A delivery partner has been engaged to support further definition of the purpose and boundaries of the Contact Officer role, selection of additional staff to undertake the role and their development. These activities will be completed by the end of June 2014.

2. **Organisational Development**

In support of the development of the Trust's strategy three important pieces of work have been undertaken during the quarter:

a. Engaging with senior leaders in the organisation on the key people and organisational development priorities, to support organisational sustainability and culture change. Leadership development and the engagement strategy

are key parts of this, however other strategic priorities have also been identified:

Values – embedding these within the Trust
Enhancing corporate communications
Learning and Development for all staff
Ensuring there is a clear link between trust, team and individual objectives
Improving processes in the patient journey in particular POAC and patient admin.
Improving cross directorate/functional working
Devolving decision making to directorates/departments

The views of stakeholders is informing the development of a draft people strategy which will be inform a discussion with Trust Board over the summer.

b. Development of Trust Values

During 2013 a series of values were developed based on stakeholder events and feedback. Although the spirit of those values reflected staff opinion, both staff and managers have indicated they are not easily memorable and have not been embedded within the Trust. In order to honour the work undertaken and staff feedback received during 2013, the intent of the values developed have been re-shaped into a draft new set of values, details of which are attached in appendix one. These will be tested with staff and stakeholders during April, May and June, starting with the stakeholder event on 25th April. These can then be embedded into the key parts of the employee journey from recruitment to development and performance review.

c. Leadership Strategy and Behaviours

One of the component parts of an effective leadership strategy will be a common shared description of effective leadership behaviours. These will be the standards against which leaders will be recruited, developed and their performance reviewed.

Preliminary work has been undertaken to develop a document that summarises the leadership behaviours for the Trust. This has jointly been undertaken with NHS Elect who have extensive experience of supporting NHS Trusts in this area, including the two other specialist acute providers in Birmingham. The framework has been designed to encapsulate the core enablers of leadership competency – Being, doing, style. The first draft

has been shared with senior leaders in the Trust who have an opportunity to contribute to the development of these these during May and June.

3. HR Evolution

a. The ESR self service project is now in pilot phase with HR, IM+T, finance and the Private Ward using the functionality. Subject to satisfactory completion of the pilot phase and the management of risk within the project relating to training capacity and engaging key stakeholders in behaviour change, the full functionality for ESR self service (manager, administrator or employee self service) will be available to all by the end of 2014. This will include the facility to book and authorise annual leave, study leave and training provision, as well as real-time availability of data for managers on key performance indicators such as absence, vacancies and mandatory training compliance. The strategic benefit of this project will be to achieve process efficiencies and support greater ownership of workforce indicators by Directorate leadership teams.

b. Discussions continue with a potential external provider of recruitment and pay administration. It is envisaged that a price for outsourcing of these services will be received during May at which point a decision can be taken on the future of this service. The decision will be taken by EMT on the recommendation of Workforce and OD Committee.

4. HR Operations

a. Pay

During the quarter agreement was reached with local trade union representatives to link incremental pay progression to completion of mandatory and statutory training, appraisal and the absence of formal concerns about competency and conduct. This agreement is an important first step to link personal pay to individual contribution towards delivery of the organisation's ambitions.

Staff with line management responsibilities will need to ensure 95% of staff in their area of responsibility are also compliant with mandatory training and appraisal requirements. Briefings for line managers were undertaken and staff made aware via written communication and face-to-face briefing sessions on 11th April. Negotiations will continue from May onwards to develop a formal local agreement for 2015/16 to link the incremental progression for individual staff to delivery of their objectives.

b. Notice Periods for Nursing Staff

Workforce and OD Committee considered a request for the notice periods for qualified nurses to be re-negotiated with staff side due to concerns about inconsistency of approach with other Trusts. The Committee reviewed information about current practices in Trusts across the region gathered via the Deputy HR Directors network. On the basis there were only two trusts in the region who had notice periods above the national terms and conditions, it was agreed that the Trust would not at this stage re-negotiate and review again at the end of quarter one.

5. External Matters

a. Friends and Family Test for Staff

The national requirements for the Staff Friends and Family Test (SFFT) have been published. All trusts are required to survey one third of staff during quarters one, two and four, as well as conduct the full staff opinion survey during quarter three. The trust will be outsourcing the administration of the SFFT to a survey provider. Staff will be randomly selected each quarter ensuring that all staff are asked to complete the SFFT once a year. The additional cost of this new national requirement is £9203 and funding for this has been agreed in business planning.

b. National Pay Agreement

The national pay agreement for staff on Agenda for Change terms for the period 2014-16 has been announced during the quarter. All staff on the top of their pay band will receive a non-consolidated payment of 1% and other staff will receive incremental pay progression, subject to meeting locally negotiated criteria (detailed above in section 4b). Doctors will be subject to the same national arrangements except meeting locally negotiated criteria (this facility was not available for negotiation locally). Staff had the opportunity to attend a briefing on this agreement in April.

c. National Education and Training Cost Collections

To inform the future education tariff, a cost collection exercise will take place shortly. It is essential that the Trust submits accurate data on the cost of delivering learning and education for all staff, particularly in support of undergraduate and postgraduate trainees from all clinical professions. Staff in education roles will be approached over the coming weeks to participate in this piece of work and their participation will be essential to ensure the Trust is

accurately re-imbursed in future for the work undertaken in education, learning and development.

6. Quarter One Priorities for the HR and Learning team

- Finalising the engagement approach following Trust Board discussions.
- Finalising the Trust Values to enable work to commence on embedding values into the core HRM policies and practices
- Finalising the leadership behaviours. This will enable an assessment to be undertaken of the likely development requirements of our existing leaders and appointment of a leadership partner to support delivery.
- Amendment to the Whistleblowing policy and consideration of opportunities to raise the profile within the Trust of how concerns can be raised, the value of staff promptly raising concerns and whistleblowing . The Trust has joined the Nursing Times, Speak out Safely campaign and Workforce and OD Committee is considering supporting the appointment of a Cultural Ambassador for raising concerns.
- Selection of additional Contact Officers and re-confirmation of the role requirements
- Revision of the Performance Development Review Policy (end July)

Date of Trust Board: 30th April 2014 **Enclosure Number: 9**

NAME OF DIRECTOR	Helen Shoker, Director of Nursing and Governance
SUBJECT	BAF Themes and Trust Risk Register
AUTHORS	Helen Shoker; Director of Nursing Alison Braham, Governance Manager; Jane Moore, Litigation Assistant and Governance Facilitator

SUMMARY

Trust Board is asked to:
- Note Trust Risk Register (TRR) actions and updates against the red/amber risks and the associated Board Assurance Framework (BAF) Themes.
- Note that each BAF risk has a number of Trust-wide red/amber risks aligned to it. Executive leads are asked to obtain regular assurance from the relevant lead(s) responsible for these individual risks in order to be able to provide an update on risk mitigation for each BAF risk.

Note the following changes:
New risk(s)
- 'Management of Change' (582)
- Poor completion of WHO checklist procedure (178)

Closed risk(s)
None noted
Increasing risk(s)
None noted
Decreasing risk(s)
- Activity targets (269)
- Financial Surplus (293)
- Patient Care meeting KPI contracted standard (12)

IMPLICATIONS

Insufficient monitoring and review of these risks, actions, progress and quality of information therein may have implications for the Trust in meeting its objectives and expected standards of service delivery.
Consideration should be given to the impact of risks on the Trust's compliance with the Care Quality Commission (Registration) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities).

RECOMMENDATIONS

Trust Board is asked to:
- **Review** the actions taken and updates associated with red/amber risks
- **Confirm** new risks to be added or removed
- **Agree** Lead Committee permission rights to escalate/de-escalate risks from/to Trust Risk Register

BOARD ASSURANCE FRAMEWORK 2013/14

This table maps all Trust-wide high level (red) risks against the 8 new 2013/14 BAF themes. Details of the 8 strategic BAF themes are given on the attached summary sheets.

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	Audit
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
12	Contractual KPIs: Trust is required to sign up to SLA contracts with our material commissioners, including performance clauses in line with national and local requirements	Quality of care reduced leading to fines and financial loss. Reputational damage.	8	Director of Nursing & Governance (changed from Director of Finance)	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			
32	Higher than expected rates of 30 day SSI within arthroplasty		16	Medical Director (As DIPC)	Lead Committee				Supporting Committee			
3	ROH shows low position for health improvement as measured by PROMs on national Information Centre figures	Patient experience Reputational damage	12	Medical Director	Lead committee			Supporting Committee	Supporting Committee			Supporting Committee
269	Failure to deliver activity targets	creates a lower in year surplus and a lower base to contract from in 2013/14 thus shrinking the organisation. Lack of ownership at Directorate level Processes not working efficiently enough to generate required throughput Lack of consultant job plan flexibility Poor activity management on a day-to-day basis	8	Director of Operations (changed from Director of Finance)				Lead Committee				Supporting Committee
33	Insufficient assurance around robust implementation of infection prevention strategies in theatres.		16	Medical Director (as DIPC)	Lead Committee				Supporting Committee			
275	Inability to consistently demonstrate learning from serious events/ claims/ complaints is embedded in practice	poor quality patient experience; reputational damage;	9	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee		Supporting Committee

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	Audit
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
27	Inability to control the use of unfunded medical temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2	lack of continuity of patient care; On going locum and agency costs	27	Medical Director	Supporting Committee			Lead Committee		Supporting Committee	Supporting Committee	Supporting Committee
New or Recently Upgraded Risks April 2014												
178	Poor completion of WHO safety procedure.		16	Medical Director	Lead Committee							
582	Risk of non-delivery of strategic objectives due to poor staff perception of the need for change and ineffective implementation of change in the recent past.	Care for patients that is less than the best; Lack of organisational sustainability	16	Director of Workforce and OD	Supporting Committee					Lead Committee		
Risks closed or downgraded In Quarter 4 2013/14												
30	Non-compliance with CQC outcome 9 "management of medicines"		8	Director of Nursing & Governance	Supporting Committee							
13	Failure to deliver contractual CQUINS			Director Finance	Supporting Committee				Supporting Committee			
8	Current clinical workforce unable to meet the needs of increasingly complex patients with multiple co-morbidities			Medical Director								
31	Absence of risk assessments on which to base a Health surveillance programme:			Director WFOD								
29	CQC outcome 4 "care and welfare of people who use services". Inadequate documentation. Concerns over the environment on Ward 11. Additional psychology support	Breach of CQC essential standards of safety and quality	6	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	Audit
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
28	Accuracy and timeliness of prescribing of medications on admission and reduction of missed doses of critical medicines		12	Director of Nursing & Governance	Lead Committee							
35	Risk of ineffective patient administration due to the impact of organizational change (admin review)	Patient experience is adversely affected due to confusing/duplicate communication concerning their care. Ineffective utilisation of resources eg Clinic capacity.	16	Director of Operations	Supporting Committee			Lead Committee		Supporting Committee		

Appendix 2

Board Assurance Framework Update – April 2014

BAF Theme	Risk	Consequence	Lead Director	Initial Risk	Current Risk	Update	Lead Committee
Standards of Care	ID 12 The expected standard for the quality of patient care does not meet the contractual KPI standard leading to a poor experience for the patient and a failure to deliver contractual KPI targets.	Patients receive care below the standard expected at the ROH. Breach of contract leading to fines and financial loss. Reputational damage amongst service users, commissioners, local community, staff.	Helen Shoker	20	8	2013/14 Year end position favourable. Quality standard not met in one category, pressure ulcers	CGC
Standards of Care	ID 32 Higher than expected rates of 30 day SSI within Arthroplasty		Andrew Pearson	None noted	16		CGC
Standards of Care	ID 3 ROH shows low position for health improvement as measured by PROMs on national Information Centre figures Old ref: 248		Andrew Pearson	15	12		CGC
Business Continuity	ID 269 Failure to deliver activity targets	Creates a lower in year surplus and a lower base to contract from in	Amanda Markell	20	8	Rectification period ended on 31st March with more patients operated in that month than any other for 3+ years. There remains a degree of risk, historically some directorates have not	EMT

		2013/14				grown in recent years, in addition case mix continues to change and a monthly forward look report of this will support further changes required including, if necessary, transfer of inpatient beds to DC beds. Directorate teams are meeting with DOPs and DOF in April to sign off activity plans which are reflective of 13/14 case mix and which add in c 1m of activity income (c 590 patients across all directorates) A more proactive approach is now embedded following rectification period which will continue to ensure that lists are well used. In addition services are being offered some support to proactively engage with GP colleagues to encourage greater referrals.	
Standards of Care	ID 33 Insufficient assurance around robust implementation of infection prevention strategies in Theatres		Andrew Pearson	None noted	16	? removed from BAF May 2013 TBC	CGC
Standards of Care	ID 275 Inability to consistently demonstrate learning from serious events/claims/complaints is embedded in practice	Patient care may continue to be adversely affected, with future patients placed at risk of similar events/harm relating to the quality of their care or experience	Helen Shoker	16	9	Year end Patient Safety Report produced Challenge to Directorate teams to cross reference and consider how learning occurs and how assured they are of same. Directorate Governance Meetings CGC annual work plan includes review of events/incidents/claims	CGC
Business	NEW -ID 27	Lack of continuity	Andrew	20	20		EMT

Continuity	Additional unplanned expenditure due to inability to control working pattern of junior doctors and inability to control the use of unfunded medical temporary/agency staffing.	of patient care Ongoing locum & agency costs	Pearson				
Standards of Care	NEW- ID 178 Poor completion of WHO safety procedure		Andrew Pearson	None noted	16		CGC
Staff Engagement	NEW – ID 582 Risk of non-delivery of strategic objectives due to poor staff perception of the need for change and ineffective implementation of change in the recent past	Care for patients that is less than the best; Lack of organisational sustainability	Anne Cholmondeley	16	16	Development of a safety culture to enable staff to feel comfortable to raise concerns internally Develop a culture where staff feel able to make change in their day to day work to improve service Develop leadership capability to lead change and engage staff Embed values into the core people management approaches of recruitment, leadership and management development & appraisal Development of the strong strategic narrative for staff to see a clear future for the organisation delivered by visible leaders Enhance internal communication approaches to develop effective 2 way communication	EMT

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 April 2014 **ENCLOSURE NUMBER: 10**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Jo Chambers, Chief Executive**
AUTHOR(S)	**Jo Chambers**
TITLE	**Governance Declaration – Quarter 4 2013/14**

SUMMARY

To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 4 2013/14 to Monitor

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 Continuity of Services risk rating of at least 3 over the next 12 months.

For Governance that:
I think we're saying – "The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

Report To	Trust Board
Report Of	Jo Chambers, Chief Executive
Report Presented By	Jo Chambers, Chief Executive
Purpose of the Report	To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 4 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 Risk Assessment Framework. The Q4 submission is due on the 30th April 2014..
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 of the Trust's financial performance for the 3 months from the 1st January 2014 to 31st March 2014 is contained in the Trust Corporate Performance Report. 2. <u>Service Performance Targets</u> The table of Monitor requirements and evidence is Appendix One of this report. The Trust has been unable to sustain the delivery of all waiting time targets having breached the 90% Admitted Referral to Waiting Time Target in Q4. All other targets have been met. The reasons for non-achievement of the target is due to a sustained increase in patients on treatment pathways, related to an increase in new out patient attendances with a corresponding increase in elective activity but without full increase in capacity within 18 weeks. A rectification plan has been in place throughout Quarter 4. 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 Trust Chairman and the Chair of Audit resigned at the end of January. The trust Vice Chair became Acting Chair and an interim Chair of Audit was externally appointed. Recruitment for replacements is underway and at the time of writing a new Chair has been appointed to take office from May1st 2014. • There have been no governor elections during the period. • 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. • The Clinical Governance Committee has met once 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 CGC 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. . • The Audit Committee met once during the period in respect to this declaration and can offer the following assurance: o Having updates on the work of the external audit and internal audit the Board is assured that work remains on plan and there are no material issues or problems to report; o Ongoing work to improve the clarity of reporting on the Board Assurance Framework was received by the committee. The committee was assured that appropriate management and mitigation of key organizational risks was taking place, and noted the further improvements planned in the supporting documentation and reporting of BAF risks. o The 2014-15 Internal Audit Strategy and Plan were received and approved. o The committee received the updated action plan relating to progress against the recommendations made as part of the Internal Audit review of the 18 week pathway, and was assured that positive progress was ongoing to address the key issues raised. o The Trust Board received assurances from Clinical Governance and the Audit Committee that the key risks have been identified.

APPENDIX ONE

The Trust provides financial information reflected in the CPR as assurance.

The Trust provides performance and quality information as set out in CPR and Patient Safety Report as assurance.

In Quarter 4 there have been no CQC inspections or comments.

In Quarter 4 no elections took place. The Chairman and Audit Chair resigned at the end of January 2014. The Vice chair assumed the role of Acting Chairman. An interim Chair of Audit was appointed from March 1st 2014.

The Trust can confirm that there are no exception reports to be provided in quarter 4 with regard to:

- Continuity of services
- Financial Governance
- Governance

There will be an exception report on failure to meet 18 week target for admitted patients.

Targets and indicators with thresholds for 2013/14

	Inicator	Threshold (A)	Weighting (B)	Source of evidence	Commentary
Access	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted **(C)**	90%	1.0	CPR	Not achieved.
	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted **(C)**	95%	1.0	CPR	Achieved
	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway **(C)**	92%	1.0	CPR	Achieved
	All cancers: 62-day wait for first treatment **(E)** from: urgent GP referral for suspected cancer NHS Cancer Screening Service referral	85% 90%	1.0	CPR	Achieved
	All cancers: 31-day wait for second or subsequent treatment **(F)**, comprising: surgery anti-cancer drug treatments radiotherapy	94% 98% 94%	1.0	CPR	Achieved
	All cancers: 31-day wait from diagnosis to first treatment **(G)**	96%	1.0	CPR	Achieved
Outcomes	Clostridium (C.) difficile – meeting the C. difficile objective **(M)**	DM* ROH target is 2	1.0	CPR	Achieved

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROH NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Date of meeting: April 2014 **Enclosure Number: 12**

Subject	**Review of compliance with Monitor's** ***The NHS Foundation Trust Code of Governance***
Author(s)	Joy Street
Presented by	Joy Street
Summary	The NHS Foundation Trust Code of Governance (the Code) was first published in 2006 and was revised in 2010. Following significant regulatory change as a result of the 2012 Act and taking account of developments in Monitor's regulatory toolkit since then, the Code has been updated and the recently published version applies from 1 January 2014. The provisions of the Code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of NHS Foundation Trust Condition 4 of the NHS provider licence (also known as the Governance condition). However, statutory requirements are highlighted within the Code, disclosure requirements are imposed and FTs are strongly encouraged to take full account of the provisions. The Strategic Report and Director's Report within the Trust's Annual Report will confirm compliance with the provisions of the Code and so it is felt best that the board has the opportunity to review itself against the new code prior to the final submission of the Annual Report.
Recommendations	The Board of Directors is asked to: - review the information provided; - confirm the statements of 'comply or explain'; - confirm suggested action/s - request any further information, review or actions.

BOARD OF DIRECTORS

A. Leadership

A.1 The role of the board of directors

Main Principle
Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation trust.

The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public

Section	Code Provision	Current Position	Recommended Action	Comply or Explain
A.1.1	▪ Sufficiently regular meetings of the BoD ▪ Formal schedule of matters reserved for decision by the BoD ▪ Clear statement detailing role and responsibilities of CoG ▪ Statement explaining how disagreements between the CoG and BoD will be resolved ▪ Annual Report to describe how BoD and CoG operate	▪ BoD meets 10 times per annum plus Away Days ▪ Constitution and Standing Orders in place ▪ The trust has a schedule of matters reserved for decision by the BoD ▪ Annual Report describes how BoD and CoG operate ▪ SID role and appointment ▪ CoG Policy – Raising Serious Concerns		Comply
A.1.2	▪ Annual Report: o to identify Chairman, Deputy Chairman, CEO and SID o Chair and members of Audit and	▪ Annual Report identifies key members of the BoD, Audit and Remuneration and Nominations Committees		Comply

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Section	Code Provision	Current Position	Recommended Action	Comply or Explain
	NRTS Committees o Number of meetings of BoD, Audit, NRTS and individual attendance of members.	▪ Number of meetings and attendance reported within Annual Report		
A.1.3	▪ BoD to issue objectives of Trust regarding balance of interests of patients, community and other stakeholders – as basis for decision making/forward planning	▪ Annual Plan sets out corporate objectives around strategic themes, and sets out to show how interests are balanced.		Comply
A.1.4	▪ Adequate systems in place to measure and monitor effectiveness, efficiency, economy and quality. Board to regularly review against regulatory requirements and approved plans	▪ Annual Plan, Board Assurance Framework Monthly Finance and Activity Report, Report and Accounts, Audit mechanisms, Annual Governance Statement, Board review of quarterly Monitor submission , Board Reports and Review, Annual Report and Accounts presented to Monitor, Parliament and published		Comply
A.1.5	▪ Relevant metrics, measures, milestones and accountabilities to be in place to assess delivery of performance ▪ Where appropriate, independent advice should be commissioned by the Board (in high risk/complex areas) to provide adequate and	▪ Corporate Performance Report collates metrics, measures, milestones and accountabilities – reported monthly ▪ Patient Quality Report monthly , Comprehensive Quality Accounts and Annual Report		Comply

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Section	Code Provision	Current Position	Recommended Action	Comply or Explain
	reliable level of assurance	▪ Independent advice sought when necessary		
A.1.6	▪ Board to report on its approach to clinical governance and its plans to improve clinical quality ▪ Board to record where, within the structure of the organisation, consideration of clinical governance occurs	▪ Annual Report to describe the Board's approach to Clinical Governance and where within the structure of the organisation consideration of clinical governance occurs ▪ Quality Improvement (QI) Strategy, QI Dashboard, Comprehensive Quality Accounts and Annual Report	**Development Action** Clinical Governance Strategy to be developed, to set out the Trust's approach to clinical governance and record where within the structure of the organisation consideration of clinical governance occurs. In light of new trust strategy and any structural changes **Director of Nursing and Governance and Company Secretary** Completion: **30 Sept 2014**	Comply
A.1.7	▪ CEO to follow procedure set by Monitor for advising BoD and CoG, and recording and submitting objections to decisions of BoD in matters of regularity and wider responsibilities of the Accounting Officer procedure.	▪ CEO fully aware of responsibilities within Accounting Officer Memorandum ▪ Annual Governance Statement and Annual Report		Comply
A.1.8	▪ BoD to establish constitution and standards of conduct for the Trust and its staff in accordance with The Nolan Principles	▪ Performance /behaviours are routinely assessed in performance development reviews.		Comply

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Section	Code Provision	Current Position	Recommended Action	Comply or Explain
A.1.9	▪ BoD to operate a code of conduct that builds on values and reflects high standards of probity and responsibility ▪ BoD should follow policy of openness and transparency and make clear how potential conflicts of interest are dealt with.	▪ The Trust's Standing Orders and confirm adoption of the Code of Conduct and Accountability ▪ Conflicts of Interest – FT Constitution sections and Standing Orders of the BoD		Comply
A.1.10	▪ Appropriate insurance cover to cover the risk of legal action against directors	▪ Directors currently covered ▪ Annual commercial contract .		Comply

A.2 Division of responsibilities

Main Principle
There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the boards of directors and the council of governors, and the executive responsibility for the running of the NHS foundation trust's affairs. No one individual should have unfettered powers of decision.

Section	Code Provision	Current Position	Action Required	Comply or Explain
A.2.2	**Statutory Requirement:** ▪ Role of Chair and CEO must not be undertaken by same individual	▪ Division of responsibility between Chair and CEO set out in writing and agreed by BoD on establishment of FT ▪ Position of Chair and CEO held by different individuals		Comply

A.3 The chairperson

Main Principle
The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.

Section	Code Provision	Current Position	Action Required	Comply or Explain
A.3.1	▪ Chairman should, on appointment, meet the independence criteria set out in B.1.1 ▪ CEO should not go on to be chairperson of the same NHS foundation trust	▪ Chairman's JD and person spec details the requirement for the Chairman to meet Monitor's current independence criteria on appointment. ▪ Annual review takes place of the independence of all NEDs, including Chairman.and confirmed in annual report		Comply

A.4 Non-executive Directors

Main Principle
As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of a board as a unitary board.

Section	Code Provision	Current Position	Action Required	Comply or Explain
A.4.1	▪ BoD to appoint Senior Independent Director (SID), in consultation with the CoG	▪ SID appointed by the BoD in consultation with the CoG		Comply
A.4.2	▪ Chairperson to hold meetings with the non-executive directors without the executives present ▪ Led by SID, non-executive directors should meet without the chairperson, at least annually, to appraise chairpersons performance and if deemed appropriate.	▪ Chair regularly meets with NEDs without Executives present prior to each Board meeting. ▪ NED's meet annually, without the Chairman present, to appraise Chair performance.with SID and lead governor		Comply
A.4.3	▪ Where directors have concerns, which cannot be resolved, they are recorded in the board minutes ▪ On resignation, director to provide written statement if have any concerns	▪ Board minutes fully record all matters raised, discussions, concerns, and agreements ▪ Draft Board minutes are reviewed at the subsequent Board meeting to ensure they provide a true account of the proceedings		Comply

A.5 Governors

Main Principle

The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of director's acts so that the foundation trust does not breach the conditions of its license. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

The council of governors is responsible for representing the interests of NHS foundation trust members, the public and partner organisations in the local health economy in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

Governors are responsible for regularly feeding back information about the trust, its vision and performance to members and the public, and the stakeholder organisations that either elected them or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.

Section	Code Provision	Current Position	Action Required	Comply or Explain
A.5.1	▪ CoG to meet sufficiently regularly – at least four times a year ▪ Governors should make every effort to attend CoG ▪ Trust should facilitate attendance	▪ CoG meetings take place on a quarterly basis at times generally agreed by governors. Attendance monitored.		Comply
A.5.2	▪ CoG not too large to be unwieldy. ▪ CoG should be of sufficient size for requirements of duties ▪ Role, structure, composition and procedures of the CoG to be reviewed regularly (see B.6.5)	▪ Composition of CoG reviewed 2013 post-Health Act amendments will be seen in new constitution May 2014		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
		▪ Standing Orders of the CoG and all key procedures in place ▪ Developmental Workshops held		
A.5.3	▪ Annual Report - to identify governors and constituency, whether elected or appointed and term of office - identifies nominated Lead Gov. ▪ Record of meetings and attendance at CoG to be kept and made available to members on request	▪ Annual Report identifies governors, constituencies, class, term of office etc. ▪ Record of governor attendance at CoG kept and available on request		Comply
A.5.4	▪ Roles and responsibilities of CoG set out in written document – with explanation of responsibilities of CoG towards members and other stakeholders, and how governors will seek views and inform them.	▪ Roles & responsibilities of the CoG are set out clearly in the Constitution, and Standing Orders. ▪ Membership and Public Engagement Strategy and Plan in place.		Comply
A.5.5	▪ Governors have a responsibility to make CoG arrangements work and should take the lead in inviting the CEO, Execs and NEDs to meetings ▪ Any Governors may raise questions about the affairs of the NHS	▪ Lead Governor fully involved in CoG Agenda- setting process. ▪ CEO attends and participates at each CoG meeting ▪ All Board members attend as appropriate to the agenda		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
	foundation trust	observe CoG meetings, and participate as required ▪ All Governors proactively invited to raise questions on any issue		
A.5.6	▪ CoG to establish policy for engagement with BoD – for concerns regarding performance of BoD, compliance with new provider licence or other matters ▪ CoG to input into board's appointment of a SID (See A.4.1)	▪ Policy for Raising Serious Concerns established by the CoG 2012 ▪ SID appointed by BoD in collaboration with the CoG.		Comply
A.5.7	▪ CoG to ensure its interaction and relationship with the BoD is appropriate and effective. ▪ Timely communication of relevant information and unambiguous language.	▪ The CoG and BoD meet jointly on two occasions per year and hold development workshops ▪ Board papers circulated to governors at same time as to Directors		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
A.5.8	▪ CoG should only use power to remove chair or NED after exhausting all other means of engagement with BoD ▪ CoG should raise any issue with Chairman with the SID in first instance.	▪ This provision covered with Constitution and would be considered if the circumstance ever arose. Has been tested in practice and worked.		Comply
A.5.9	▪ CoG to receive and consider other appropriate information to discharge its duties, including clinical and operational data	▪ All relevant information made available appropriately to CoG regarding clinical developments, key business challenges through summary corporate performance report and access to full board papers		Comply
A.5.10	**Statutory Requirement:** ▪ CoG to hold NEDs individually and collectively to account for the performance of the BoD	▪ Governor attendance at Board meetings. ▪ NED attendance and interaction at CoG meetings. ▪ NED attendance and interaction at CoG Subgroups. ▪ BoD and CoG Development Workshops take place on several occasions during the year. ▪ CoG approved NED appraisal and performance review process ▪ CoG established sub-committee for detailed review of NED appraisal and performance review, and final CoG review and approval ▪ CoG appoints all NEDs and ensures this responsibility is highlighted during selection and	NED appraisals out of date at April 2014 due to recent turnover. Lead Governor, new Chair and SID to consider. **Action Company Secretary by June 2014**	Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
		appointment process.		
A.5.11	**Statutory Requirement:** ▪ CoG to receive the annual accounts; any report of the auditor on them; and the annual report.	▪ Received at AGM but seen at joint meeting prior to final submission		Comply
A.5.12	**Statutory Requirement:** ▪ Governors provided with agenda prior to any meeting of the board, and a copy of approved minutes as soon as practicable afterwards	▪ Governors receive agenda prior to each board meeting and minutes as soon as practicable following. Also receive papers.		Comply
A.5.13	**Statutory Requirement:** ▪ CoG may require one or more directors to attend a meeting to obtain information about trust performance or directors performance of duties to help CoG decide on proposing a vote on trust or directors performance	▪ Constitution sets out that the CoG has this ability ▪ Governors aware of this ability ▪ Directors attend all CoG meetings.		Comply
A.5.14	**Statutory Requirement:** ▪ Governors can refer question to independent panel for advising governors. ▪ More than 50% of governors must approve this referral ▪ CoG should have dialogue with BoD before considering a referral.	▪ Governors aware of this facility,		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
A.5.15	**Statutory Requirement:** ▪ Governors to use their rights and voting powers to represent interests of members/ public on major decisions taken by BoD: - More than half BoD and CoG to approve a change to constitution of the NHS foundation Trust - More than half BoD and CoG to approve significant transaction - More than half BoD and CoG to approve merger, acquisition, separation or dissolution - More than half BoD and CoG to approve increase to non-NHS income ≥ 5% a year - Governors to determine whether non-NHS work will significantly interfere with trust's principal purpose.	▪ Appropriately set out in ROH Constitution		Comply

B. Effectiveness

B.1 The composition of the board

Main Principle
The board of directors and its committees should have the appropriate balance of skills, experience, independence, and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.1.1	▪ BoD to identify in annual report each NED it considers to be independent ▪ BoD should determine whether NEDs are independent in character, judgement and whether there circumstances or relationships could exist that affect such independence ▪ BoD to state its reasons if it determines that a director is independent despite relevant circumstance/criteria	▪ Annual Report identifies each NED considered by the BoD to be independent. ▪		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
B.1.2	▪ At least half the BoD, excluding chairperson, should comprise independent NEDs	▪ All current NEDs considered to be independent ▪ Annual review of NED independence for Annual Report (April each year).		Comply
B.1.3	▪ No individual should hold at the same time position of director and governors of any NHS foundation trust	▪ Trust constitution prevents an individual holding office as both director and governor at the same time		Comply
B.1.4	▪ Annual Report to detail each director's area of expertise and clear statement about BoD's balance, completeness and appropriateness to the FT ▪ Both statements to be available on FT's internet site	▪ Annual Report details each director's area of expertise and gives a clear statement about BoD's balance, completeness and appropriateness to the FT ▪ Annual Report available on FT's internet site		Comply

B.2 Appointments to the board

Main Principle
There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence.

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.2.1	▪ Nominations committee(s) to be responsible for the identification and nomination of executive and non-executive directors ▪ Nominations committee(s) should give full consideration to succession planning taking into account future challenges, risks and opportunities facing the FT and skills and expertise required within the BoD to meet them.	▪ BoD established Nominations, Remuneration and Terms of Service Committee for Exec Directors : ➢ reviews the structure, size and composition of the BoD and, where appropriate, make recommendations to the BoD for change ➢ determines succession plans for the CEO and other EDs and assist in determining the responsibilities of and procedures for appointment of EDs, including the CEO ☐ CoG established Nominations, Remuneration and Terms of Office Committee for Non-Executive Directors.		Comply
B.2.2	▪ Directors and governors to meet "fit and proper" persons test described in provider licence i.e. without recent criminal conviction or director disqualification and not bankrupt. ▪ Trusts to abide by CQC guidance regarding appointments to senior positions	▪ All directors and governors meet "fit and proper" persons test. Information recorded by Company Secretary. ▪ Robust compliance regime in place – CQC registration requirements	Trust to review any changes to CQC compliance requirements in 2014. **Director of Nursing and Governance by May 2014**	Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
B.2.3	▪ There may be one or two nominations committees, if two one for Exec Directors and one for Non-Exec Directors ▪ Nominations committee(s) should regularly evaluate the balance of skills/experience on the board and prepare a description of the role and capabilities for a particular appointment, including Chair	▪ BoD's Nomination and Remuneration Committee responsible for nominations of EDs and CoG's has com mittee for nominations of NEDs. ▪ BoD's committee is responsible for evaluating the balance of skills on the BoD, advising CoG re NED positions, and preparing role and capabilities of a particular appointment (Exec or NED), including the Chairman.		Comply
B.2.4	▪ Chairman or an independent NED to chair the nominations committees ▪ A Governor should chair the committee for the appointment of NEDs or Chairman	▪ Chairman chairs nominations and remuneration Committee ▪ When the Chairman's performance or remuneration being considered by the CoG's rem comm, the Lead Governor chairs the Committee supported by SID for performance aspects.. ▪ Requirements of this provision re: Governor to chair committee - appt of NED or Chairman, noted and enacted (Confirmed in code from 1 January 2014)		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
B.2.5	▪ Governors should agree with the nominations committee a clear process for the nomination of a new chair and non-exec directors ▪ Nominations committee should make recommendations to the CoG	▪ CoG agreed recruitment process in place ▪ CoG'S Nominations and Remuneration Committee has completed several NED and Chair appointments and reappointments and made recommendations to CoG		Comply
B.2.6	▪ Nominations committee responsible for appointment of NEDs, and any interview panel, should consist a majority of governors	▪ Selection Panels consist majority of governors and non-governors may not be afforded entitlement to vote.		Comply
B.2.7	▪ CoG to take into account the views of the board of directors on the qualifications, skills and experience required for each non-executive director position	▪ BoD Chair reviewed composition in January 14 and advised CoG about quals, skills and experience required for Chair and NED positions and subsequently progressed recruitment processes to appoint Chair and NEDs with the required skills.		Comply
B.2.8	▪ Annual report should describe the appointment process followed by CoG for NEDs and Chair	▪ Process described in Annual Report		Comply
B.2.9	▪ An independent external adviser should not be a member or have a vote on nominations committee(s)	▪ Independent external advisers do not have vote on nominations committees.		Comply

B.2.10	▪ Separate section of the annual report should describe work of nominations committee, including board appointments process ▪ Role of nomination/s committee should be set out in publicly available, written terms of reference	▪ Annual Report includes section about the nominations and Recruitment Committee and details of any Exec Director appointment processes ▪ Work of the committee also included in Annual Report, including details of any NED appointment processes ▪ Written terms of reference available on request		Comply
B.2.11	**Statutory Requirement:** ▪ Chairperson, NED's and, except in case of appointment of CEO, the CEO appoint executive directors	▪ Chairperson, NEDs and CEO lead all ED appointments (CEO does not approve a CEO appointment) through the Nominations and Remuneration Committee		Comply
B.2.12	**Statutory Requirement:** ▪ CoG to approve CEO appointment following appointment by committee of chair and NEDs	▪ Constitution requires CEO appointment to be CoG approved		Comply
B.2.13	**Statutory Requirement:** ▪ CoG responsible for appointment, reappointment and removal of chairperson and other NED's	▪ CoG's Nominations and Remuneration Committee is responsible for overseeing the processes leading to CoG appointment, reappointment or removal of chairperson and other Non-Executive Directors.		Comply

B.3 Commitment

Main Principle
All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.3.1	▪ Chair's appointment: nominations committee should prepare JD, including time commitment and availability in times of emergency ▪ Chair's significant commitments to be disclosed to the CoG before appointment and disclosed in annual report ▪ Changes in commitments to be reported to CoG as they arise and disclosed in next annual report ▪ Chair of FT cannot, at the same time, be the substantive chair of another FT	▪ BoD gives initial advice to CoG Rem Comm who , with support of external headhunters, prepare the role description covering time commitment and availability ▪ Commitments reviewed by CoG's Nominations and Remuneration Committee and CoG during appointment process to ensure no significant commitments that would interfere with the demands of the role.		Comply
B.3.2	▪ NED terms and conditions should be made available to the CoG ▪ Letter of appointment should set out expected time commitment ▪ NEDs to undertake to have sufficient time to fulfil role ▪ NED significant commitments should be disclosed to CoG before appointment and as changes arise	▪ NED terms and conditions are agreed by CoG and minuted. ▪ Letter to NED on appointment – sets out expected time commitment ▪ NEDs undertake to have sufficient time to fulfil role ▪ Significant commitments disclosed to CoG prior to appointment.		Comply

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.3.3	▪ BoD should not agree to full-time exec taking on more than one non-exec directorship of an FT or other organisation of comparable size/complexity, nor chairmanship	▪ This provision would be reviewed if the circumstance arose.		Comply

B.4 Development

Main Principle
All directors and governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge.

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.4.1	▪ Chair should ensure new directors and governors receive full, formal and appropriate induction ▪ Directors should seek to engage with key stakeholders ▪ Directors to have access to training courses	▪ Induction programmes are put in place for directors and governors ▪ Directors have access to individual and collective training /development as necessary or as requested	Review governor induction pack and process **Company Secretary by June 2014**	Comply
B.4.2	▪ Chair to regularly review and agree with each director training and development needs	▪ All Directors are reviewed via chairman (for NEDs and EDs vis a vis their Director activity at board) Chairman aware of all training and development needs for individual Board members		Comply
B. 4.3	**Statutory Requirement:** ▪ Board to ensure CoG have skills and knowledge to discharge duties appropriately	▪ Development workshops held for CoG on duties under new Act and on holding NEDs to account. .		Comply

B.5 Information and Support

Main Principle
The board of directors and the council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties. Statutory requirements on the provision of information from the board of directors to the council of governors are provided in 'Your Statutory Duties: A reference guide for NHS foundation trust governors'.

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.5.1	▪ BoD and CoG should be provided with high quality, appropriate information. ▪ BoD and CoG should agree their information needs with EDs through the Chair ▪ Information for boards should be concise, objective, accurate and timely, accompanied by clear explanations of complex issues ▪ BoD should have complete access to any information necessary, including access to senior managers and other employees	▪ High quality reports and background information provided to Board and CoG ▪ Standardised front sheet for all BoD and CoG papers to ensure clarity and appropriate review of paper. ▪ BoD has full access to all sources of info.		Comply
B.5.2	▪ In challenging assurances received from Executive, BoD need not seek to appoint adviser for every issue, but should ensure sufficient information and understanding to make informed decision. ▪ When complex or high risk issues arise, first course of action should be to encourage deeper analysis in timely manner within the FT. On occasion, NEDs may reasonably decide that external assurance is appropriate.	▪ Effective challenge and request for further information and analysis demonstrated at Board and Audit Committee – evidenced within relevant minutes, action sheet and follow-up actions		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
B.5.3	▪ BoD to ensure NEDs have access to independent professional advice and training courses/material where judged necessary ▪ Decisions to appoint an external adviser should be collective decision of the majority of NEDs ▪ Availability of independent external sources of advice should be made clear at appointment	▪ Independent advice, information and training made available as necessary/requested		Comply
B.5.4	▪ Committees and CoG to have sufficient resources to undertake duties	▪ Committees and CoG provided with sufficient resources		Comply
B.5.5	▪ NED's should consider whether they are receiving necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the board	▪ High quality reports and background information provided to NEDs ▪ Standardised front sheet for all BoD papers to ensure clarity and appropriate review of paper. ▪ BoD has full access to all sources of information ▪ Chair meets with NEDs prior to every Board meeting to review information and required challenge		Comply
B.5.6	▪ Governors should canvass the opinion of their members, and for appointed governors the bodies they represent, on the FTs forward plan ▪ Annual Report to state how this requirement has been undertaken	▪ CoG membership group agreed use of membership for surveys on key issues ▪ BoD and CoG workshops to discuss opinions and views about forward plan, incl. objectives, priorities and strategy ▪ Description within Annual Report		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
		about how this requirement has been undertaken		
B.5.7	▪ BoD should take account of the views of the CoG on the forward plans and communicate where views have been incorporated, and if not, reasons for this	▪ Board members present when forward plan is discussed by CoG and views are taken into account .		Comply
B.5.8	**Statutory Requirement:** ▪ BoD must have regard for the views of the CoG on the trust's forward plan	▪ As described at B.5.6 and B.5.7 above.		Comply

B.6 Evaluation

Main Principle
The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

The outcomes of the evaluation of the executive directors should be reported to the board of directors. The chair should take the lead on the evaluation of the executive directors.

The council of governors, which is responsible for the appointment and re-appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chairman and the non-executives, with the chairman and the non-executives. The outcomes of the evaluation of the chairman should be agreed by him/her with the SID. The outcomes of the evaluation of the non-executive directors should be reported to the governors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chairman.

The council of governors should assess its own collective performance and its impact in the NHS foundation trust.

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.6.1	▪ BoD should state in the annual report how evaluation of board, committees and directors has been undertaken	▪ Statement included in Annual Report		Comply
B.6.2	▪ Evaluation of FT boards should be externally facilitated at least every three years. ▪ Monitor's board leadership and governance framework to be used as basis for this evaluation ▪ External facilitator to be identified in annual report and statement made to any connection to Trust	▪ Board Assurance Framework (including performance evaluation against each objective) reviewed monthly throughout 2013/14 and	.**Development Action:** In light of changes to the Board, an external review will be commissioned by new Chairman and CEO in support of board development and evaluation of current position. **Chairman/CEO** Completion end October 2014	Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
		at year-end. ▪ Board performance evaluation and that of its committees reported within Annual Report ▪ The Chairman undertakes an annual performance assessment of each NED and reports to CoG via Nominations and Remuneration Committee .		
B.6.3	▪ SID to lead performance evaluation of Chairperson, within framework agreed by CoG	▪ Appraisal process for chairman, led by SID, within framework agreed by CoG		Comply
B.6.4	▪ Chairperson, with assistance from Company Secretary, should use performance evaluations to determine individual and collective professional development programme for NEDs	▪ Process for NEDs agreed via Chairman. And Company Secretary		Comply
B.6.5	▪ CoG should assess its collective performance and communicate to members how they have discharged duties	▪ Covered in Annual Report ,	**Development Action** Consider in light of B6.2	Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
B.6.6	▪ Clear policy and a fair process for the removal of any governor that consistently and unjustifiably fails to attend CoG meetings, has a conflict of interest, or fails to discharge their responsibilities ▪ Removal may be appropriate where behaviours or actions by a governor or group of governors is incompatible with values/behaviours of Trust ▪ Independent assessor can be used	▪ Approved Code of Conduct in place that outlines circumstances that would result in removal of governor - agreed by all governors ▪ Standing Orders state conditions and process for removal of governor.		Comply

B.7 Re-appointment of directors and re-election of governors

Main Principle
All non-executive directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The performance of executive directors of the board should be subject to regular appraisal and review. The council of governors should ensure planned and progressive refreshing of the non-executive directors

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.7.1	▪ Chair to confirm to governors that performance of NED proposed for re-election continues to be effective ▪ Any term beyond six years (two three year terms) for NED – rigorous review and take account of the need for progressive refreshing of the BoD ▪ In exceptional circumstances, NEDs may serve longer than six years (two three-year terms following authorisation of the FT) but subject to annual reappointment. May affect independence.	▪ Term of office for NEDs and Chair considered and agreed by Nominations and RemunerationCommittee, in full consideration of Monitor's guidance of terms of no more than three years (B.7.4). ▪ Chairman reports comprehensively to rem comm and CoG on performance of NED at reappointment		Explain

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Section	Code Provision	Current Position	Action Required	Comply or Explain
B.7.2	▪ Elected governors must be re-elected at regular intervals – no more than three years ▪ Biography details to be made available at election ▪ Prior performance information, such as attendance records to also be made available at election	▪ Elected governors' term of office set at no more than three years ▪ Biography details and past attendance published during election.		Comply
B.7.3	**Statutory Requirement:** ▪ CoG to approve CEO appointment at first General meeting following appointment by committee of chair and NEDs ▪ Appointment of all other execs by committee of CEO, Chair and NEDs	▪ Constitution requires CEO appointment to be CoG approved ▪ Exec Director appointments to-date by committee of CEO, Chair and NEDs		Comply
B.7.4	**Statutory Requirement:** ▪ NED's, including chairperson, appointed by CoG for specified terms subject to re-appointment thereafter at intervals of no more than three years	▪ Term of office for NEDs and Chair considered and agreed by rem comm, in full consideration of Monitor's guidance of terms of no more than three years		Comply
B.7.5	**Statutory Requirement:** ▪ Elected governors subject to re-election by members at regular intervals not exceeding three years	▪ Elected governors' term of office set at no more than three years		Comply

B.8 Resignation of directors

Main Principle
The board of directors is responsible for ensuring on going compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board of directors, and puts in place appropriate succession planning.

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.8.1	▪ The Board of Directors should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract, including but not limited to service of their full notice period and/or material reductions in their time commitment to their role, without the Board first having completed and approved a full risk assessment.	▪ This provision would be reviewed if the circumstance arose.		Comply

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C. Accountability

C.1 Financial, quality and operational reporting

Main Principle
The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects

Section	Code Provision	Current Position	Action Required	Comply or Explain
C.1.1	▪ Directors should explain responsibility for preparing annual report and accounts in the annual report ▪ Directors should state that the report and accounts are fair, balanced and understandable ▪ Should be a statement by auditors about their reporting responsibilities ▪ Directors should also explain approach to quality governance.	▪ Annual Report includes all required statements		Comply
C.1.2	▪ Directors should report that the FT is a going concern	▪ Annual Review of Going Concern at Audit Committee and relevant inclusion within Annual Report		Comply
C.1.3	▪ At least annually, BoD should set out financial and operating objectives and sufficient information to allow members/governors to evaluate FT's performance	▪ Annual Plan, Annual Report and Accounts, Quarterly Assurance Briefing to Governors .		Comply
C.1.4	**Statutory Requirements:** ▪ BoD must notify Monitor, CoG and the public if appropriate, about any major new developments which may lead to a substantial financial, performance or reputation change ▪ BoD must notify Monitor and CoG	▪ BoD provides quarterly reports to Monitor and CoG. ▪ Routine discussions with relationship manager at Monitor		Comply

Section	Code Provision	Current Position	Action Required	Comply or Explain
	and consider whether to bring to public attention all information concerning a financial or performance change which would have a significant impact on the FT if made public			

C.2 Risk management and internal control

Main Principle
The board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.

The board of directors should maintain a sound system of internal control to safeguard public and private investment, the NHS foundation trust's assets, patient safety and service quality. The board should report on internal control through the Annual Governance Statement (formerly the Statement on Internal Control) in the annual report.

Section	Code Provision	Current Position	Action Required	Comply or Explain
C.2.1	▪ Directors to maintain oversight of risk management and internal control and report to members and governors ▪ Review should cover financial, clinical, operational controls, compliance controls and risk management systems	▪ Effective Board Assurance and Risk Framework in place. ▪ Annual Internal Audit Plan – constructed in full collaboration with Audit Committee ▪ Annual Governance Statement (AGS), prev. Statement of Internal Control, compiled by the CEO, reviewed by Auditors, Audit Committee and approved/signed by CEO ▪ Annual Report presented to Governors and Members at CoG and AGM		Comply

Section	Code Provision	Current Position	Action Required	Comply or Explain
C.2.2	▪ Disclose in Annual Report if trust has internal audit function, structure and role it performs. If it does not have an internal audit function, processes it employs for evaluating and continually improving internal control processes	▪ Confirmation and relevant information included in Annual Report		Comply

C.3 Audit committee and auditors

Main Principle
The board of directors should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.

Section	Code Provision	Current Position	Action Required	Comply or Explain
C.3.1	▪ BoD must establish an audit committee composed of at least three independent NEDs ▪ BoD should satisfy itself that at least one member of audit committee has recent/ relevant financial experience	▪ Audit Committee fully established with independent NEDs ▪ BoD has appointed Chair of Audit Committee with relevant financial experience.		Comply
C.3.2	▪ Main roles and responsibilities of audit committee should be set out in publicly available, written ToR ▪ The Council of Governors should be consulted on the terms of reference that should be refreshed regularly	▪ Appropriate terms of reference established for Audit Committee and publicly available – annual review and refresh ▪ Auditors meet with the Council of Governors annually at AGM.		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
	▪ ToR should include how Audit Committee will: ➢ monitor integrity of financial statements and any formal financial announcements; ➢ review internal financial controls and review the internal control and risk management systems; ➢ monitor and review effectiveness of internal audit function; ➢ review and monitor external auditor's independence/objectivity and effectiveness of audit process ➢ develop and implement policy on engagement of external auditor to supply non-audit services ➢ report to CoG - matters for action or improvement	▪ TORs reflect requirements and issues are raised with CoG as necessary		
C.3.3	▪ CoG should take lead in agreeing with audit committee the criteria for appointing, reappointing and removing auditors	▪ CoG took lead in agreeing with Audit Committee the criteria for appointing/ reappointing or extending contract with auditors		Comply
C.3.4	▪ Audit Committee should make a report to CoG about the performance of the external auditor to enable the CoG to consider re-appointment. ▪ Audit Committee should make recommendations about	▪ External auditor contract extended during 2013/14 by CoG having been fully advised by Audit Committee. recommendation about		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
	appointment, re-appointment and removal of external auditor, and approve remuneration and terms of engagement of the external auditor	.		
C.3.5	▪ If the CoG does not accept the audit committee's recommendation, the BoD should include explanatory statement in annual report – setting out reasons why CoG has taken different position	▪ Information to be included in Annual Report if situation arose		Comply
C.3.6	▪ FT should appoint external auditor for a period of three to five years	▪ Current Auditor extended by CoG for one year		Comply
C.3.7	▪ When CoG ends an auditor's appointment in disputed circumstances, chair should inform Monitor of reasons behind decision	▪ Chair provides an update to Monitor about significant CoG changes/issues – an issue of this nature has not arisen to date but would be included		Comply
C.3.8	▪ Audit committee should review arrangements by which staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. ▪ Audit committee should ensure proportionate and independent investigation and follow-up action	▪ Audit Committee has previously reviewed Whistle-blowing Policy and systems in place to ensure staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. ▪ Regular counter-fraud update reports received by Audit Committee		Comply
C.3.9	▪ Annual Report should describe how Audit Committee has discharged its responsibilities, including: - Significant issues in relation to financial statements,	▪ Section within the Annual Report that comprehensively reports on how Audit Committee has discharged its responsibilities		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
	operations and compliance and how addressed; - How it assessed effectiveness of external audit process and approach to appointment of external auditor, value of service, length of tender and when tender last conducted - If auditor provided non-audit services, value of non-audit services provided and how auditor objectivity and independence is safeguarded			

D. Remuneration

D.1 The level and components of remuneration

Main Principle
Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead the NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements

Section	Code Provision	Current Position	Action Required	Comply or Explain
D.1.1	In designing schemes of performance-related remuneration of executive directors, the remuneration committee should: ▪ Consider whether directors should be eligible for annual bonuses. If so, conditions should be relevant, stretching and designed to match long term interests of public. ▪ Payouts should be subject to challenging performance criteria reflecting FT objectives ▪ Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed ▪ Remunerations Committee to consider pension consequences and associated costs of basic salary increases, especially directors close to retirement - only basic pay should be pensionable	▪ The terms of reference for the BoD's Nominations and Remuneration Committee cover the requirements of this provision		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
D.1.2	▪ Levels of remuneration for chair and other NEDs should reflect time commitment and responsibilities	▪ Level of remuneration for Chairman and NEDs reviewed by CoG's Remuneration Committee, reported to and approved by CoG – time commitment and responsibilities taken into account. Remuneration benchmarked - all FTs using FTN data		Comply
D.1.3	▪ When exec director is released to work as non-executive elsewhere, the remuneration disclosure of the annual report should include whether or not director will retain such earnings	▪ Situation has not arisen – annual report would include relevant information if this situation arose		Comply
D.1.4	▪ Remuneration committee should carefully consider compensation commitments of directors' in the event of early termination – the aim to avoid rewarding poor performance	▪ Provision covered within terms of reference for BoD's Nominations and Remuneration Committee		Comply

D.2 Procedure

Main Principle
There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration

Section	Code Provision	Current Position	Action Required	Comply or Explain
D.2.1	▪ BoD must establish remuneration committee of NEDs, including at least 3 independent NEDs ▪ Remuneration Committee terms of reference to be made available ▪ Where remuneration consultants are appointed, statement made available about whether connection with FT	▪ BoD's Remuneration Committee established – all NEDs independent ▪ BoD's Committee terms of reference available for review via Company Secretary ▪ Statement re Remuneration consultants would be included in relevant Annual Report		Comply
D.2.2	▪ Remuneration committee to have responsibility for setting remuneration for all exec directors, including pension rights and any compensation payments ▪ Remuneration committee should recommend and monitor the level and structure of remuneration for senior management	▪ BoD's Remuneration Committee terms of reference set out all aspects of this provision		Comply
D.2.3	▪ CoG should consult with external professional advisers to market-test remuneration levels of the chair and other non-execs at least once every three years	▪ CoG'S Nominations and Remuneration Committee's terms of reference enable invitation of an external adviser as required ▪ Remuneration for NEDs previously set using FT Network Survey results		Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
D.2.4	**Statutory Requirement:** ▪ CoG responsible for setting remuneration of NED's and Chairperson	▪ CoG'S Nominations and Remuneration Committee is responsible for annually reviewing remuneration of NEDs and chairperson and making recommendation to CoG, which is responsible for setting remuneration for Chair and NEDs		Comply

E. Relations with stakeholders

E.1 Dialogue with members, patients and the local community

Main Principle
The board of directors should appropriately consult and involve members, patients and the local community.

The council of governors should represent the interests of trust members and the public. This is a statutory requirement.

Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.

Section	Code Provision	Current Position	Action Required	Comply or Explain
E.1.1	▪ BoD should make available a public document setting out its 'involvement' policy	▪ Membership and Public Engagement Strategy in place – initially approved by BoD and CoG, ▪ Strategy is publicly available through Annual Report and in summary in Annual Plan	**Development Action** In light of new strategy and amended constitution, the involvement strategy covering patients, public and stakeholder should be revised. **Patient and Public Services Manager for completion by September 2014**	Comply
E.1.2	▪ BoD should clarify in writing how public interests will be represented ▪ Approach to addressing overlap and interface between governors and local consultative forums in place to be included	▪ Annual Plan describes aims to represent public interests ▪ Membership and Public Engagement Strategy and Plan describes approach between governors and local consultative forums	see E1.1	Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
E.1.3	▪ The Chairman should ensure the views of governors and members are communicated to the BoD ▪ The Chair should discuss the affairs of the FT with governors ▪ NEDs to attend governor meetings ▪ SID should attend sufficient meetings of governors to listen to views and develop understanding	▪ Chairman reports to the BoD from each CoG meeting – views of governors/members conveyed ▪ Chairman ensures appropriate discussion of the Trust's affairs with governors ▪ NEDs invited to attend all CoG meetings,		Comply
E.1.4	▪ BoD should ensure effective mechanisms for communication between governors and members from its constituencies ▪ Contact procedures for members that wish to communicate with governors and/or directors should be made clearly available to members on the FTs website and in the annual report	▪ Patient and Public Services Manager acts as membership engagement manager ▪ Public Engagement Strategy and Plan established ▪ Contact your Governor page established in Trust Internet	See E1.1	Comply

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Section	Code Provision	Current Position	Action Required	Comply or Explain
E.1.5	▪ BoD should state in annual report how members of the Board, in particular NEDs, develop an understanding of the views of governors and members	▪ Information included in Annual Report, including attendance at CoG meetings. BoD to CoG meetings, training and development sessions.		Comply
E.1.6	▪ BoD should monitor how representative its membership is, and the level and effectiveness of engagement and include in Annual Report ▪ This should be used to review the Membership Strategy, taking into account emerging best practice	▪ Membership and Public Engagement Strategy established and reviewed via CoG ▪ Annual Report includes comprehensive membership report.	see E1.1 above	Comply
E.1.7	**Statutory Requirement:** ▪ BoD must make board meetings and annual meeting open to public	▪ Board meetings open to public ▪ Annual Meeting open to public		Comply
E.1.8	**Statutory Requirement:** ▪ Trust must hold annual members meetings, director to present annual report and accounts and any report of the auditor on the accounts	▪ Annual meeting held in September Agenda available on website.		Comply

E.2 Co-operation with third parties with roles in relation to NHS foundation trusts

Main Principle
The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.

Section	Code Provision	Current Position	Action Required	Comply or Explain
E.2.1	▪ BoD should maintain a schedule of the third party bodies to which the FT has a duty to co-operate ▪ Directors should be clear of the form and scope of the co-operation	▪ The Trust's Commissioning Manager holds a register of third party bodies	**Development Action:** In light of new strategy a revised register should be developed an held by the **Company Secretary from June 2014**	Comply
E.2.2	▪ BoD should ensure mechanisms are in place to co-operate with relevant third party bodies and that relationships are maintained ▪ Annually the Board should review effectiveness and relationships and take steps to improve them	▪ Major stakeholder event launched April 2014 ▪ Board development has included review of stakeholders and development of key relationships	see E2.2	Comply

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th April 2014 **Enclosure Number: 13**

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**Ward Review – Safe Staffing**

SUMMARY

The attached briefing gives the board a high level summary of the Trust's range of considerations in order to provide assurance that our wards are properly staffed and our patients safe.

This work began in 2013 and began with considering our response to the Francis Inquiry and it is likely that progress will be reviewed by external inspections and visits by regulators and commissioners. Board members will receive regular reports on staffing levels and are encouraged to ask questions about any of the areas outlined when visiting ward areas.

IMPLICATIONS eg. financial, operational, risk, etc

Patient Safety & experience, Quality of Care, Staff welfare, Operational, Financial and Reputational risks are associated with failing to meet the NQB guidance.

RECOMMENDATIONS

Trust Board is asked:

- To familiarise itself with the national agenda drivers and the purpose of this ongoing work.
- To note the existing and planned work being undertaken across our ward teams and Nursing project group
- To support the work of the Matrons and Director of Nursing/Deputy Director of Nursing.

Briefing Paper

Within 'Hard Truths, The Journey to putting patients first', the Government's response to the Francis Inquiry, it is highlighted that safe ward staffing is a fundamental element of high quality care and positive patient experience. In November 2013 the National Quality Board (NQB) issued guidance to NHS providers on this subject which were endorsed by Jane Cummings, Chief Nurse, and Mike Richards, Chief Inspector of Hospitals, in March 2014. These guidelines include:-

- to publish staffing data from April and, at the latest, by the end of June 2014,
- A Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible & to be presented to the Board every six months,
- Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level,
- A Board report containing details of planned and actual staffing on a shift by-shift basis at ward level for the previous month. To be presented to the Board every month,
- The monthly report must also be published on the Trust's website, Trusts will be expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices.

Two stock takes of progress will be undertaken by NHS England, this month and in June. Monitor and the CQC will take specific interest in this area during their planned business with provider organisations.

The Matrons and Director of Nursing have worked to address this, the following steps have been taken to date:-

- Tested nationally recognised acuity tool, November 2013
- Action plan to address the guidance, January 2014
- Baseline risk assessment completed for each ward, February 2014
- Commenced bi weekly Quality Debriefs to review planned and actual staffing and patient risk, January 2014
- Proactive shift by shift management undertaken, ongoing aligned to Debrief
- Established a comprehensive data collation tool, January 2014

- Developed weekly reporting tools for/to wards
- Monthly report to EMT and Board, Briefing paper April 2014 and first report May 2014
- Established weekly ward reporting, April 2014
- Set up training sessions, May 2014 onwards
- Standing agenda item at Nurses' Forum, May 2014 onwards
- Agreed ward staffing displays 'Your Care, Our Service pilot', May 2014

Next steps:

- Promotion and awareness raising sessions across the wider organisation
- Safe Staffing Policy development to guide our practice
- Website and NHS Choices report uploads
- Trust Board will receive more detail at May and subsequent meetings
- Quarterly review of risk assessments referenced to ward review reports

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD ON
WEDNESDAY 30TH APRIL 2014,
8.30AM – 12.00 NOON IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
04/14/51	**Apologies & Welcomes** Chairman		To Note	
04/14/52	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
04/14/53	**Minutes of Public Board Meeting held on the March 26th 2014** Chairman		For Approval	Enc. 1
04/14/54	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
04/14/55	**Chairman & NED update** Chairman		For Assurance	Verbal
04/14/56	**Chief Executive's Report** Chief Executive Officer		For Assurance	Enc. 3
04/14/57	**Medical Director's Report** Medical Director		For Assurance	Enc. 4
	Performance Management / Assurance Reports			
04/14/58	**Corporate Performance Report (inc CIP & clinical Programme Board)** Director of Finance		For Assurance	Enc. 5
04/14/59	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 6
04/14/60	**Staff Engagement** Director of Workforce & OD		For Assurance	Enc. 7
04/14/61	**Quarterly Workforce** Director of Workforce & OD		For Assurance	Enc. 8
04/14/62	**Board Assurance framework** Director of Nursing & Governance		For Assurance	Enc. 9
04/14/63	**Quarterly Governance Declaration** Company Secretary		For Assurance	Enc.10
	Strategy			
04/14/64	**To be discussed at workshop**		For Assurance	

	Board Committees			
04/14/65	**Audit Committee report** Director of Finance		For Assurance	Enc. 11(to be tabled)
04/14/66	**Remuneration Committee**	No Meeting held		
04/14/67	**Charitable Funds Committee**	No Meeting held		
04/14/68	**Clinical Governance Committee** Director of Nursing & Governance		For assurance	verbal
04/14/69	**Any Other Business**			
04/14/70	**Review of Compliance with Monitors – Code of Governance** Company Secretary			Enc. 12
04/14/71	**Ward review – Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 13
	Date of Next Meeting: **Friday 23rd May 12.30pm – 4.30pm Joint Trust Board & Council Of Governors**			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enclosure 1

Minutes of the Trust Board Meeting held in public on Friday 23rd May 2014 in the Boardroom

Present:

Trust Board

Dame Yve Buckland (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director
Mr Mike Flaxman, Interim Non-Executive Director
Mr Tim Pile,Non-Executive Director

In attendance:

Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mrs Lisa Kealey, Public and Patient Services Manager (Agenda item 05/14/85 only)

Mr Andy Clark, Stakeholder Governor (University of Birmingham)
Ms Karen Hughes, Staff Governor
Ms Marion Thompson. Stakeholder Governor (BCU)
Ms Dia Martin, Governor
Mr Alan Last, Governor
Mrs Yvonne Scott, Governor
Mrs Stella Noon, Governor
Mr Rob Talboys, Governor
Ms Jean Rookes, Governor

Mr Julian Denney, (Preparing Board Minutes)

Apologies:

Ms Joy Street Company Secretary
Mr Roger Tillman, Deputy Medical Director
Ms Sue Arnott, Governor
Mr Paul Sabapathy, Governor
Mr Ronan Treacy, Staff Governor
Mrs Marion Betteridge, Governor

Agenda No.	Agenda Item	ACTION
05/14/72	**Apologies and welcomes** The Board welcomed Dame Yve Buckland in her first meeting as Chair. She introduced herself and thanked all Board members, Governors and staff for their contribution and in particular Tim Pile for acting as interim Chair and Mike Flaxman for acting as Chair of Audit . Apologies were received from Joy Street, Company Secretary, Roger Tillman, Deputy Medical Director and Sue Arnott, Governor, Paul Sabapathy, Governor, Mr Ronan Treacy, Staff Governor, Mrs Marion Betteridge, Governor	
05/14/73	**Declarations of Interest** No Declarations of Interest other than those registered previously.	
05/14/74	**Patient Case – an illustration of the work we do** This was presented by Anita Killingworth, Advanced Nurse Practioner, covering a very complex case which had been in general handled very well by the Trust and with important wider learning for example in relation to the handling of patient data regarding medication/ pain control with the potential for a greater use of IT.	
05/14/75	**Minutes of the Trust Board meeting held on 30th April 2014** In relation to page 9 (04/14/62) the Chair asked the CEO to ensure that the statement of compliance was independently reviewed given that Board members had queried a number of the areas of stated compliance at the previous Board and also that the Governors felt that the statement did not accurately reflect their experience; the CEO agreed to ensure this was discussed further. Regarding Page 10 (04/14/64) it was agreed that the words 'for weekends' should be removed and the investment figure should have been £230k not £300k. **Resolved:** With the above changes, the minutes were approved as a true record	**JC**

05/14/76	**Trust Board Action Points** The action notes were updated (see separate sheet). Regarding the compliance with annual leave policy – it was agreed that there was a need to define more clearly what an appropriate exception is and to provide greater assurance that the learning from conferences and other absences is embedded within the organisation.	**AC**
05/14/77	**Chairman and NEDs' update** . The Chair made the following points : • She had been invited to the meeting of the Birmingham Heath Economy Chairs – it was agreed they would find a focus for every Chair to work on e.g. Health promotion •She had met a group of former staff and the ROHBOTs fundraising group and had been highly impressed by the enthusiasm and commitment of both groups •She had also attended a ROH nurses event at which a lot of suggestions for improvement made •She had reflected on her initial experiences of working with the Board and considered that it would beneficial to alternate development meetings and traditional formal Board meetings.	
05/14/78	**Chief Executive's Report** Jo Chambers introduced her report and made a number of supplementary points as follows and the Chair invited Board comment: **Monitor Feedback** - There had been feedback from Monitor that in general Trusts have been over optimistic in the Annual Plan submissions made particularly concerning their five year position. She had discussed a number of risks from Monitor's perspective including the stabilisation of the Board, engagement of staff, and the achievement of the CIP programme. The Trust specific letter from Monitor to ROH had not yet been received but informal feedback indicated that they had no specific areas of concern and the Trust was expected to remain in a low risk category **Commissioning** - There has been a tightening of service specifications in relation to specialist services. The Trust is now increasingly involved in helping inform commissioners'	

	plans which should enable it to better predict how it may need to adapt its services in response to commissioners' evolving intentions. The financial challenge faced by commissioners is expected to be a major feature in the effort to change services for the future. **2015 Challenge Declaration** - There is an opportunity for the Trust to become a co signatory to a letter covering seven key challenges for the NHS being sponsored by the NHS Confederation. It was felt that more time was needed to consider the report before deciding whether the Trust should become a signatory. The CEO will circulate the document for Board members to read as the weblink did not appear to be working properly. ***Board Comment*** - in general, the Specialist Orthopaedic Alliance was the most appropriate forum for wider presentation of the Trust's views, and care must be taken to avoid spreading limited resources too thinly **ROH Strategy** – this work is being progressed and its various components will be synthesized in due course **Academic Health Science Network (AHSN)** – She has now taken her seat on the AHSN Board and will take lead responsibility for the Central Spoke (Birmingham and Black Country) **Future directions for the NHS** - She has attended a dinner where the keynote speaker was Andy Burnham This is a part of a process to help the Trust to understand emerging polices from all political parties **Communications** - an expert has been engaged to support the Trust which will particularly valuable as the strategy is developed **NHS Partners** - She has met the CEO of Sandwell and West Birmingham Hospitals NHS Trust and, jointly with the Chair, the Chair and CEO of University Hospitals Birmingham NHS Foundation Trust; both organisations are key strategic partners of the ROH. There had been constructive discussions with each. **Medical Staff Committee** - She has had further discussions with the MSC and is developing deeper and more informal	**JC**

	relationships with them. The CEO reported that the leadership of the MSC were keen for members of MSC to have the opportunity to meet with the Board. ***Board Comment*** -One opportunity to deepen the dialogue with the MSC could be via a lunch at a development meeting of the Board. It was important that ways to engage other staff groups were also considered so that they could be made aware of the Board's thinking and strategy. This could be done in a variety of ways e.g. visits to theatre by Board members. **Executive Management Team** - Paul Athey reported that a key issue discussed was the IM&T strategy which will be brought back to the Board in June. Also considered was the OBC for the e-prescribing system which was approved to move forward to the specification and procurement stage of the project plan. **Resolved:** That the Chief Executive's Report be noted **External Governance Reviews –** The CEO had attended an event organised by Monitor to provide feedback on the pilot Trust's experience of the new external governance reviews that all foundation trusts would be required to undertake every three years. In discussion with the Chair, it had been agreed that as the Board has a number of new members including the Chair and CEO, it would be beneficial to commission a review now to establish a baseline and also support the organisational and board development plans. The guidance, published in the last couple of days would be circulated to Board members for information.	**JC/YB** **JC**
05/14/79	**<u>Medical Director's Update</u>** Andrew Pearson gave an update making the following key points: **CQC Inspection** - He had been invited to participate as an observer in a CQC inspection at the Royal National Orthopaedic Hospital NHS Trust. The inspection process is still evolving and there are still challenges in recruiting inspectors. The process focuses on five qualities and seeks to triangulate what has been declared in the pre inspection pack, what is available in the public domain and what is found in the	

	inspection. There is a focus on theatres and theatre equipment, drugs, WHO checklist, record keeping, infection control and leadership. One of the ways leadership is considered is by assessing junior staff awareness of the organisation's strategy and their ability to handle critical incidents. The Chair invited a discussion as follows : • The ROH is well prepared to host its own inspection which will start on Tuesday 3rd June with an offsite meeting and a listening event in the evening followed by onsite visits on Wednesday and Thursday the 4th and 5th of June •It would be worth providing a briefing regarding the ROH strategy to help prepare staff •Governors are welcome to come to the listening event in a capacity as patients or carers •CQC are taking a more sophisticated and nuanced approach to inspections, forming a view from a variety of sources. • The CQC lead inspector will speak to a number of Board members in advance of the inspection. It was agreed that both the Chair and Tim Pile will speak to CQC prior to their visit	**ALL** **YB/TP**
05/14/80	**<u>Corporate Performance report</u>** Paul Athey introduced his report and highlighted the following points: •All three 18 week treatment targets have now been achieved •ROH has overachieved in planned activity overall •There was a deficit in April of £189K associated with the low activity plan and case mix; this is typical at this position in the year •There has been a good early start for CIPs •Workforce has improved to an amber rating The Chair invited a discussion as follows : •Regarding theatres and anaesthetics CIPs it is planned to allocate CIPs linked to implant savings to directorates and consider innovative approaches to procurement to mitigate the risk of underperformance which has been experienced in the past. In addition work is being done to improve theatre utilisation and to drive harder non pay savings. The question of whether the CIP targets were too high was discussed , but overall the Board felt that they should be kept at their current	

	level • R&D should be considered as having the potential for CIPs across the full extent of its budget •The Governors reminded the Board that it had been agreed that more information would be provided to the public regarding the use of car parking charges and requested that more information be provided regarding Café Royale and WRVS profits •Locum workforce costs will be reviewed at a further meeting **Resolved:** That the Corporate Performance report be noted including the need for further scrutiny around the Cost Improvement Programme	**PA**
05/14/81	**<u>The Patient Quality Report</u>** Helen Shoker introduced her report and highlighted the following : •Conversations are continuing with Directorate teams regarding incident reporting , the use of the risk register, mitigating actions and any need to escalate to Executive Director or Corporate level •There has improvement nationally in incident levels reported; this explains an apparent relative decline in ROH performance. Work is being done to improve incident reporting at ROH. •A survey of staff members is being done regarding their understanding of incident reporting •'Days between harm' is now being included as a quality measure •So far this year there have been no patients with Grade 3 or 4 pressure ulcers which is a major achievement and a very positive step forward •ROH is on track to achieve regarding the WHO checklists measure •Charitable funds have agreed to purchase additional High Low beds to help prevent falls The Chair invited a discussion as follows : • WHO checklists are now considered to be based on robust data with previous concerns having been rectified •The majority of falls happen in Ward 3 which handles the most complex cases – the team are focusing on improvements including better planning and staff training • Areas of concern included care of patients with dementia or multiple comorbidities, and medical cover at the weekends	

	The Chair said that in summary good progress had been made with some areas for further focus as noted above **Resolved:** That the Patient Quality report be noted	
05/14/82	**<u>Safe Staffing</u>** Helen Shoker introduced her report highlighting a number of issues including : •The work done on safe staffing risk assessment and the escalation process •The use of incident reporting •The action plan that is now in place and is being implemented •The very effective fill rate for bank and agency staff when required - while acknowledging that the use of agency staff should be minimised •The intention that Safe Staffing be reported monthly to the Board The Chair said that good progress had been made but that the use of agency and bank staff needed to be kept under review **Resolved:** That the Safe Staffing report be noted	
05/14/83	**<u>Board Assurance Framework (BAF)</u>** Helen Shoker presented the BAF and the Chair invited a discussion as follows: **General Risks** • Regarding the Medical Records Scanning project it has now been agreed with the CD that some further Spinal medical records no longer required will be destroyed. All medical records will be located within the new medical records library by October 14 to enable demolition of wards 5 and 7 to take place in Q4. •The Clinical Director for Spinal has spent a great detail of his own time manually retrieving necessary data to ensure the outcomes CQIN was achieved following issues corruption of the Spinal database. The Board acknowledged his work with thanks •The RTT targets overall have been achieved with some concerns remaining around spinal deformity RTT which will be disaggregated as a risk on its own in future	

	Housekeeping and Cultural Issues •There is a lot of work being carried out in theatres minimising the risks to contamination of equipment this is likely to be focus for CQC •There have been are also incidents involving staff leaving theatres in gowns •The Governors have identified some risks associated with the storage of linen on corridors •There have been a number of key staff and management changes which create the potential for improvement and a development programme is being created including the possible implementation of "Productive Theatre" •The Chair said this was a key issue to be taken off line with the right mixture of staff ownership , training and sanctions being applied and urged all Directors and Governors to challenge everything they see that is not right **Strategic Risks** •An area for development of the BAF is to consider risks from the perspective of the Trust's ability to realise its strategic intent •This could be developed in a Board workshop which could also consider early warning signs regarding major or new risks **Resolved:** That the Board Assurance Framework be noted with a further review covering the strategic picture in June	**Executive Team** **YB/JC**
05/14/84	**<u>Annual Report and Accounts – including self certifications</u>** Paul Athey gave a presentation on the Annual Report and Accounts which had previously been scrutinised by the Audit Committee with no major areas of concern. The independent auditor's report confirmed that the accounts gave a true and fair view of the Trust affairs, and that there were no matters on which the auditors were required to report with regards to securing economy, efficiency and effectiveness in the Trust's use of resources. **Resolved:** •That the Board ratify the recommendation by the Audit Committee to approve the Annual Report and Accounts •That the Board authorise the CEO and Chair to sign Certifications G6 and CoS7 referring to "Systems for compliance with license conditions" and "Continuity of services	

	condition 7 – Availability of Resources" respectively	
05/14/85	**National Inpatient Survey** The paper was summarised by Lisa Kealey. focusing on the evaluation of last year's action plan. In summary: • The Trust continues to perform strongly when compared to other organisations • The Trust is in the top 20% of best performing trusts in 5 out of 9 sections, compared with 7 out of 9 sections last year. • The section relating to operations and procedures has dropped into the middle 60% of trusts. • The Trust has further improved in 5 out of 9 sections overall from last year, (improvement in 7 out of 9 sections last year). **Key points raised in discussion:** • It was noted that the Trust was working to learn more from the best performers •All items on the action plan are in hand • Board members would find more trend information helpful for the most significant categories Board members were interested to know why the Trust had dropped out of the top 20% of trusts for 2 areas and it was agreed that this would be reviewed and members advised. **The Chair's summing up:** •It would be helpful to identify what was needed to achieve all of the actions in the current year action plan and how long this would take •There is some more work to be done in terms of linking the this work to wider activities in the Trust for example in relation to Clinical Governance **Resolved:** That the Board note the results of the 2013 national inpatient survey	**LK**
05/14/86	**Carbon Reduction Strategy** Amanda Markall, presented the Carbon Reduction Strategy and detailed the progress being made notwithstanding the age	

	of the estate Points made in discussion : • As a large user of energy the ROH should be a position to obtain support from utility providers to become more efficient e.g. around automatic systems to improve energy and water utilisation •Business cases for new assets need to reflect sustainability e.g. based on the building research sustainability criteria. •ROH should seek to learn from best practice elsewhere **Resolved:** That the Board note the Carbon Reduction Strategy bearing in mind the comments made above	
05/14/87	**<u>Francis Inquiry Update</u>** Helen Shoker presented the update and highlighted the importance of integrating this work within existing reporting mechanisms, risk management processes and lead committee structures so as to embed the recommendations and to provide a clear audit trail regarding what is being done **Key points raised in discussion:** The core values for the organisation have been shared with staff and have been well received by them. This presents a potential issue in that previously the Board had agreed to review and approve the values in advance. The Board's view was that the next step would be for it and the Executive to reflect on whether any further evolution of the values was required. **Resolved:** That the Board : • Note the progress to date and proposed next steps • Agree to review whether further work is required regarding values as part of the Board development day • Confirm that Tim Pile is the Director for whistle blowing • Approve the proposed reporting mechanism, risk management and lead committee structure so as to embed the	

	Francis recommendations with ROH core work and to provide a clear audit trail regarding what is being done	
05/14/88	**Clinical Governance Committee** Tauny Southwood highlighted a number of issues raised by the CGC including: •Leadership - e.g. high turnover of clinical audit committee chairs and over reliance on single individuals • Concerns regarding the accuracy of some data and its interpretation and use across the organisation • The need to establish the baseline of the issues The Chair requested an action plan to address these issues and the CEO commented that this should be covered as part of the governance and strategy review **Resolved:** That the Board : •Note the assurances provided by the CGC meeting subject to the action above	**TS/ HS/AP**
05/14/89	**Charitable Funds committee** Frances Kirkham presented the report of the Committee and made the following comments : • The figure for the purchase of 10 High-Low beds in the report was an error – it should have been £36k not £336k • FK encouraged all to put forward ideas for consideration for funding – there were significant funds available which needed to be spent **Resolved:** That the Board : •Note the Charitable Funds Committee Report with the above amendment and endorsed the request for further bids	
05/14/90	**Any Other Business** Regarding the Volunteers' Summertime 'Pop-in' on Thursday 31st July 2014 Café Royale, 2.30 -3.30pm – the Chair encouraged Board members and Governors to attend	

	The Chair thanked Mike Flaxman for his support to the Board as an interim NED	

Date and Time of Next Trust Board Meeting

Wednesday 25th June 2014 at 8.30am in the Board Room . In addition there will be an informal meeting of the Board on Monday 9th June between 8-12 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 MEETING
TO BE HELD JOINTLY WITH THE COUNCIL OF GOVERNORS
ON
FRIDAY 23 MAY 2014,
1.00PM IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
05/14/72	**Apologies & Welcomes** Joy Street, Company Secretary Roger Tillman, Deputy Medical Director		To Note	
05/14/73	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
05/14/74	**Patient Case – an illustration of the work we do** Director of Nursing and Governance			
05/14/75	**Minutes of Public Board Meeting held on the 30th April 2014** Chairman		For Approval	Enc. 1
05/14/76	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
05/14/77	**Chairman & NED update** Chairman & NEDs		For Information	
05/14/78	**Chief Executive's Report** Chief Executive Officer		For Information and Assurance	Enc. 3
05/14/79	**Medical Director's Update** Medical Director	On annual leave, so no paper	For Assurance	Verbal
	Performance Management / Assurance Reports			
05/14/80	**Corporate Performance Report** Director of Finance	To follow on Wednesday 21 May	For Assurance	Enc. 4
05/14/81	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 5
05/14/82	**Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 6
05/14/83	**Board Assurance Framework** Director of Nursing & Governance		For Assurance	Enc. 7

05/14/84	**Annual Report and Accounts – including self certifications** Director of Finance	The report is being presented to Audit Committee at 11am on Friday morning prior to the Board. Final copies maybe available on demand at the Board meeting. Copies of the certification will be available	For Ratification of recommendation for Approval by Audit Committee	Enc. 8 – to be tabled
05/14/85	**National Inpatient Survey** Director of Nursing & Governance	Lisa Kealey to be invited to present	For Assurance	Enc. 9
	Strategy			
05/14/86	**Carbon Reduction Strategy** Director of Operations		For Assurance	Enc. 10
05/14/87	**Francis Inquiry Update** Director of Nursing & Governance		For Assurance	Enc. 11
	Board Committees			
05/14/88	**Clinical Governance Committee**		For Assurance	Enc. 12
05/14/89	**Charitable Funds Committee**		For Assurance	Enc. 13
05/14/90	**Any Other Business**	Volunteers' Summertime 'Pop-in' Thursday 31st July 2014 Café Royale, 2.30 - 3.30pm – Board representation needed		
	Date of Next Meeting: Wednesday 25 June 2014 at 8.30am			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD JOINTLY WITH THE COUNCIL OF GOVERNORS
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FRIDAY 23 MAY 2014,
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	Date of Next Meeting: Wednesday 25 June 2014 at 8.30am			

Enclosure 1

Minutes of the Trust Board Meeting
held in public on Wednesday 30th April 2014 in the Boardroom

Present:
Trust Board
Mr Tim Pile, (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director
Mr Mike Flaxman, Interim Non-Executive Director

In attendance:
Dame Yve Buckland, Chair designate
Ms Joy Street, Company Secretary
Mrs Anne Cholmondeley, Director of Workforce & Organisational Development

Agenda No.	Agenda Item	ACTION
04/14/50	**Apologies and welcomes** There were no apologies. Welcome to Dame Yve Buckland, Chair Designate who takes up the role on May 1st.	
04/14/51	**Declarations of Interest** No other Declarations of Interest than those registered previously.	
04/14/52	**Minutes of the Trust Board meeting held on 26th March 2014** The minutes were approved. In response to a query from Frances Kirkham, Helen Shoker advised that the issue raised under AOB last time following a radio programme on new infections had been passed to CGC.	
04/14/53	**Action Points** The action notes were updated (see separate sheet). Tim Pile advised that MSC had sent three letters raising issues. The preferred stance was for the CEO to respond on behalf of the board, face to face wherever possible. .	

04/14/54	**Chairman and NEDs' Reports** Tim Pile advised that his pertinent issues were on the agenda. .	
04/14/55	**Chief Executive's Report** **1 Care Quality Commission Update – New Inspection Regime** **The Board noted** that the Trust would receive a new style inspection commencing on 2 June 2014 as one of two pilots for specialist orthopaedic hospitals, the other being the Royal National Orthopaedic Hospital in Stanmore. The inspection will provide a rating in each of five domains and an overall Trust rating of outstanding, good, requires improvement or inadequate. The five domains are: • Safe • Effective • Caring • Responsive • Well-led Jo Chambers updated the Board following her discussions with Sir Mike Richards to confirm that there would be a measured approach to the way in which the current acute hospital inspection model would be adjusted for specialist hospitals. A fewer number of inspectors would attend for fewer days reflecting that not all 8 service areas were applicable. It was also recognised that the CQC are still in a learning phase and the purpose of the pilot inspection sites is to test and develop the approaches; it is likely therefore that suggested changes might be made after this first round of inspections. The rating will be placed in the public domain and is an important judgement on the Trust, however, Mrs Chambers was reassured by the approach outlined by Sir Mike Richards. **2 Strategy Development – Stakeholder Engagement** As part of the Trust's strategy refresh a number of stakeholder engagement activities have been undertaken which culminated in a large scale event on 25 April involving over 100 participants comprising governors, staff, commissioners, partner organisations, patient groups and board members. This	

would be further reflected upon in the workshop to be held immediately after the Board. The evaluations had been majority positive.

Tim Pile felt it was a fantastic step forward in terms of eliciting opinions from a wide spectrum of people and the strategy will now be stronger as a result. Frances Kirkham concurred that it had been a good and positive day.

3 Executive Management Team – March 2014

The Board noted the key points to note from April's Executive Management Team meeting.

- Care Quality Commission meeting with the Specialist Orthopaedic Alliance
- The annual Quality Account draft was reviewed and discussed, noting the need for the 2014/15 quality improvement initiatives to be clearly embedded in normal working practice.
- A review and update on the corporate performance report, the patient quality report and workforce report. Updates from the Clinical and IM&T Programme Boards were also received.

The following decisions and approvals were made:

MRI Scanner – the business case to bring additional MRI scan capacity on-site, together with the quality enhancement of in-house reporting had been approved. It was highlighted that this was a case of listening to concerns from our clinicians about the variability of reporting through an external contract and taking action, albeit with a quality premium, but responding to ensure greater confidence and timeliness of reporting. The additional capacity will reduce waiting times for patients. This would be in place by Autumn following building the pad as its base and ensuring services are connected.

The **2014/15 business planning bids** that advanced from round 1 to round 2 were received as outline business cases.
Priority had been given to investment in:
- senior nurse capacity to support the implementation of the recommendations arising from the Robert Francis report into the failings at Stafford Hospital,

and making a 4th matron post substantive;
- oincreasing diagnostic and therapies capacity;
- oimplementing the Friends and Family Test, which is a national requirement;
- oinvestment to support staff involvement in creating change;
- oinvestment in a workforce analyst;
- oproject manager for IM&T in recognition of the considerable work involved in accelerating the Trust's ambition for improved systems and information.

- A number of other schemes were to be progressed where further work is required to identify the potential to be self-funding service improvements, or where there is a longer timeline for potential implementation.
- The Major Incident Plan, the Hospital Evacuation and Shelter Plan and the Road Fuel Shortage Plan were all approved.
- The Patient Access policy was approved.
- The Study Leave policy was approved.
- The Harassment and Bullying policy was approved.

Frances Kirkham asked if any board committees had scrutinised these and was advised that these had only been overseen by EMT as the committee of the Board with delegated authority for these particular policies. Mike Flaxman reminded colleagues that there was scrutiny of some policies by internal audit.

4 Monitor's Strategy 2014 - 2017

The Board noted that Monitor had recently published its own strategy for 2014 to 2017 which sets out the organisation's aims and priorities for the next three years. A central aim of the strategy is to "create a stable and coherent framework of incentives" to support innovation and sector redesign. ROH will need to pay more attention to service specifications. Paul Athey advised that he had attended a short notice meeting of specialist commissioners which had been called because NHS England had refuse to sign plans. The commissioners now had to work within resources and there was a national gap. National quality improvement schemes had been identified - using national benchmarking. The pressures will be greater for ROH in the longer term as most of the QIPP schemes relate to areas

	in which ROH does not operate. Block contracts may not be favourably viewed in the future and the situation means our specialist services will be under pressure for the future. **5 Specialist Orthopaedic Alliance** The Board noted that Royal Orthopaedic Hospital would host the next board meeting of the Specialist Orthopaedic Alliance (SOA), due to take place on 16 May 2014. There have been discussions about amending the governance arrangements of the SOA to reflect the changing membership and also the fact that some of the founder members are no longer stand-alone organisations but have become part of larger organisation. The CEO, MD and FD usually attend. Andrew Pearson and Paul Athey were unable to attend and **it was asked that the Deputy MD attend if at all possible.** Jo Chambers added that she was continuing to develop the Trust's external network and had met again with the CEO of Birmingham Children's Hospital which is a key strategic partner of the ROH and had an introductory meeting with the CEO of Heart of England Foundation Trust as well as the new chair of the Academic Health Science Network. These meetings would continue.	
04/14/56	**<u>Medical Director's Report</u>** Andrew Pearson introduced his report and gave more detail on the issues of clinical concern and work undertaken by the bone infection unit. The review noted some failures to adhere to all best practice standards – an example being that instrument trays were being kept in areas outside the laminar flow within the theatre. Work was underway to ensure greater and sustained levels of compliance. The issues in arthroplasty had given cause for concern but there did not appear to be an immediate need to use Bioquell, rather to again improve adherence to standards of best practice. Tim Pile urged speedy response to these issues (which were confirmed as a blip, rather than sustained lower performance). The work on ROH performance prepared by Professor Sir Tim Briggs had been well received (and challenged) by Trust executives and clinicians.	

	Tauny Southwood felt that the first items would have benefited from data – e.g. how many CDs were falling behind the desired standard and an indication of the numbers involved in having yet to sign off job plans. Frances Kirkham hoped to discuss the management role of CDs in more detail. She would also like to know what special and clever work was being done by clinicians and also what research activity. Elizabeth Mountford asked if Andrew Pearson needed support for gaining the data necessary to support quality enhancement. Andrew Pearson advised that data was more robust, but although some triangulation takes place (for example when a patient post-operatively goes to their GP with an infection issue) more could still be done. Helen Shoker commented that it was a real sign of a healthy team that clinicians themselves had spotted the issues and opened themselves to review. This is good news for the CQC. **The Board noted the report** which gave updates on clinical leadership, medical staffing resource, issues of clinical concern and external policy.	
04/14/57	**Medical Staff Committee Report** None received from meeting on April 25th although the Interim Chairman was in receipt of three letters.	
04/14/58	**Corporate Performance report (inc. CIP & RTT Rectification Plan)** PA reported a positive end to the year – not quite good enough to bring the Trust back to its plan , but only £200k short. The impairment in the accounts as a result of revaluation of the Day Care Unit was £2.6million (the building having already been in use for healthcare). CIP was short by £500K and this was indicative of the difficulties the Trust faces in taking out cash from services. There had been an over-performance on CCG contracts but an under performance on specialist contracts in outturn. Capital spend had been £1.4million under budget due to using space for additional ward capacity that would otherwise have been subject to investment. Mike Flaxman commented that it was a good, solid outturn. AM presented the data for March, which showed the Trust having done more work than since March 2011 (when the additional capacity of ward and theatre was available at BMI). Looking forward, as the pattern of work seemed to have changed, so the pattern of the organisation must change. Amanda Markall heralded lower performance in April due to bank holidays and planned theatre maintenance. Tim Pile	

	echoed the thanks and recognised that the quantum of sustained efforts and the challenge of maintaining such efforts. Mike Flaxman noted that the numbers for paediatric bed occupancy had changed and Paul Athey explained that the calculation methodology had been reviewed following comments at the last Board meeting. HS commented that the temporary environment was much better than the ward from which children had been decanted and that occupancy at the highest level would not be commended as best practice in a temporary environment. Amanda Markall made special note that the food satisfaction rate was now 98.20% in March and 89.08% for the year. **Tauny Southwood suggested that the feedback from oncology patients should be considered as their response to taste is altered**. This could be possible using the Friends and Family test data from the oncology ward. Amanda Markall noted that the activity target for admitted referral to treatment had not been achieved for the fifth month, but she felt that this would be met in April 2014as the backlog was now within the accepted tolerance. **Tim Pile asked that all board members give feedback on what they would like to change or add to in the CPR for next year.** .	**JS**
04/14/59	**<u>The Patient Quality Report</u>** Helen Shoker introduced the report and asked for comment. Tauny Southwood felt that the change in reporting was welcomed. Mike Flaxman felt that the legal development work was a really good initiative. Elizabeth Mountford felt it was a good example of us learning from an issue after having transparently discussed something and having subsequently identified a future solution. Frances Kirkham asked how the Trust intended tackling the lower than hoped for PROMs score on knees would be dealt with. Andy Pearson advised that Nikki Mason was working with the knee surgeons to offer enhanced physiotherapy and they were also considering changing length of stay as possible support mechanisms for improved outcomes.	
04/14/60	**<u>Staff Engagement</u>** Anne Cholmondeley gave a presentation to the Board which augmented the paper which had been circulated. She used the presentation to highlight issues of engagement, development, valuing people and alignment of skills and capabilities to business needs. There was significant support for the ideas presented, with concern expressed about singling out individual staff groups for special treatment. Discussion followed regarding the need to treat everyone with consistency, the need for active listening (without which engagement is hard)	

	and the need to define the parameters of empowerment because the organisation needs to remain compliant with the regulatory framework. It was also recognised that engagement approaches would benefit from being tailored to the different staff groups that existed within the Trust. Tim Pile felt that there was a debate to be had about values where he felt that it has to start at the Board which must develop the values and demonstrate the delivery of them. Tauny Southwood felt it would be really helpful to find a way of identifying the visionaries within the organisation – although he did not have a concrete idea of how the Trust could do that .Anne Cholmondeley felt that it was equally good to see everyday staff deliver small items of individual change.	
04/14/	**<u>Quarterly Workforce report</u>** Anne Cholmondeley presented her report and advised that the development funding from charitable funds for bands 1-4 was being used already. Appraisal and Mandatory training being linked to pay progression has improved take up of training. Unite and Unison will be considering industrial action following the pay review. Elizabeth Mountford asked if the Trust was working with union representatives to mitigate impact and Anne Cholmondeley advised that this was underway. The staff friends and family test will be run by an external provider. Frances Kirkham welcomed the forward looking quarter one priorities and commended this as an approach.	
04/14/61	**<u>Board Assurance framework</u>** Helen Shoker presented the BAF. Appendix 2 gives additional information on risks and offers an update on the previous position, providing a greater level of detail for the Board to receive assurance about how risks are being managed. The executive team is undertaking work to develop the detail still further. The board agreed that Board committees could take risks off rather than them stay on the BAF. Jo Chambers felt that the next stage of development for the BAF was to consider the big external risks and strategic risks, which may be encapsulated in the eight high level themes, but may also include others. Further work is necessary to identify and scope these risks for inclusion in the next BAF. **BAF to come back to the Board in two months' time.**	**HS**
04/14/62	**<u>Quarterly Governance Declaration</u>** The Board approved the following submissions to Monitor:	

	For Finance that: The Board anticipates that the Trust will continue to maintain a Continuity of Services risk rating of at least 3 over the next 12 months. *For Governance that:* **"The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.**	
04/14/63	**<u>Review of Compliance with Monitor's Code of Governance</u>** The Board noted the new NHS Foundation Trust Code of Governance (the Code) which applies from 1January 2014. It was further noted that the provisions of the Code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of NHS Foundation Trust Condition 4 of the NHS provider licence (also known as the Governance condition). However, statutory requirements are highlighted within the Code, disclosure requirements are imposed and FTs are strongly encouraged to take full account of the provisions. It was noted that the Strategic Report and Director's Report within the Trust's Annual Report confirm compliance with the provisions of the Code. **The Board supported the actions:** **1.A1.6 Development of a Clinical Governance Strategy by September 2014** **2.A 4.2 New Chair and Interim Chair to devise a new process for regular meetings of NEDs without executives present.** **3.A5.10 NED appraisals to be considered and process agreed with governors by June 2014** **4.B4.1 Governor and Director Induction Pack to be reviewed** **5.B4.2 Director development needs to be reviewed by new Chair as appropriate** **6.B6.1 New Chair to identify how evaluation of the Board, committees and Directors should be**	**HS/JS** **YB/TP** **YB/JS/Alan Last** **JS** **YB** **YB**

	undertaken ready for 2015 Annual report **7.B6.2 Commission an external governance review by end October 2014** **8.E1.1 In addition to the development of a public. Patient and stakeholder policy, the Board should consider its role in engagement (in support of Trust strategy) by September 2014**	**YB/JC** **YB/JC**
04/14/64	**<u>Ward Review - Safe Staffing</u>** The board noted the summary of the Trust's range of considerations in order to provide assurance that its wards were properly staffed and its patients safe. All wards are gathering data from April, reviewing day to day and then reporting, in arrears, through EMT. Reports will come to the Board from May. **Trust Board members agreed to:** • **familiarise themselves with the national agenda drivers and the purpose of this ongoing work.** • **note the existing and planned work being undertaken across our ward teams and Nursing project group** •**support the work of the Matrons and Director of Nursing/Deputy Director of Nursing.** **Board members were encouraged to meet with Helen Shoker or Lisa Pim to discuss things.** Helen Shoker expressed thanks for the investment in nursing which allows substantive appointment to the fourth matron; support for supervisory time for senior sisters to be with their teams and patients, offering leadership support, resolving complaints as and when and talking to families; a supernumerary bleep holder for weekends offering senior clinical leadership (this was previously a role allocated to an on duty staff member with on-ward duties). This investment of over £300k will help support delivery of the recommendations arising from the Robert Francis report recommendations and the investment exceeds the uplift included within the tariff for 2014/15 to deliver Francis recommendations.	**All**
04/14/65	**<u>Audit Committee Report</u>** Mike Flaxman introduced the report of the meeting held on 17th April 2014. • The early draft annual accounts were presented, and the main themes were discussed including impairments and the changes required by the 2013/14 Annual Reporting Manual.	

	The Trust's very strong liquidity position was noted. Progress in drafting the Annual Report was also noted. • The draft quality account was presented, and the main themes were discussed. The Quality Improvement priorities for 2014/15 were noted. • Internal Audit progress was noted, with only 1 planned audit report on Best Practice Tariffs for 13/14 outstanding. • Progress against previous Internal Audit and Counter Fraud recommendations were reviewed. The committee asked for particular assurance that CQC audit actions were being reviewed more rapidly than suggested in light of the forthcoming inspection. • Audit Committee were updated on progress against the 18 week audit recommendations, and were satisfied that appropriate steps were being taken to address the concerns raised. • The updated Board Assurance Framework and process was presented to the Audit Committee prior to report to the Board. After some debate around the supporting or lead committee structure, the committee agreed that the process was well structured, clear and should be adopted by the Trust Board subject to Board comment and regular review. **It was agreed that draft accounts would be circulated as soon as possible to all board members who should respond to Paul Athey as appropriate.** **The Board noted the Audit Committee report.**	**All/PA**
04/14/66	**Clinical Governance Committee** No meeting held but Helen Shoker and Tauny Southwood had developed a workplan and circulated it.	
04/14/67	**Remuneration Committee** No meeting	
04/14/68	**Charitable Funds committee** No meeting.	
04/14/69	**Any Other Business** Frances Kirkham asked for an update on IT and Paul Athey advised that many meetings had taken place and the draft strategy would come to the Board in June.	
Date and Time of Next Trust Board Meeting May 23rd 2014 at 12.30pm 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.

Enclosure 2

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 26th March 2014

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
01/14/07	Corporate Performance Report & Programme Board Update EM asked that the compliance with annual leave policy be reviewed to identify the extent of breaching	AM/AC	May 2014		
03/14/41 Medical Staff Committee Report (26.03.14)	It was agreed that feedback would be best given verbally to MSC and the CEO and Chair would meet the Chair of MSC.	TP/JC	April 2014		
03/14/44 Corporate Performance Report (26.03.14)	FK asked that a report on paediatrics be given to a future meeting.	AM	end June 2014		To be handled as part of Strategy Development
04/14/58	Data from patients on satisfaction with food should be disaggregated to see if satisfaction levels among oncology patients are as high as others	JS	end May 2014		The team has been asked to disaggregate information from both Friends and Family and real time survey data. As these are held on paper-based systems the information is not yet ready, but may be for verbal update at the board.
04/14/61	BAF to come back to Board in June	HS	June 2014		
04/14/63	**Review of Compliance with Monitor's Code of Governance**				

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	The Board supported the actions: 1. A1.6 Development of a Clinical Governance Strategy 2. A 4.2 New Chair and Interim Chair to devise a new process for regular meetings of NEDs without executives present. 3. A5.10 NED appraisals to be considered and process agreed with governors 4. B4.1 Governor and Director Induction Pack to be reviewed 5. B4.2 Director development needs to be reviewed by new Chair as appropriate 6. B6.1 New Chair to identify how evaluation of the Board, committees and Directors should be undertaken ready for 2015 Annual report 7. B6.2 Commission an	HS/JS YB/TP YB/JS/Alan Last JS YB YB	by September 2014 by end June 2014 December 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	external governance review **8.** E1.1 In addition to the development of a public. Patient and stakeholder policy, the Board should consider its role in engagement (in support of Trust strategy)	YB/JC JS/JC	by end October 2014 by September 2014		
04/14/64	**<u>Safe staffing</u>** Trust Board members agreed to: • familiarise themselves with the national agenda drivers and the purpose of this ongoing work. • note the existing and planned work being undertaken across our ward teams and Nursing project group • support the work of the Matrons and Director of Nursing/Deputy Director of Nursing. Board members were encouraged to meet with	All			

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	Helen Shoker or Lisa Pym to discuss things.				
04/14/65	It was agreed that draft accounts would be circulated as soon as possible to all board members who should respond to Paul Athey as appropriate.	**PA/All**	Early May	✓	Annual report circulated

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 23 May 2014 **ENCLOSURE NUMBER: 3**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Chief Executive's Report**

SUMMARY

To update the Board on national and local issues.

IMPLICATIONS

To ensure Board members are aware of the context and policy framework in which the Trust is operating, to support and inform the development of strategy and Board oversight of performance.

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update the Board on national and local issues.
Recommendation	The Board is asked to note the contents of the report and discuss items as appropriate.

This report provides Board members with an overview of key issues in relation to the Trust.

1 Care Quality Commission Inspection – Pilot for new regime

The Trust will receive a new style Care Quality Commission (CQC) inspection starting on 3 June 2014. The first day will involve executives attending an off-site meeting with the inspection team and a CEO presentation of key issues facing the Trust will be delivered. The inspection team have already received a data pack which will have been analysed for trends or themes of particular note. Our internal preparations will include reviewing our own data and drawing out key points for the initial CEO presentation.

The inspection at the Royal Orthopaedic Hospital is one of two pilots at specialist orthopaedic hospitals to test how the standard acute hospital methodology should be varied to take account of the different type of hospital; it is likely that further changes will then be made based on the learning from our visit that will be incorporated into future inspections.

The inspection will provide a rating in each of five domains and an overall trust rating of outstanding, good, requires improvement or inadequate. The five domains are:

- Safe
- Effective
- Caring
- Responsive
- Well-led

2 Strategy Development

The Trust continues to develop its strategic intent following several months of internal review, the stakeholder event on 25 April and our assessment of the external policy and commissioning environment.

Further challenges have been highlighted in relation to specialised services which are commissioned by NHS England and are subject to significant demand and budgetary pressures. Service specifications will be tightened and managed more closely in the current financial year, but increasing financial pressures are likely in

future years. The Trust receives approximately 27% of its income for its specialist work.

The Birmingham, Solihull and Sandwell health economy chief officers met at the beginning of May to consider the overall future of services in the area. There are significant challenges within the urgent care system, services for the frail elderly population and mental health (especially dementia) provision. The priority focus for our commissioners will be to develop primary care services, progress mental health services redesign, redesign the urgent and emergency care system, and develop partnership working. Under the heading of partnerships the outline commissioning strategies of our two main commissioners includes the intention to improve productivity in elective care and support specialised centres of excellence.

Specific commissioning objectives include:

- Commissioning elective care based on better total outcomes
- Enhanced specialist advice
- Improved productivity in elective care and more collaboration with specialist centres of excellence
- Reduce emergency admissions
- Reduced length of stay in hospital
- Increase out of hospital care
- Better primary, community and social care

The implication of these broad objectives is that there will be fewer hospital beds in the acute sector in the future and greater provision of services in community settings.

This emerging picture demonstrates that the Trust's strategy is consistent with the overall direction of travel and highlights the importance of elements of the strategic intent of the ROH, in particular:

ROH Strategic Intent	Strategic Imperative
Delivery of exceptional patient experience and world class outcomes	In the future commissioners will be looking to commission based on best overall outcomes for patients. Our higher volumes and specialised workforce will achieve better outcomes and higher levels of patient satisfaction. We will continue to develop our rehabilitation services.
Developing our reputation for our specialist work to position the Trust as the de facto specialist centre of excellence and provider of choice for orthopaedic care in Birmingham, the West Midlands and beyond	Driving innovation through research & early adoption of new procedures. Delivering high quality care in specialised services through volume based improvements in treatment and outcomes.
Developing our services to meeting the changing MSK needs of our population	Working in partnership with primary care to support independent living, through delivery of preventative services; by providing early diagnosis, advice and guidance and low level therapeutic interventions.
Seek continuous improvement in operational efficiency and effectiveness.	Meet the year on year efficiency and tariff deflator requirements of around 4% per annum.

It has been agreed that further work is necessary across the whole Birmingham local health economy, including Solihull and Sandwell, in order to clarify activity and financial assumptions, avoid double counting of savings and efficiencies, clarify the future bed base and develop workforce planning taking into account new roles for the future and the lead time required for training.

The next meeting is due to take place on 12 June and Birmingham Cross City CCG will lead on gathering the baseline finance and activity information from all organisations giving the position now, plans for 5 years' time and the assumptions behind the plans.

The work to develop the Trust's strategic narrative and transformational initiatives is continuing and will be considered by the Board at a workshop on 9 June. The 5 year plan is being produced in line with Monitor's recommendations and will be finalised following the workshop, taking into account the wider system proposals and commissioner plans as they continue to crystallise.

3 The 2015 Challenge Declaration

The NHS Confederation has collaborated with 7 other bodies to identify and articulate the nature of the challenge facing the NHS at the 2015 general election and beyond. It is a statement which sets out the case for change to ensure the NHS remains a modern, fit for purpose and sustainable institution as a crucial health and well-being system. The report identifies 7 key challenges for the future reflecting changing need challenge; the culture challenge; the design challenge; the finance challenge; the leadership challenge; the workforce challenge and the technology challenge. The themes are consistent with the Trust's own assessment of the national context and environmental framework which is influencing the development of our own strategy. The full report is available at:
http://www.nhsconfed.org/Publications/Documents/2015_Challenge_Declaration_Report.pdf

4 Specialist Orthopaedic Alliance

The Royal Orthopaedic Hospital is to host the next board meeting of the Specialist Orthopaedic Alliance (SOA), due to take place on 16 May 2014. A new governance framework is being discussed and negotiated by founder members to strengthen the work of the alliance. Proposed new governance arrangements will be presented to the Board in due course; however, the proposed draft is attached for discussion with a view to approving the final draft.

The strategy of the SOA, contained in the attachment, sets out a collaborative approach to strengthening the evidence base upon which specialist orthopaedic hospitals can promote the additional quality of care and improved outcomes for patients treated in specialist centres of excellence, as well as providing a united voice to support and inform the Department of Health and NHS England in the development of their strategies.

5 Federation of Specialist Hospitals Report – May 2014

A report has been published on the outcomes achieved by specialist hospitals (May 2014), which can be found in full at http://fsh.net/news.php.

This report highlights the role that specialist hospitals play in the system, treating high volumes of patients with the most complex conditions, whilst also facilitating integrated care in community and general hospital settings. NHS England has been considering a greater concentration of specialist services in a fewer number of centres to ensure sufficient volumes to drive improvements in outcomes and improved productivity. Specialist hospitals, such as The Royal Orthopaedic Hospital, are leaders in the development and early adoption of new therapies and techniques. Additionally, the report demonstrates the contribution of specialist hospitals on three fronts:

- Their ability to treat the most complex cases where treatment may not otherwise be available;
- Their excellent outcomes in more routine services which arise as a result of specialisation; and
- The non-clinical outcomes that show specialist hospitals perform highly against the requirements of modern hospitals – they are safe, compassionate and recommended by staff and patients alike.

The report also considers the ways in which funding and commissioning models can support efforts to ensure equitable and sustainable access to the specialist sector, recognising the need for payment systems to reflect the complexity of work and the inspection regime to provide for the different type of work undertaken.

Whilst the ROH is not a member of the Federation, it is a founding member of the associated Specialist Orthopaedic Alliance, which is particularly sponsoring the development of outcomes and clinical standards in specialist orthopaedic centres.

The report provides further evidence in support of the Trust's developing strategy and its ambition to differentiate itself on the basis of better outcomes than anywhere else, treating more patients requiring specialist care and developing its broader musculoskeletal health and well-being services.

6 Executive Management Team – May 2014

The Executive Management Team meeting is scheduled to take place on 21 May and the Board will receive a verbal update of key points discussed or agreed.

7 Conclusion

This paper provides a high level overview of the range of significant activities going on at a national and local level which will impact on how the Trust moves forward and develops its own strategic response.

There is clear and compelling evidence of both the environmental factors influencing the development of health policy and the design of services, and growing alignment of the response that providers need to develop to meet evolving commissioner requirements.

The Trust's developing work on strategic intent is well aligned to this national and local picture. The Trust needs to continue to develop its strategic transformational initiatives, establish its collaborative approaches and implement the changes necessary to continue to thrive as a successful organisation delivering exceptional patient experience and world class outcomes for our patients.

7 Recommendation

The Board is asked to note the contents of this report and discuss as appropriate.

Enclosure 3a

Specialist Orthopaedic Alliance
Terms of Reference and Governance Arrangements

Update May 2014

NB - These were first drafted in November 2008, updated in December 2010 and May 2013 and then only updated for changes in role and membership.

1. Introduction

1.1 What is the SOA?

The Alliance was formed in the late 1990s from a group of specialist centres dedicated to providing orthopaedic services ranging from the straightforward to the highly specialised, to patients across the UK. The Alliance works to heighten national awareness of specialist orthopaedics in order to protect and enhance services, and quality of experience, for patients and staff. Alliance activity is focused on making both a clinical and an economic case for specialist orthopaedics – in terms of patient care, teaching and research.

The Alliance now has 14 members and the approach to membership and meetings requires updating to ensure maximum value to members. Increased funding from the extended membership has already allowed funding for a formalised benchmarking programme and information analyst support to enhance all policy engagement activity.

1.2 Vision[1] – "Excellence in Orthopaedic Care"

The vision of the Specialist Orthopaedic Alliance is to be a primary source of support and expertise to the NHS and elsewhere on the provision of orthopaedic services. This will promote the sharing of best practice, the delivery of high quality outcomes for patients, better value for money through productivity and long term cost savings with better outcomes and therefore lower cost to the NHS.

[1] See Appendix 1 for Vision and Strategy document.

1.3 Themes/workstreams

SOA activity will cover the following four areas:

Theme 1 - Outcomes: Expanding the outcomes evidence base for specialist orthopaedic services

Specialised orthopaedics services are those services which due to rarity, complexity or the required expertise. These services are currently provided in 25-30 hospitals in England. To support this, it is vital that the SOA aims to facilitate an expanded evidence base for demonstrating what defines a "better outcome" for patients in orthopaedics and thereby supports the evidence base that specialist services deliver this more effectively and at lower cost. Specialist Orthopaedic services deal with a higher proportion of complex work than general elective orthopaedic services. Therefore, the outcomes evidence base needs to ensure that appropriate consideration is given to patient case mix complexity.

Theme 2 - Innovation

In addition to providing specialist activity to an appropriate critical mass to achieve better outcomes for patients with complex conditions, specialist units should also act as hubs which drive forward best practice, innovation, teaching, research, development and trialling new technologies across all providers of orthopaedic services, in primary care and secondary care general hospitals. The SOA will therefore collate evidence that specialist services provide best practice, innovation and translational research that improves patient outcomes and support clinical, operational and financial benchmarking across specialist orthopaedic services.

Theme 3 – Commissioning

The SOA will provide a primary source of advice to Department of Health and Monitor on the NHS Activity Funding system to support shifting from Payment by Volume to Payment by Result/Outcome. For example, continuing to advise on the development of patient pathway tariffs that recognise the probable long term cost of caring of complex patients and reward.

The SOA will also be a source of support to the Department of Health and Commissioners (NHS England and CCGs) in delivering the transfer of specialist orthopaedics services to specialist commissioners, including providing direct input into the creation of the new contract terms and continuing to provide input into the work on the transition of spinal services that the is being undertaken by the national spinal review.

External partners and stakeholders

The Specialist Orthopaedic Alliance will facilitate collaboration within the NHS and outside to support the delivery of its vision. The SOA will interface with Westminster and Whitehall, NHS England, specialist commissioners, and partner bodies such as the British

Orthopaedic Association, Royal College of Surgeons, and the British Orthopaedic Directors Society. This will include supplying information, reporting, commentary and other support and expertise on national or local policy initiatives that impact the delivery of orthopaedic services.

2. Membership

2.1 Criteria

SOA members fall into three categories (see below) but there are two overriding characteristics that define the membership –

- A highly specialised case load and mix – as indicated by a material volume of specialised work meeting national specialised services definition sets

and/or

- A high volume of orthopaedic activity leading to a significant expertise in all orthopaedics or specific sub-speciality areas of orthopaedics

Potential members are asked to submit a document outlining the scale and type of their orthopaedic activity, case mix, staff numbers and skill mix, facilities and evidence of research, education and innovation in orthopaedics. The application reviewed by the chief executives of the founder members and a vote taken by these chief executives on the application.

2.2 Membership types

2.2.1 Founder Members

Founder Members are:

- Responsible for Governance including holding an Annual SOA Board Meeting to agree:
    - overall vision, strategy and aims of the SOA
    - Annual financial review and budget,
- Elect the lead Chair and Lead Chief Executive (see below) and agree new members to confirm they meet the necessary membership criteria.
- Are responsible for reporting the outcome of the Annual SOA Board Meeting to wider membership as part of notifying the annual membership subscription.
- Only continue as Founder members following annual review at the Annual Board Meeting that will confirm active participation during the year – this will be measured by regular attendance throughout the year and evidence of taking leadership on particular initiatives on behalf of the SOA. Rather than prescribing the detailed

nature of "regular" attendance and "taking leadership" the Founder members will review this annually at the Annual Board meeting and vote, if necessary, on the inclusion of any Founder members deemed to not be fulfilling these criteria.

- Will hold meetings 4 times a year or as necessary to provide assurance that the aims of the SOA are being met during the course of the year to agree mitigating actions rather than awaiting the annual SOA Board meeting.

2.2.2 Members

- Nuffield Orthopaedic Centre NHS Trust*
- Robert Jones and Agnes Hunt NHS Trust*
- Royal National Orthopaedic Hospital Trust*
- Royal Orthopaedic Hospital Trust*
- Wrightington, Wigan and Leigh NHS Trust*
- Avon Orthopaedic Centre, North Bristol NHS Trust
- Musgrave Park Hospital, Belfast Health and Social Care NHS Trust
- Cappagh National Orthopaedic Hospital, Dublin
- South West London Elective Orthopaedic Centre
- Cardiff and Vale Orthopaedic Centre
- Newcastle University Hospitals NHS Foundation Trust
- Royal Devon and Exeter NHS Foundation Trust
- Guy's and St Thomas's NHS Foundation Trust

**currently designated as Founder Members.*

Members will receive the following:

- Inclusion in benchmarking activity
- Individual advice and support on managing regulatory and configuration issues
- Inclusion in campaigning activity
- Inclusion in consultation exercises
- Promotion of their membership of the Alliance

2.2.2 Independent Sector Members

- The Horder Centre

The rights of Independent Sector Members are the same as for members but they are not in attendance at any sections of meetings with a sensitivity relating to independent providers.

2.3 Membership obligations

Each member and attendee will be asked to register any relevant or conflicting interests, for example roles within implant companies or at independent providers, with the SOA so that a view can be taken if a conflict is likely or the potential for conflict flagged up at the

beginning of a briefing session or meeting. Initially a register will be created by circulating a short form to all regular attendees.

2.4 Fees (as at March 2014)

It is proposed that the membership fee will be £7,000 for all members.

3. Governance

3.1 SOA Board

The SOA Board comprises the chairs, Chief Executives and Medical Directors of the Founder Members and will meet a minimum of once per year for an annual board meeting (frequency can be increased in agreed/needed) by agreement, to receive an annual report from the SOA Lead Chief Executive and Chief Officer to agree ongoing Terms of Reference, vision/strategy/objectives, governance arrangements, and include a financial report. This board is accountable to the boards of the founder members via their CEO/Chair. The board reports to the SOA membership (see below).

The quorum for the meeting will be:

- SOA lead chair or SOA chair (lead Chief Executive)[2]
- Chief Executive/Chair from 3 out of 5 founders; sub-group lead or representatives for each sub-group; SOA Chief Officer

Administrative arrangements will be provided by Chief Officer and their administrative team.

3.2 SOA membership group

SOA members will receive an annual report from the SOA Board and will participate in a series of events through the year (of which there will be a minimum of three) – events designed to further the objectives of the SOA.

The members will receive regular updates from the sub-groups on their projects/work streams.

3.3 Events

SOA events will include:

- Collaboration with external organisations
- Workshops based on sharing practice with regard to specific subjects e.g. coding, specialised commissioning, etc.
- Sub-group sessions to develop policy and respond to consultation

[2] See section on roles

4. Roles

(Appendix B provides names of current incumbents)

- **SOA Lead Chair**
    i. Act as Chair of Annual SOA Board and SOA events throughout the year
    ii. Lead Chair participation in the work of the SOA from Chairs/NEDs of member Trusts
    iii. Serve a term of 3 years with up to 2 terms ie a maximum of 6 years but subject to re-election after 3 years – ideally these terms will be staggered against the Lead Chief Executive to avoid changes in Lead Chair and Chief Executive at the same time.
    iv. The lead Chair will be from a different founding member organisation to the lead Chief Executive
- **SOA Lead Chief Executive**
    i. The lead figurehead of the SOA internally and externally – the central "voice" of the SOA
    ii. Line manager of the SOA Chief Officer
    iii. Chairing SOA Chief Executive meetings and other events on behalf of the lead Chair as necessary/appropriate
    iv. Propose changes in governance, vision, strategy and objectives of the SOA.
    v. Serve a term of 3 years with up to 2 terms ie a maximum of 6 years but subject to re-election after 3 years – ideally these terms will be staggered against the Lead Chair to avoid changes in Lead Chair and lead Chief Executive at the same time.
    vi. The lead Chief Executive will be from a different founding member organisation to the lead Chief Executive

- **SOA Chief Officer**
    i. Manages and implements day to day operations of the Alliance and reports to the SOA Lead Chief Executive.
    ii. Produces Annual Report, financial monitoring and annual financial plan and budget including proposed membership fees
    iii. Line manages administrative support to the SOA

SOA participant roles

Post	SOA role
Chairs	Provide strategic overview and political guidance and are closely involved with interface with parliamentarians (i.e. Ministers and other MPs and Peers) and chairs of other organisations.
Chief Executives	Guide the day to day policy decisions dictating the SOA's activity and provide support, expertise and ***informati***on from their trusts as required by the agreed work plan and/or events.
Sub-group leads	To oversee and lead the agreed programme for their Sub-group and to work with the Chief Officer to encourage member trusts to take an active part in the programme. The Sub-group lead will present papers / updates on the Sub-groups work at relevant SOA events during the course of the year. Sub Group leads are not elected but will be reviewed annually at the SOA Board meeting who will decide and recommend changes to the membership.
Other relevant directors and managers	In addition to taking participating in the work of any relevant sub-groups and to provide the relevant expertise as required. For example Clinicians will be asked to become SOA Champions for particular themes

5. Sub-groups

In addition to the overall events organised by the SOA sub-groups of specialist managers or clinicians will be formed to take forward individual themes including policy development, consultation responses, benchmarking and other auditing. The groups will work to inform the development of programmes and to ensure expert input from all members to all SOA outputs. The SOA Chief Officer will administer the activity of the sub-groups and liaise with their leads – unless there are exceptional circumstances it is suggested that groups function online in a virtual format rather than meeting. The following sub-groups will form the core of SOA programmes but others will if necessary be set-up:

Medical Sub-group

The Medical Sub-group will own, oversee and report on the following work streams.

- A programme and process for outcomes evaluation.
- Develop proposals, and recommend sources of information, for the creation of briefing papers for a wide range of clinical and political audiences.

Finance and Benchmarking

The Finance Sub-group will own, oversee and report on the following work streams.

- A series of benchmarking exercises, including reference costs and income.
- Regular procurement, clinical coding and cost-saving programme audits, reports and workshops.

The Benchmarking Sub-group/work stream will own, oversee and report on the following work streams.

- A series of benchmarking exercises, including general performance metrics and performance against access targets.

6. Financial arrangements and employment governance

SOA income, expenditure and employment are currently hosted by the RNOH. Income and expenditure is monitored within the trust's exchequer funds and monitoring reports are provided to the SOA board on an annual basis.

Appendix A

Specialist Orthopaedic Alliance

Vision & Strategy

1. *Vision – "Excellence in Orthopaedic Care"*

The vision of the Specialist Orthopaedic Alliance is to be a primary source of support and expertise to the NHS and elsewhere on the provision of orthopaedic services. This will promote the sharing of best practice, the delivery of high quality outcomes for patients, better value for money through productivity and long term cost savings with better outcomes and therefore lower cost to the NHS. At its most basic this can be described as supporting the NHS ensure that its policies and systems promote appropriate orthopaedic referrals getting to the right experts, in the appropriate setting, at the right time who, by getting it right first time, reduce complications, and use evidence based treatments. Coupled with appropriate innovation and different modes of working, this approach will improve the quality of care for patients.

This will deliver greater patient satisfaction and enhanced outcomes. It will also produce significant annual savings to the NHS and reduce waiting times.

2. *Strategy*

To support the delivery of this far reaching vision our strategy is to focus on the following 3 key themes

Theme 1 - Outcomes: Expanding the outcomes evidence base for specialist orthopaedic services

Specialised orthopaedics services are those services which due to rarity, complexity or the required expertise. These services are currently provided in 25-30 hospitals in England. This includes those that provide the most specialised nationally commissioned services, those that provide a range of complex multidisciplinary team delivered services and those that deliver trauma services where they are designated major trauma centres within a recognised Trauma Network.

- Rarity – Due to the relative small activity seen by individual clinicians and providers – it requires the concentration of activity to a small number of clinicians and providers to allow the development of expert skills in a small group of clinicians and multi-disciplinary staff. Supports the efficient use of resources, staff training and audit.

- Complexity – Due to the complexity of the conditions and the procedures and the relative low volumes seen by individual clinicians and providers it requires activity to be undertaken by a limited number of clinicians and multi-disciplinary staff who are trained, experienced and work collectively in a multi-disciplinary model at recognised specialist centres or through a network / hub and spoke / outreach model. Supports efficient use of resources, staff training and audit.

- Tertiary – The referral of the most complex cases, often where previous treatments have been unsuccessful, or where serious or multiple co-morbidities exist, or where a second opinion is required – it requires the concentration of activity to a small number

of clinicians and providers to allow the development of expert skills in a small group of clinicians and multi-disciplinary staff. Supports the efficient use of resources, staff training and audit.

There is existing evidence that excellence in orthopaedics is supported by specialist services being delivered in a critical mass in specialist units. However this evidence base needs to continue to be expanded.

To support this, it is vital that the SOA facilitates an expanded evidence base for demonstrating what defines a "better outcome" for patients in orthopaedics and thereby supports the evidence base that specialist services deliver this more effectively and at lower cost. Specialist Orthopaedic services deal with a higher proportion of complex work than general elective orthopaedic services. Therefore, the outcomes evidence base needs to ensure that appropriate consideration is given to patient case mix complexity.

The SOA will therefore:-

- Collate the existing evidence base for orthopaedic outcomes and provide a view on the strengths and weaknesses of this evidence
- Support the agreement of appropriate definitions of excellent patient outcomes in orthopaedics
- Support the agreement of appropriate definitions of drivers of case mix complexity and the means by which outcomes measures should take these into account. This will include clinically led evidence that specialist services deal with a higher proportion of complex cases than general elective orthopaedic services
- Support the process for recommending how the evidence base needs to be refined and expanded

Theme 2 - Innovation

In addition to providing specialist activity to an appropriate critical mass to achieve better outcomes for patients with complex conditions, specialist units should also act as hubs which drive forward best practice, innovation, teaching, research, development and trialling new technologies across all providers of orthopaedic services, in primary care and secondary care general hospitals.

The SOA will therefore:-

- Collate evidence that specialist services provide best practice, innovation and translational research that improves patient outcomes in the NHS
- Support the process for recommending how the cascading of best practice, innovation and translational research could be improved in orthopaedics.

- Support clinical, operational and financial benchmarking across specialist orthopaedic services, including international benchmarking – for example across the International Society of Orthopaedic Centres.

Theme 3 - Commissioning

The Commissioning landscape in the NHS is changing significantly and the SOA welcomes the direction of travel to move the commissioning of all services defined as specialist to new regional specialist commissioning boards

International experience is that case mix related funding systems, such as the Healthcare Resource Group system "Payment by Results" used in the NHS struggle to reflect case mix complexity of specialist services. The sustainability of specialist orthopaedic services in the NHS is dependent on a funding system that, as well as driving best practice and efficiency, also reflects complexity appropriately.

The SOA will:-

- Provide a primary source of advice to Department of Health and Monitor on the NHS Activity Funding system to support shifting from Payment by Volume to Payment by Result/Outcome

- Continue to play a key role in supporting the Department of Health annual process to sense check and road test annual tariff changes and the potential future equivalent under Monitor's new role.

- Support the Department of Health and Monitor in developing the tariff structure and value to incentivise best outcomes and effective and efficient service delivery. For example, continuing to advise on the development of patient pathway tariffs that recognise the probable long term cost of caring of complex patients and reward.

- Be a source of support to the Department of Health and Commissioners in delivering the transfer of specialist orthopaedics services to specialist commissioners, including providing direct input into the creation of the new contract terms and continuing to provide input into the work on the transition of spinal services that the is being undertaken by the national spinal review.

External partners and stakeholders

The Specialist Orthopaedic Alliance will facilitate collaboration within the NHS and outside to support the delivery of its vision. The SOA will interface with MPs, Ministers, Health Select Committee, the NCB, specialist commissioners, and partner bodies such as the British Orthopaedic Association, Royal College of Surgeons, and the British Orthopaedic Directors Society. This will include supplying information, reporting, commentary and other support and expertise on national or local policy initiatives that impact the delivery of orthopaedic services.

3. *Summary SWOT Analysis*

Strengths	**How will we build on these strengths?**
We have established a track record of working positively and constructively with the Department of Health on Payment by Results tariff issues	Expand clinical input into supporting the Orthopaedic Expert Working Group
We have an open door to influence the development of specialised commissioning and need to ensure we continue to add value.	Continue to provide expertise and clinical input into the process of setting up the NHS Commissioning Board.

Weaknesses	**How will we manage these weaknesses?**
We may be deemed to be an elitist lobby group protecting organisational boundaries	Focus on patients and services, not organisations

Opportunities	**How will we exploit these opportunities?**
We can be a source of support in expanding outcomes evidence base	Facilitate the expansion of orthopaedic outcomes evidence base

Threats	**How will we manage these threats?**
Wider NHS environment and organisational issues distract the ability of specialist units to support the SOA	Focus on patients and services, not organisations

Appendix B
May 2014
Current Roles

Lead Chair – Russell Hardy, Chairman of RJAH NHS Foundation Trust (September 2010 - May 2014 – now due for re-election)

Lead Chief Executive – Rob Hurd, RNOH NHS Trust (January 2012 - January 2015 – opportunity for re-election)

Lead for Medical Engagement and Clinical Workstreams Sub Groups - Peter Kay, Wrightington, Wigan & Leigh NHS Foundation Trust

Lead for Financial and Operational Benchmarking Workstreams - John Grinnell, Finance Director, RJAH NHS Foundation Trust

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: May 2014 **ENCLOSURE NUMBER: 5**

SUMMARY OF REPORT TO Trust Board

DIRECTOR LEAD:	Helen Shoker, Director of Nursing & Governance
AUTHORS:	Lisa Pim, Interim Deputy Director of Nursing & Governance Alison Braham, Governance Manager
SUBJECT:	**Patient Quality Report**

SUMMARY

This paper provides an update on patient quality, safety and experience activity during April 2014 and sets out the 2014/15 national and regional contractual and ROH NHSFT quality standards.

The quality of care we deliver, our patients' safety and their experience remains a high priority for the organisation and it is anticipated this report will assist the Trust Board and EMT in bringing together key quality issues for debate, assurance and information.

Key areas of note this month:-

- Directorate Teams to consider last quarter incident trends and reported incident numbers and review Directorate Risk Register. Are the risks reflected within the risk register? Is the mitigation working? Does the risk require escalation to the Corporate Risk Register?
- Latest publication from The National Reporting and Learning Service report, section 1.5
- 2014/15 quality contractual details
- New for 2014/15 Days between harm for pressure ulcers and patient falls is to be recorded
- HDU to continue with Central Venous Cannula (CVC) returns to IC team
- April WHO checklist 98.6%, standard not met

RECOMMENDATIONS

The Trust Board and EMT are 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

PATIENT SAFETY

Reporting Requirements - National Incident Reporting Requirement & Quality KPI Contractual Requirement

1.1 Serious Incidents requiring investigation (SIRI) (April 2014)

There were 3 SIRI reported in April. These concerned a wrong dose of heparin through a Hickman line, a wrong side local anaesthetic, and a Grade 3 pressure ulcer. (See Appendix 1 for full SIRI details – new and ongoing.)

1.2 All other incidents requiring an investigation

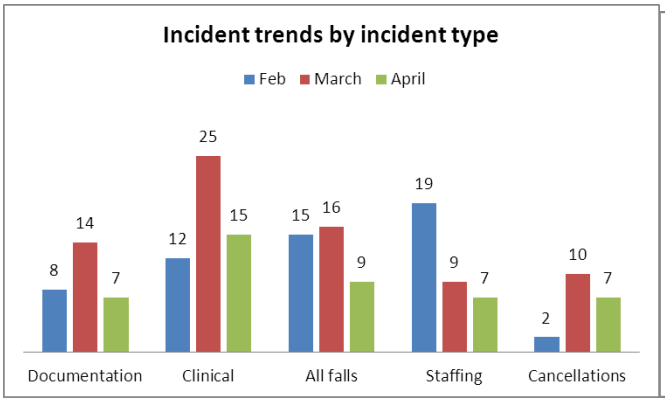
12 additional incidents were reported that subsequently required an RCA investigation to be undertaken (See Appendix 2).

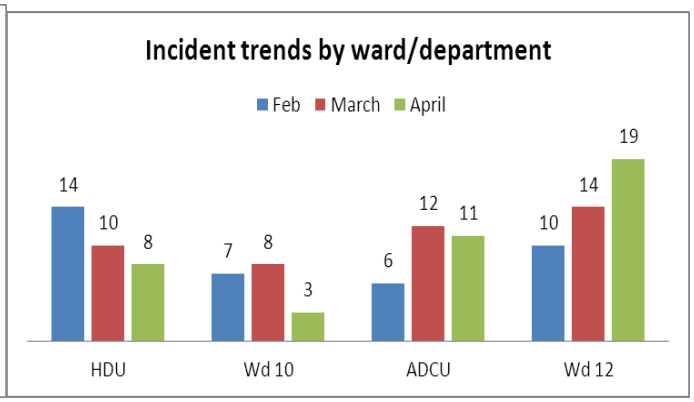
1.3 Deaths

There were no inpatient deaths in April 2014.

1.4 Incident trends

There were 159 incidents reported during April, compared to 178 incidents reported during March. The graphs below indicate the incident trends by incident type and the clinical areas with the highest levels of incident reporting.





1.5 NRLS Organisational report

The latest report has recently been released by the National Reporting and Learning Service, covering incidents from the period April-September 2013. This report demonstrates:-

- Our reporting rate has gone up from 6.3% to 7.1% per 100 admissions. However the cluster group has increased as a whole resulting in the ROH appearing below both the average (8.9%), and the median (7.3%) for the cluster group.
- The ROH is meeting the requirement to report every month.
- The time between reporting of incident within the ROH and reporting to NRLS has improved– now 50% of our incidents are reported over 10 days after the incident, as opposed to over 33 days in the last report.
- The ROH has 1.3% of incidents classified as serious harm (cluster average; 0.4%), and the report shows 0.8% of incidents are patient safety deaths (cluster average: 0.1%).
- The above data indicates an improvement on the numbers of incidents reported within the organisation with the need to monitor serious patient incidents and embed lessons remaining a key priority for the organisation.

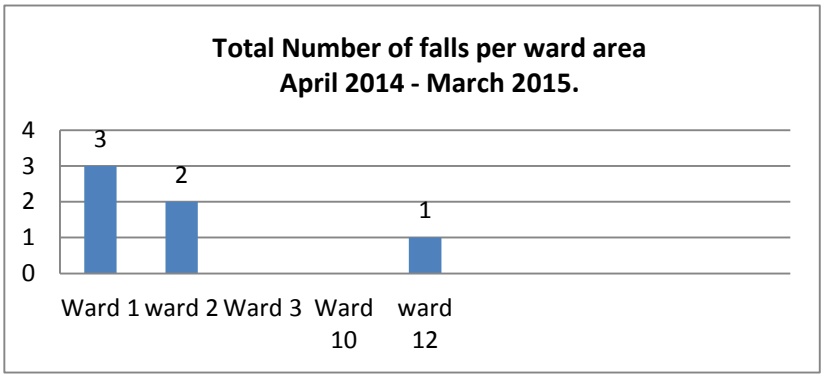
The full report is shown at Appendix 3. The next report cut-off date is the end of May 2014 and the data will be checked before this date, especially for the severe harm and death incidents, to establish as accurate reporting as possible.

1.5 Falls
Reporting requirement- Contractual Quality KPI requirement & National Safety Thermometer CQUIN

Falls data is collected monthly to meet the contract and quarterly for Safety Thermometer. A new addition for 2014/15 relates to days between harm which is now included per area within this report.

Reportable incidents for in April categorised as (adult) in-patient falls total 6 incidents, all of which are deemed unavoidable. All reportable falls have been individually reviewed and were found to be unwitnessed by staff members. 3 falls occurred whilst maintaining patient privacy and dignity in hospital toilets and bathrooms. The patients were noted as being in the post-operative period of their recovery and had been deemed safe for independent mobilisation using their recommended aid. 2 falls were as a result of patients mobilising independently to the toilet. It is to be noted, these patients were actively rehabilitating post-surgery. 1 fall happened at the patient's bedside whilst attempting to stand independently to void urine. All 6 patients had full mental capacity. Of the 6 falls, 5 had a falls questionnaire completed at the time of reporting.

Reportable Falls per ward area.



Harm suffered as a result of inpatient falls.

Of the 6 reportable Falls, 2 caused no harm and four resulted in minor harm. This continues the pattern of no significant harm caused reported throughout 2013/14. This month's falls data highlights the requirement for the project work which is about to commence, the "Throne Project". This project will be a useful indicator of unnecessary environmental risks within bathroom and toilet areas, which may exacerbate patient harm, caused by a fall or increase the likelihood of a patient fall.

Falls Risk Assessments & Care Planning - Quality indicator requirements.

Qu1.	Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	91% compliance required each month by ward	April Results 96%
Qu2.	If the patient is identified as high risk is a care plan in place? Yes/ N/A	91% compliance required each month by ward	April Results 96%

With the exception of Ward 3 all areas achieved 100% compliance with the above.

Following reporting of poor levels of compliance with falls risk assessments and high risk care planning for the last 2013 quarter, a further audit of high risk areas was undertaken, reviewing a further 10 patients documents. Wards 1 & 3 have been identified as high risk areas given the nature and complexities of the patient population they serve. They have also shown, on occasions, poor utilisation of falls risk

assessment and care planning. In particular, ward 3 showed a significant underutilisation of the documentation through the months of January and February 2014. A further unannounced audit was undertaken in April with the following results:-

.**Ward 1:**

- All 10 patients had a falls risk assessment document.
- All 10 had correctly been identified by staff as being at high risk of falls.
- 5/10 consequently had a high risk care plan in place. 5 were left blank.
- 5/10 had been reviewed appropriately. 2 were not due a review at the time of auditing.

Ward 3:

- 8/10 patients had a falls risk assessment document. 2/10 had no document at all. 1 was a recovering in-patient. 1 was attending for therapy purposes.
- 7 had correctly been identified by staff as being at high risk of falls. 1 was not deemed to be of high risk.
- Of the 7, 4 had a high risk care plan in place. The remaining 3 were blank.
- 1 of the 8 had their falls risk reviewed as per protocol. The same patient did not have a high risk care plan in place. 1 patient was not due a review at the time of auditing.

The audit has indicated a clear training need in respect to accurate completion of these documents. The clinical nurse tutor with the assistance of falls working group representatives are refining the falls risk assessment document to enable the document to be more user friendly and less open to misinterpretation which will should improve compliance with completion. It is perceived that the new documentation booklet formatting the current falls paperwork within a booklet of risk assessments required on admission, has helped.

The charitable funds bid for new equipment and falls prevention/patient education packs was approved on May 13th.

1.6 Infection Prevention and Control, Tissue Viability and Nutrition.

Reporting Requirement - Contractual Quality KPI, National Safety Thermometer CQUIN & National Reporting Requirement

Tissue Viability: There were no avoidable pressure ulcers (grade 2, 3 or 4) reported during April.

Nutrition: Nutritional data and information is reported quarterly although it is not presently in the current local or national contract. Previously the reporting requirement was a quarterly report of completion of MUST scores within 6 hours of admission.

Surgical Site Infection: There is an ongoing look back exercise relating to an apparent increase in primary arthroplasty patients requiring readmission due to infection throughout April. This requires detailed analysis and careful investigation. The report is due for completion in the next week and will be shared at EMT and reported to Board as appropriate.

Exception Report: The following indicators have not been met:

Indicator: Percentage of relevant emergency cases MRSA screened

MRSA screening for all emergency patients has been in place at ROH for over a decade. Recent employment of a data analyst with IPC has enabled and enhanced data reporting.

Trust policy states that all emergency admissions must be screened for MRSA, a number of emergency admissions were not screened on admission during April although they were all isolated in side rooms on arrival. Analysis of the data has identified 3 wards responsible for breaching of this requirement; they have been reminded of the clinical importance of adhering to the Trust policy.

Indicator: Infection Prevention Society (IPS) Rapid Improvement Tool (RIT) percentage score for Central Venous Catheter –continuing care.

The organisation is in the process of changing to new audit tools which has resulted in no data submission for April. HDU have been reminded that it is a requirement for them to return 20 observations of CVC continuing care each month.

1.7 Patient Safety Alerts

Reporting Requirement - National Reporting Requirement & Quality KPI Contractual Requirement

Closed alerts for April 2014

Ref	Alert Title	Issued by	Issue Date	Response	Deadline
EFN/2014/11 (U)	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (UPDATE) - ABB Low Voltage Fuse Cabinets	DH Estates and Facilities	29-Apr-14	Action Not Required	27-May-14
MDA/2014/014	Samaritan® public access defibrillator Model: PAD 500PManufactured by HeartSine Technologies Spe ...	MHRA Medical Device Alerts	28-Apr-14	Action Not Required	28-May-14
MDA/2014/013	S74 Elite Sport Scooter with Leoch 20 amp/hour batteries Manufactured by Pride Mobility Products Ltd ...	MHRA Medical Device Alerts	28-Apr-14	Action Not Required	30-Jun-14
MDA/2014/012	Laboratory reagents requiring manual handling for use in combination with cobas c 502 analyser made ...	MHRA Medical Device Alerts	16-Apr-14	Action Not Required	16-May-14
NHS/PSA/W/2014/008	Residual anaesthetic drugs in cannulae and intravenous lines	NHS England	14-Apr-14	Action Completed	13-May-14
EFN/2014/26	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Schneider Electric - RN2c Ring M ...	DH Estates and Facilities	11-Apr-14	Action Completed	13-May-14
NHS/PSA/W/2014/007	Minimising risks of omitted and delayed medicines for patients receiving homecare services	NHS England	10-Apr-14	Action Not Required	09-May-14
EFN/2014/25	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Schneider Electric - RN2c - Ring ...	DH Estates and Facilities	08-Apr-14	Action Completed	06-May-14
EFN/2014/24	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Brush Switchgear - Ring Main Unit	DH Estates and Facilities	02-Apr-14	Action Not Required	30-Apr-14

Alerts with on-going action status

Ref	Alert Title	Issued by	Issue Date	Response	Deadline
NHS/PSA/D/2014/006	Improving medical device incident reporting and learning	NHS England	20-Mar-14	Action Required: Ongoing	19-Sep-14
NHS/PSA/	Improving medication error incident reporting and learning	NHS England	20-Mar-14	Action Required:	19-Sep-14

D/2014/005				Ongoing	

Action taken
NHS/PSA/D/2014/006 – Alert has been issued to the medical devices lead on the medical devices committee. Awaiting feedback from the Committee.
NHS/PSA/D/2014/005 – Alert been issued to the Head of Pharmacy. Action plan has been put in place:

1.8 WHO compliance
Reporting Requirement - Contractual Quality KPI Report & National Reporting Requirement

The total number of WHO checklists that met the 100% standard for patient safety was 98.69%. **This fails to meet the expected contractual requirement of 99%.**
Compliance audits are completed each day for every patient cared for within the department. Data is recorded by Surgeon as opposed to Theatre. The checklist is reviewed for omissions against the standard in all sections. This includes;

- No checklist evident in notes
- Sign in Section incomplete
- Time out section incomplete
- Sign out section incomplete
- Omission of signatures present on the checklist

The weekly report is circulated to all Clinical Directors for attention at Directorate level with support for improvement provided by the Medical Director and Director of Nursing. The data is shared at Clinical Audit-there is no trend or pattern of note.

1.9 CQUIN Schemes
Reporting Requirement - National and Local CQUIN Requirement

Scheme Description	and annual financial value of CQUIN 2013/14
Friends and Family Test	£79,043
NHS Safety Thermometer	£79,043
Dementia	£79,043
VTE	£79,043
Medicines Management	£224,862
Formulary adherence	
Medicines Management	£224,862
Transfer of medicine information with patients on discharge	
Heel Pain	£224,862
Reducing avoidable Pressure Ulcers	£224,862
Spinal PROM	£136,965
Spinal MDT	£136,965
Highly Specialised Dashboard	£45,655
Highly Specialised - Collaborative Outcome Group	£45,655

Quarter 4 2013/2014 CQUIN Schemes achieved.

1. Friends and Family Test
2. Dementia
3. VTE Risk Assessment
4. Safety Thermometer
5. Medicines Management Formulary
6. Medicines Management Discharge Medicines

7. Heel Pain
8. Reducing Avoidable G2 Pressure Ulcers

2013/2014 CQUIN Schemes not achieved.

1. Reducing Avoidable G3&4 Pressure Ulcers –Q4 and year end quality standard was not achieved, 2 G3 & 1 G4 avoidable pressure ulcers were reported in the year which in addition to the patient harm caused has resulted in a £1000 penalty.

New CQUIN Schemes for 2014/2015

CQUIN	CQUIN Description
NHS Safety Thermometer (National CQUIN)	Measurement and reduction of harm. Pressure Ulcers and falls
Dementia (National CQUIN)	Find refer & assess, Clinical leadership & staff training
Staff Friends and family (National CQUIN)	Staff and patient experience CQUIN
Reviewing the Patient Journey	Service user & carer involvement in the patient process
Patient Safety Culture	Review of current practice in relation to clinical supervision, actions and engagement to disseminate and improve good practice.
Telephone Follow Up	Local audit of communication with patients' GPs
Knee Exercise	Provision of an exercise intervention for patients with osteoarthritis of the knee
SSI Surveillance	Surgical Site Infection (SSI) Surveillance for Arthroplasty

2 PATIENT EXPERIENCE

Reporting Requirement - Contractual Quality KPI Reporting & National Reporting Requirement

Summary April Compliments, PALS Contacts and Complaints.

Directorate	PALS	Complaints	Compliments
Clinical Support	36	1	19
Corporate	22	0	37
Small Joint	9	1	5
Large Joint	20	3	141
Oncology	10	0	15
Paediatrics	7	0	56

Spinal	13	4	70
Theatres	5	1	112
Total	**122**	**10**	**455**

COMPLIMENTS
Number of compliments received this month is 455 down from last month's total of 552, (-97 or 17%).It is suggested this is based on the decreased activity undertaken in April due to the Bank Holidays within the month.

PALS
Number of contacts this month was 122 which is up from last month's volume of 89 which is an increase of 33 or 37%. As a regular holiday time this is one of the peaks of contact we would expect to see.

Of the 122 contacts, 42 were general enquiries (34%) and 80 were concerns (66%)
Greatest areas of concern were:

- Orthotic service provision
- Physio wait times
- Delays between having MRI scan and getting results/having OPA
- Patients with complex needs – safeguarding concerns, social services involvement, mental health or other medical conditions – requiring much support and organisation
- Delays to have injection (dates in ADCU)

Highest volumes of general enquiries were:

- PP enquiries
- Copy medical records
- Cannot reach other colleagues/how to contact other colleagues
- How to access services at the Trust

COMPLAINTS
Number of complaints received this month is 10 down from 13 in February, a decrease of 3 or 23%. The % of complaints resolved within timeline was 100% (2/2) against KPI of 80%.
Areas of concern:

- Clinical outcome x 2
- Surgery cancelled twice on the day (within 2 weeks) x 1
- Nursing care/approach x 4
- Orthotics service x 1
- Poor service and delays x 1
- Approach of Registrar x 1

2.6 LITIGATION
Reporting Requirements - ROH NHSFT Good Practice

2.6.1 April 2014 update

New Cases

Ref	Date of Incident	Details	Directorate
Clinical Negligence Cases			
T444	Nov-11	Surgical outcome	Spinal
T443	Aug-13	Surgical outcome - open wound & nerve damage following knee revision	Oncology
T440	Jan 2012 onwards	No x-rays for 15 month period. Also a SIRI and complaint	Oncology/ X-ray

T439	2008 onwards	Hip reconstruction, pelvic & valgus osteotomy; nerve damage; delay in treatment clawing of foot	Paeds & small joints
Public Liability Case			
T441	Aug 2013	Injury to hand clearing shrubbery overgrowing private property from Hospital grounds	Corporate - Estates

Existing Cases: Formal letters of claim were received in the following cases

Ref	Date of Incident	Details	Directorate
T413	Feb 2013	Unexplained patient injury – also a complaint and SIRI	Large joints

Closed Cases

T386 – Oncology patient alleged leg length discrepancy following THR in Aug 2011. Liability was denied.
- Damages £0
- Claimant's Costs £0
- Defence costs £900

T308 – Paediatrics adult patient underwent complex primary total hip and alleged she consented for hip resurfacing and femoral osteotomy, not a total hip replacement. The femoral head had to be exchanged by further surgery. Liability admitted. Also a complaint & SIRI
- Damages £51k
- Claimant's costs £37k
- Defence Costs £1.4k

Coroner's Inquests: none

2.1 Single Sex Compliance
Reporting requirements - National Requirement & Contractual Reporting Requirement

There were no single sex compliance breaches in April.

2.2 Patient Reported Outcome Measures (PROMs)
Reporting Requirements -National Requirement & ROH NHSFT Good Practice

During April the 90% target compliance rate for completed questionnaires for both hip and knee replacement surgery was achieved. The figures are based upon the actual theatre activity according to ORMIS and are checked against the patient details in PAS.

The PROMS questionnaire compliance data for April 2014 is detailed below:

	Indicator	April 2014
4A N13ii	PROMs: Hip replacement - % patients completing questionnaires.	96.3%
4A N13iv	PROMs: Knee Replacement- % patients completing questionnaires.	100%

2.3 National Joint Registry (NJR) Update

Reporting Requirements -National Requirement & ROH NHSFT Good Practice

Compliance progress 2014
Uploading of the 2014 backlog is almost complete, with a small amount of data inputting to be completed for April 2014 and a small number of forms outstanding for delivery to the department for January-March 2014. Regular meetings continue to address missing information.

Compliance Progress January – April 2014

	Jan 14	Feb 14	March 14	April 14
% Compliance	88%	92%	90%	89.8%

Consent Progress January-April 2014
The NJR regional representative recently visited the POAC team at their team meeting and a discussion was held as to improving the consent rate on the patient's first visit. Actions to be taken include giving the consent form to the patient at the rapid assessment clinic, then collecting the form/checking the form has been signed at the POAC appointment. POAC will be monitoring the consent figure more closely with the support of the NJR regional rep and the hospital data manager.
Currently all patients who have not signed consent are written to retrospectively.

	Jan 14	Feb 14	March 14	April 14
% Consent	29%	45%	51%	52%

3. EFFECTIVENESS OF CARE

3.1 Safety Thermometer – Data unavailable at time of writing
Reporting requirements - National Requirement

3.2 Matron KPI
Reporting Requirements - ROH NHSFT Good Practice

On review the following are noted;
Large/Small Joints Directorate
Sustained performance is noted across Wards 2, 10, and 12. Ward 10 has remained as an overall rating of green, with wards 2 and 12 remaining amber this month although continued improvement in metrics is noted. Key areas of required focus appear to be safety checks and elevated staff.sickness.

Theatres/Anaesthetics and Critical Care Directorate
Sustained performance is noted for this Directorate. Theatres of note are Theatre 1, 5, 6, 8, 9, and 10, which have no additional patient safety red indictors (other than the efficiency KPI). Theatres 2, 3, 4, and 7 show 2 reds with training, workforce and safety highlighted as individual red indictors with in different theatres.

Support Services Directorate
Performance is notable with 2 out of the 4 clinical areas achieving an overall green rating, ROCS, and Pain Management. POAC has achieved an amber rating with areas of focus required on training and safety checks and there are elevated levels of sickness within the department. OPD KPI's were in complete at time of compiling this report.

Spinal Directorate
Ward 1 remains at an overall amber rating this month with improving metrics notable on this ward specifically around training, workforce and safety.

Paediatric Directorate
Ward 11 has sustained an amber rating. Key areas of focus appear to be safety checks, elevated staff sickness and outcomes.

Oncology Directorate
The KPI was incomplete at the time of compiling this report.

APPENDIX 1

1.1 New SIRIs April 2014

Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior to RCA completion)	Directorate	Progress	Final report due
12645/6/7 STEIS 2014/10796	28/03/14	02/04/14	Wrong drug Hickman line	Near miss	Theatres & Anaesthetics	Investigation underway	10/06/14
12640 STEIS 2014/10893	28/03/14	03/04/14	Wrong side LA	No harm	Theatres & Anaesthetics	Investigation underway	11/06/14
12814 STEIS 2014/13976	26/04/14	29/04/14	Grade 3 pressure ulcer	Moderate harm	Paediatrics	Investigation underway	03/07/14

1.2 Ongoing/Submitted SIRIs:

Ref	Incident date	Description	Directorate	Progress/ date submitted	Date report due	Findings summary
12383 STEIS 2014/4895	10/02/14	Confidentiality breach	Corporate	Report submitted 16/4/14.	16/4/14.	There was no formal registered audit and no information sharing agreement for sharing this information. Therefore despite the good intentions for improving service delivery, this incident does breach the requirement that information that is shared for the benefit of the community should be anonymised. However there was no risk of identity theft and no harm has occurred to patients. Procedures and guidance have been implemented to avoid this happening in future.
12412 STEIS 2014/5869	11/02/14	Pt transfer	Theatres & Anaesthetics	Investigation underway	25/04/14	
12532 STEIS 2014/8553	10/03/14	Delayed diagnosis	Oncology	Investigation underway	20/05/14	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: Friday 23rd May **ENCLOSURE NUMBER: 6**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**Safe Staffing – April 2014**

SUMMARY

The National Quality Board (NQB), Care Quality Commission and NHS England have jointly published recommendations to NHS Providers to ensure safe staffing of wards to deliver safe, high quality patient care.

- In April there were no unsafe staffing incidents raised.
- ROH NHSFT completed the NHS England Safe Staffing stocktake in April
- ROH NHSFT commenced work in November, prior to publication of the NQB recommendations, to review the ward establishments.

The action plan has been developed to provide EMT and Trust Board with a progress report (Appendix One)

Caution is advised when reviewing the April data, during the month we identified a number of enhancements and additions which will enable analysis to be undertaken within the June report. This will greatly inform understanding and decision making about ward establishments, skill mix and patient acuity. Data collection will continue weekly.

IMPLICATIONS

Patient safety and experience
Staff satisfaction
Organisational reputation

RECOMMENDATIONS

Trust Board are asked to:-

- Note the progress made by ward teams, Matrons and project lead since November
- Recognise and acknowledge the importance to ROH NHSFT of the national guidance in regards to our patient welfare and future strategy
- Be assured that the Trust is compliant with requirements for patient safety in this regard.

Appendix 1

Safe Staffing – Ward Review- Action Plan

Key - Level of Assurance	Colour
Completed	
No delays, expect to complete on time	
Slight delays, complete on time	
Slight delays, delayed completion	
Significant delays, delayed completion	
Activity not yet commenced	

Subject& Recommendation Reference	NQB Ref No CQC Ref	Lead	Current Position	Review Date	Timeline for delivery	Level
The Board receives a report every six months on staffing capacity and capability which has involved the use of an evidence based tool. **This report:** **• Draws on expert professional opinion and insight into local clinical need and context** **• Makes recommendations to the Board which are considered and discussed** **• Is presented to and discussed at the public Board meeting** **• Prompts agreement of actions which are recorded and followed up on**	**1,3,7** **CQC A**	**HS Matron**	**Board and EMT report to May Committee meetings**	**Monthly**	**Six Monthly**	
Clearly display information about the nurses present and planned in each clinical **setting on each shift. This should be visible, clear and accurate.** **Significance of**	**8** **CQC B**	**HS SL Matron**	**Staffing boards on display within wards in place, stating staff on duty and Nurse in Charge** **Posters of staff uniforms displayed on wards** **Entrance to ward notice boards ordered and locations agreed** **ROH standard format of entrance notice boards designed by Matrons/Senior Nurses**	**June**	**June**	

different uniforms and titles used. To summarise, the displays should: • Be in an area within the clinical area that is accessible to patients, their families and carers • Explain the planned and actual numbers of staff for each shift (registered and non-registered) • Detail who is in charge of the shift • Describe what each role is						
The Board receives an update containing details and summary staffing • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap • Evaluates risks associated with staffing issues • Seeks assurances regarding contingency planning, mitigating actions and incident reporting • Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly area of the website	**1,7 CQC C**	**HS**	**Board and EMT paper to May Committees Developments to Safer Nursing Care Tool undertaken with support from DDoF and Project Manager No unsafe staffing incidents reported in April Quality Debrief continues Active shift management by Senior Sisters, Sisters and ward staff Bank and Agency use report received**	**May Monthly**	**Monthly ongoing**	
The Trust will ensure that the published monthly update is available	**1,7**	**HS WP**	**Report to be published following May Trust Board Confirmation of process to NHS Choices**	**Monthly**	**June**	

to the public via not only the Trust's website but also the relevant hospital(s) profiles on NHS Choices.	**CQC A, D**	**Comms**				
The Trust: **• Reviews the actual versus planned staffing on a shift by shift basis** **• Responds to address gaps or shortages where these are identified** **• Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care**	**2** **CQC E**	**Matron** **HS**	**Wards & HDU completed daily acuity and staffing tool, commenced 1st April** **Project Manager support for data collection, inputting and analysis (WP)** **Weekly analysis** **Bi weekly Quality Debrief continues** **Matrons and Senior Sisters proactive management of each shift daily** **No unsafe staffing incidents completed in April** **Bank and Agency monthly report provided to DoN/Matrons showing fill rate and RN/HCA usage**	**Bi weekly**	**April**	
Safe Staffing Policy, to include escalation process	**N/A**	**HS**	**Draft policy completed in April** **Circulation and comments through May & June to stakeholders** **To EMT and Trust Board in July for approval**	**June**	**July**	
Ward based safe staffing risk assessments	**N/A**	**Matron**	**Safe staffing and minimum staffing levels confirmed**	**Quarterly**	**April**	
Acuity Tool, Safer Nursing Care Tool development	**CQC A**	**HS** **AG** **WP**	**Initial development of the tool undertaken in January** **Trialled by wards March** **Officially commenced 1st April** **Feedback from Senior Sisters and Matrons received** **Refinements to tool undertaken in May** **Expect final version to be used from 1st June**	**Monthly**	**June**	
Staff awareness	**N/A**	**HS** **Matron** **WP** **LP**	**National Quality Board report circulated to all Matrons and Ward Teams** **Nurse Leaders Forum discussions** **6C's@ROH events programme commences May** **EMT and Trust Board monthly reports** **Audit Committee presentation July and October**	**Monthly**	**Ongoing**	
Quality Debrief	**N/A**	**HS LP**	**Bi weekly Quality Debrief continues (commenced January)**	**Six**	**Bi**	

		Matron AM	**Provides forum to reflect and plan over the week for matters associated with the day to day patient safety/experience and safe staffing** **Summary email sent to all Senior Nurses and DOps** **Provides forum to escalate issues to DoN & DOps**	**monthly review of effectiveness**	**weekly**	

HS	Helen Shoker
SL	Stuart Lovack
WP	Wendy Prestage
AG	Alex Gilder
LP	Lisa Pim
AM	Amanda Markall

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: Friday 23rd May 2014 **ENCLOSURE NUMBER: 7**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR	Helen Shoker, Director of Nursing and Governance
SUBJECT	BAF report and Risk Register
AUTHORS	Alison Braham, Governance Manager Jane Moore, Litigation Assistant and Governance Facilitator

SUMMARY

The Trust Board is asked to:

1. Review the BAF themes and updates (see appendices 2 and 3), and note the following changes:

New risk(s) added to the BAF

- 51 'Medical Records' – Trust-wide risk escalated to a red
- 625 'Spinal Database' – new red Trust-wide risk

Confirmation of the lead Committees for these risks is required.

Closed risk(s)

- none

Increasing risk(s)

- None

Decreasing risk(s) – Assurance to be sought from lead committees that the risk(s) should be de-escalated from the BAF.

- 275 'Learning from SIs, complaints & claims'
- 269 'Activity targets'
- 12 'KPIs'
- 414 'PROMS'

IMPLICATIONS

Insufficient monitoring and review of these risks, actions, progress and quality of information therein may have implications for the Trust in meeting its objectives and expected standards of service delivery. Consideration should be given to the impact of risks on the Trust's compliance with the Care Quality Commission (Registration) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities).

RECOMMENDATION

Trust Board is asked to:

- **Review** the risks that it oversees
- **Confirm** new risks to be added or removed
- **Ensure** that all risks which they oversee are **discussed and reviewed** with operational leads.
- **Review** progress against action plans

BOARD ASSURANCE FRAMEWORK 2013/14 (Last updated: 13.5.14 for review at EMT)

This table maps all Trust-wide high level (red) risks against the 8 new 2013/14 BAF themes. Details of the 8 strategic BAF themes are given on the attached summary sheets.

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	Audit	Audit
Trust-wide risks with a red/amber risk rating			RAG status	Exec Lead								
I.D.	RISK	CONSEQUENCES										
32	Higher than expected rates of 30 day SSI within arthroplasty		16	Medical Director (As DIPC)	Lead Committee				Supporting Committee			
33	Insufficient assurance around robust implementation of infection prevention strategies in theatres.		16	Medical Director (as DIPC)	Lead Committee				Supporting Committee			
27	Inability to control the use of unfunded medical temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2	lack of continuity of patient care; On going locum and agency costs. potential successful banding claims Pre-monitoring exercise has highlighted potential breaches of national New Deal standards.	27	Medical Director	Supporting Committee			Lead Committee		Supporting Committee	Supporting Committee	Supporting Committee
178	Poor completion of WHO safety procedure.		16	Medical Director	Lead Committee							
582	Risk of non-delivery of strategic objectives due to poor staff perception of the need for change and ineffective implementation of change in the recent past.	Care for patients that is less than the best; Lack of organisational sustainability	16	Director of Workforce and OD	Supporting Committee TBC					Lead Committee		

New or Recently Upgraded Risks May 2014

51	Medical Records: Non compliance with Information Governance/ data protection regulations.Retention of records unnecessarily. Insufficient destruction of medical records in line with policy.	Potential financial penalty due to data protection/IG breaches.	16	Director of Operations	**Lead Committee TBC**		**Supporting Committee TBC**					

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
	Leading Committee				CGC	EMT	CGC	EMT	EMT	EMT	Audit	Audit
I.D.	Trust-wide risks with a red/amber risk rating RISK	CONSEQUENCES	RAG status	Exec Lead								
625	Spinal database relating to outcomes and CQUINS held in R& T - data corrupted.	Adversely impacts upon delivery of quarter 4 CQUINS report and potential financial loss to Trust	16	Director of Finance	**Supporting Committee TBC**		**Supporting Committee TBC**	**Supporting Committee TBC**	**Lead Committee TBC**			**Supporting Committee TBC**

Risks downgraded (to be removed from the BAF)

275	Inability to consistently demonstrate learning from serious events/ claims/ complaints is embedded in practice	poor quality patient experience; reputational damage;	9	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee		Supporting Committee
269	Failure to deliver activity targets	creates a lower in year surplus and a lower base to contract from in 2013/14 thus shrinking the organisation. Lack of ownership at Directorate level Processes not working efficiently enough to generate required throughput Lack of consultant job plan flexibility Poor activity management on a day-to-day basis	8	Director of Operations (changed from Director of Finance)	Supporting Committee			Lead Committee				Supporting Committee
12	Contractual KPIs: Trust is required to sign up to SLA contracts with our material commissioners, including performance clauses in line with national and local requirements	Quality of care reduced leading to fines and financial loss. Reputational damage.	8	Director of Nursing & Governance (changed from Director of Finance)	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			
414	ROH shows low position for health improvement as measured by PROMs on national Information Centre figures	Patient experience Reputational damage	12	Medical Director	Lead committee			Supporting Committee	Supporting Committee			Supporting Committee

Risks closed or downgraded In Quarter 4 2013/14

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
					CGC	EMT	CGC	EMT	EMT	EMT	Audit	Audit
Trust-wide risks with a red/amber risk rating			RAG status	Exec Lead	Leading Committee							
I.D.	RISK	CONSEQUENCES										
30	Non-compliance with CQC outcome 9 "management of medicines"		8	Director of Nursing & Governance	Supporting Committee							
13	Failure to deliver contractual CQUINS			Director Finance	Supporting Committee				Supporting Committee			
8	Current clinical workforce unable to meet the needs of increasingly complex patients with multiple co-morbidities			Medical Director								
31	Absence of risk assessments on which to base a Health surveillance programme:			Director WFOD								
29	CQC outcome 4 "care and welfare of people who use services". Inadequate documentation. Concerns over the environment on Ward 11. Additional psychology support	Breach of CQC essential standards of safety and quality	6	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			
28	Accuracy and timeliness of prescribing of medications on admission and reduction of missed doses of critical medicines		12	Director of Nursing & Governance	Lead Committee							
35	Risk of ineffective patient administration due to the impact of organizational change (admin review)	Patient experience is adversely affected due to confusing/duplicate communication concerning their care. Ineffective utilisation of resources eg Clinic capacity.		Director of Operations	Supporting Committee			Lead Committee		Supporting Committee		

Appendix 2

Board Assurance Framework Update – May 2014

(date updated: 13th May 2014)

BAF Theme	Risk	Consequence	Lead Director	Initial Risk	Current Risk	Update	Lead Committee
Standards of Care	ID 51 Medical Records: Non-compliance with Information Governance/ data protection regulations. Retention of records unnecessarily. Insufficient destruction of medical records in line with policy.	Potential financial penalty due to data protection/IG breaches.	Amanda Markall	20	20	Newly escalated to the BAF as a Trust-wide red risk	TBC
Contract with Commissioners	ID 625 Spinal database relating to outcomes and CQUINS held in R& T - data corrupted.	Adversely impacts upon delivery of quarter 4 CQUINS report and potential financial loss to Trust	Paul Athey	15	15	New Trust-wide red risk	TBC
Standards of Care	ID 32 Higher than expected rates of 30 day SSI within Arthroplasty		Andrew Pearson	None noted	16		CGC
Standards of Care	ID 33 Insufficient assurance around robust implementation of infection prevention strategies in Theatres		Andrew Pearson	None noted	16		CGC

BAF Theme	Risk	Consequence	Lead Director	Initial Risk	Current Risk	Update	Lead Committee
Business Continuity	ID 27 – Jnr Docs working pattern and temporary/agency medical staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2.	Lack of continuity of patient care Additional unplanned expenditure Ongoing locum & agency costs and potential successful banding claims Pre-monitoring exercise has highlighted potential breaches of national New Deal standards.	Andrew Pearson	20	20		EMT
Standards of Care	NEW- ID 178 Poor completion of WHO safety procedure		Andrew Pearson	None noted	16		CGC
Staff Engagement	NEW – ID 582 Risk of non-delivery of strategic objectives due to poor staff perception of the need for change and ineffective implementation of change in the recent past Need for change driven by the changing NHS	Care for patients that is less than the best; Lack of organisational sustainability	Anne Cholmondeley	16	16	Development of a safety culture to enable staff to feel comfortable to raise concerns internally Develop a culture where staff feel able to make change in their day to day work to improve service Develop leadership capability to lead change and engage staff Embed values into the core people management approaches of recruitment, leadership and management development & appraisal	EMT

BAF Theme	Risk	Consequence	Lead Director	Initial Risk	Current Risk	Update	Lead Committee
	environment					Development of the strong strategic narrative for staff to see a clear future for the organisation delivered by visible leaders Enhance internal communication approaches to develop effective 2 way communication	
Risks downgraded (to be removed from the BAF): assurance to be sought from Lead Committee(s) that the risk is de-escalated							
Standards of Care	ID 12: KPIs The expected standard for the quality of patient care does not meet the contractual KPI standard leading to a poor experience for the patient and a failure to deliver contractual KPI targets.	Patients receive care below the standard expected at the ROH. Breach of contract leading to fines and financial loss. Reputational damage amongst service users, commissioners, local community, staff.	Helen Shoker	20	8	"All 3 RTT targets have been achieved for April after failing the admitted target for 5 consecutive months. The DM for Patient Access is now in post (6-9 months) and is responsible for achievement of RTT and for improving pathways and processes. Spinal Deformity waiting times are a concern, 1 patient was treated >52 weeks in Q4 and initial waiting times to 1st appointment have been in excess of 15 weeks. A work programme led by the directorate but with input from clinical support and theatres is being established to ensure capacity all through the patient pathway can be assured. Monitoring takes place on a weekly basis via ARG and monthly via EMT"	CGC
Standards of Care	ID 275 Inability to consistently demonstrate learning from serious events/claims/complaints is embedded in practice	Patient care may continue to be adversely affected, with future patients placed at risk of similar events/harm relating to the	Helen Shoker	16	9	Year end Patient Safety Report produced Challenge to Directorate teams to cross reference and consider how learning occurs and how assured they are of same. Directorate Governance Meetings CGC annual work plan includes review of events/incidents/claims	CGC

BAF Theme	Risk	Consequence	Lead Director	Initial Risk	Current Risk	Update	Lead Committee
		quality of their care or experience					
Business Continuity	ID 269 Failure to deliver activity targets	Creates a lower in year surplus and a lower base to contract from in 2013/14	Amanda Markell	20	8	Rectification period ended on 31st March with more patients operated in that month than any other for 3+ years. There remains a degree of risk, historically some directorates have not grown in recent years, in addition case mix continues to change and a monthly forward look report of this will support further changes required including, if necessary, transfer of inpatient beds to DCbeds. Directorate teams are meeting with DOPs and DOF in April to sign off activity plans which are reflective of 13/14 case mix and which add in c 1m of activity income (c 590 patients across all directorates) A more proactive approach is now embedded following rectification period which will continue to ensure that lists are well used. In addition services are being offered some support to proactively engage with GP colleagues to encourage greater referrals.	EMT
Standards of Care	ID 3 ROH shows low position for health improvement as measured by PROMs on national Information Centre figures Old ref: 248		Andrew Pearson	15	12		CGC

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: Friday 23 May 2014 ENCLOSURE NUMBER: 9

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Joy Street** **Company Secretary(Helen Shoker to cover)**
Author	**Lisa Kealey**
SUBJECT:	**Results of the 2013 National Inpatient Survey**

SUMMARY

This paper will provide an overview of the results of the 2013 national inpatient survey and an associated action plan.

Results are analysed by CQC and the Picker Institute and overall demonstrate that:

- The Trust continues to perform strongly when compared to other organisations
- The Trust is in the top 20% of best performing trusts in 5 out of 9 sections, compared with 7 out of 9 sections last year. The section relating to operations and procedures has dropped into the middle 60% of trusts.
- The Trust has further improved in 5 out of 9 sections overall from last year, (improvement in 7 out of 9 sections last year).

CQC results

The high level scores published by CQC demonstrate significant improvement in 22 comparable questions from last year with no questions scoring significantly worse

In comparison with other trusts, the ROH ranked significantly better than average on 72 of the 85 questions and average on the remaining 14. There were no questions where the Trust ranked significantly worse than average.

Action Plan 2012/13

A summary review of the actions identified from the 2012 survey is attached, measured against the 2013 survey results. All eight identified actions have shown an improvement in score, four of which were significant. Two of the agreed actions have moved into the top 20% best performing trusts section.

It should be noted that the National Inpatient Survey is no longer connected to a CQUIN.

Action Plan for 2013 Survey Results

After discussion with the Director of Nursing and Governance, it has been suggested (subject to approval by Quality Committee and the Board)that we replace the dedicated inpatient survey action plan with one that covers all sources of Patient Experience data. This will ensure that the focus of effort is placed on the areas that have been identified by patients as concerns or issues. This will operate in the same manner as the previous action plans with service leads agreeing necessary steps. Monitoring of this plan will be undertaken at Quality Committee and be coordinated by the Public and Patient Services Manager.

IMPLICATIONS

Reputational

The findings of the national inpatient survey must be considered and action taken where necessary to ensure that the organisation continues to deliver a high quality service that is responsive to patient feedback.

Financial

Failure to accurately reflect the work needed to complete actions arising from the survey may result in financial penalty from the CCG who monitor compliance with the action planning.

RECOMMENDATIONS

The Board is asked to:

- **Note** the results of the 2013 national inpatient survey and the improvements
- **Agree** the introduction of the new proposed Patient Experience Action Plan to replace the Inpatient Survey action plan
- **Support** the development, agreement and monitoring of the action plan to address the findings by the Quality Committee

.

Inpatient Survey Report Detail

1.0 Background

The national inpatient survey is conducted annually in August of each year, with the results published in April of the following year. The results are used by the Care Quality Commission (CQC) to measure patient experience. The information from this survey is used to triangulate other data collected by the CQC to inform the Quality and Risk profile (QRP) held by the CQC on each organisation

Overall the results demonstrate that the ROH continues to improve in the inpatient survey.

2.0 Survey results

This section is divided into the results published by the CQC and the more detailed results provided by Picker, the survey provider

CQC results

CQC present the national results of all acute trusts surveyed nationally and analyse the results to provide a high level summary under 10 headings – this was published on their website on 8 April 2013 and identifies that the Trust is ranked in the top 20% of Trusts others in 5 out of the 9 overall areas (The Trust is not scored on the section relating to A&E Experience). The remaining 4 areas are all in the higher end of the middle 60% of Trusts

Heading	2012 score	2012 comparison to others	2013 score	2013 comparison to others
Waiting lists/planned admissions	9.2	Same	9.0	Same
Waiting to get to a bed	8.7	Better	9.1	Better
Hospital and ward	8.6	Better	9.0	Better
Doctors	9.1	Better	9.0	Better
Nurses	8.9	Better	8.6	Same
Care and treatment	8.2	Better	8.0	Same
Operations and procedures	8.4	Same	8.5	Same
Leaving hospital	8.1	Better	8.0	Better
Overall views	6.2	Better	6.4	Better
Emergency patients	na	na	Na	Na

The comparative results identify that the ROH is ranked in the:

- Top 20% of all trusts for 22/70 or 31% of questions
- Middle 60% of all trusts for 48/70 or 69% of questions
- Bottom 20% of all trusts for 0 questions

The CQC report also provides detail of where the Trust scoring against individual questions has significantly improved or decreased from the previous survey.

Significant improvements were made against the following questions:

- Admission: process not at all or fairly organised
- Admission: had to wait a long time to get to bed on ward
- Admission: member of staff did not explain reason for wait
- Hospital: didn't get enough information about ward routines
- Hospital: bothered by noise at night from staff
- Hospital: room or ward not very or not at all clean
- Hospital: not all staff introduced themselves
- Hospital: food was fair or poor
- Hospital: not always healthy food on the menu
- Hospital: not always offered a choice of food
- Hospital: patients did not get the food they ordered
- Nurses: sometimes, rarely or never enough on duty
- Care: could not always find staff member to discuss concerns with
- Surgery: not told how to expect to feel after operation or surgery
- Discharge: was delayed
- Discharge: not told how long delay in discharge would be
- Discharge: not told of danger signals to look for
- Discharge: did not receive copies of letters sent between hospital doctors and GP
- Discharge: letters between hospital doctors and GP not written in a way that could be understood
- Overall: rated experience as less than 7/10
- Overall: not asked to give views on quality of care
- Overall: did not receive any information explaining how to complain

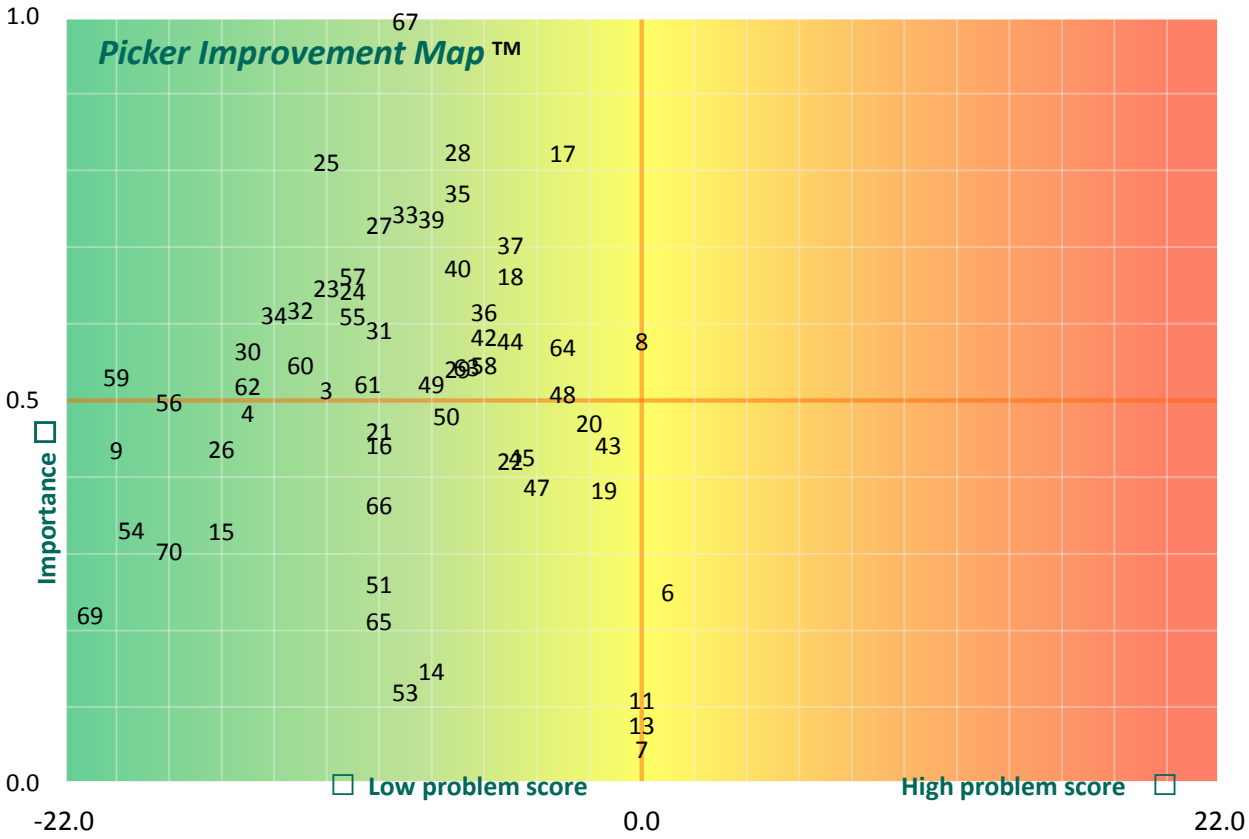
There were no questions where significant decreases in response occurred compared to the 2012 results.

<u>Picker Institute results</u>

The Picker Institute provides an additional report for Trusts that contract them to undertake the survey (which we do). There are an additional 4 pages of questions that are not part of the CQC core questionnaire and these results are not submitted to the CQC. This report is designed to be used for action planning by individual Trusts rather that for national overview. It is simply the results of all of the questions asked and has not been standardised by age, gender and route of admission (as happens with the CQC data.)

	Scores in brackets reflect the 2012 results and are measured against the 75 other Trusts that also commissioned Picker to undertake their survey (where they are comparable) The response rate for the ROH was 60.7%, higher than the Picker average of 46% <u>In comparison to last year's results</u> the Trust scored: • Significantly **better** on 72 (2) questions • Significantly **worse** on 0 (5) questions <u>In comparison to other trusts using Picker</u> the Trust scored: • Significantly **better** than average on 72 questions (53) • Significantly **worse** than average on 0 questions (7)
3.0	**Areas of improvement** The Trust improved its performance in 5 out of the 9 sections within the national survey. Picker has provided priority mapping graphs this year and these are attached. They should provide additional reassurance that the Trust has dramatically improved and monitoring is effective. These graphs will be used to inform areas of improvement to be monitored via the patient experience action plan.
4.0	**Identified questions to formulate actions (based on the Picker mapping)** • In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you? • How do you feel about the length of time you were on the waiting list before your admission to hospital? • When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or a bay, with patients of the opposite sex? Further investigation will be undertaken to look at how best to undertake actions to improve patients perception and experience in these areas

5.0	**Actions** Using these results the Quality Committee will develop and agree an patient experience action plan at their May meeting and monitor its progress at each subsequent meeting. Progress reports will be provided to the CGC via the quarterly quality report.
6.0	**Risk consideration** The findings of the national inpatient surveys must be considered and action taken where necessary to ensure that the organisation continues to deliver a high quality service that is responsive to patient feedback. This is key to the delivery of the ROH vision to be the first choice provider of orthopaedic services. The increasing importance of the patient experience agenda creates an opportunity for the Trust to continue to deliver high quality care and receive nationally published feedback regarding its performance from the patient perspective. The impact of feedback – positive or negative – cannot be disregarded and the Trust needs to ensure that the feedback continues to improve year on year to protect its reputation. The national inpatient survey provides reassurance that the Trust takes the opinion and views of its patients seriously and strives to improve in areas that patients identify as needing this.
7.0	**Communication** The summary results of the survey will be published in internal communications and briefings, our web-site and to relevant media. Opportunities that arise to highlight the improvements will also be utilised.
8.0	**Recommendations** The Board is asked to: • **Note** the results of the 2013 national inpatient survey and the improvements • **Agree** the introduction of the new proposed Patient Experience Action Plan to replace the Inpatient Survey action plan • **Support** the development, agreement and monitoring of the action plan to address the findings by the Quality Committee



Top right quadrant shows questions that are both important and in which the Trust is performing poorly compared to the average. Therefore, probably the first to look at when planning improvement

2013 NATIONAL INPATIENT SURVEY
Evaluation of ACTION PLAN Feb 2014

ADMISSION			
Not offered a choice of admission dates (Picker question)	Jayne Cox	Roll out of booked admission project underway, commenced May 2013	Trust lower than the Average Slight improvement from last year
Planned admission: not given printed information about condition or treatment	Lisa Kealey/ Jan Walshaw/ Lynn Talbot	LK to meet with Lynn Talbot to look at Patient Information PMO Project and Review Progress LK and Jan Walshaw to identify any opportunities to improve timeliness of provision of patient information and provide this information to Lynn Talbot and to Admin Process Review Group Changes to provision of patient information to be discussed and agreed with PMO project group Agreed Changes to be implemented and evaluated	Trust lower than the average Slight improvement from last year
CATERING			
Not always healthy food on the menu (Picker Question)	Emma Bridge	Since the last survey we have introduced a new menu with unlimited fruit and vegetables. The menu is also coded to highlight the healthy options so patients are more aware.	Trust lower than the average Significant improvement in Trust score from last year

Being offered a choice of food	Emma Bridge	Since the last survey we have introduced the personal menu ordering system so patients have a choice of what they would like and it is cooked to order. This should no longer be an issue.	Trust higher than the average Significant improvement in Trust score from last year.
NURSING			
Nurses: sometimes, rarely or never enough on duty	Director of Nursing and Governance	Evaluate walk round handover and make changes accordingly Undertake skill mix review in ward areas Consider evidence base for care rounds and their introduction here	Trust higher than average Significant improvement in Trust score from last year
CARE			
Not enough explanation about what would be done during the operation or procedure	Medical Director	Review of consent process being undertaken Audit of post-operative rounds by consultants being undertaken	Trust higher than average Slight improvement in Trust score from last year
Not being told how they could expect to feel after having an operation or procedure	Medical Director	Review of consent process being undertaken Audit of post-operative rounds by consultants being undertaken	Trust higher than average Significant improvement in Trust score from last year
Not given enough information about how the operation or procedure had gone	Medical Director	Review of consent process being undertaken Audit of post-operative rounds by consultants being undertaken	Trust higher than average Slight improvement in Trust score from last year.

Reporting of results has changed so direct comparison is more difficult. The narrative indicates the change of results from last year and the colour indicates the approximate position of the Trust in rank (Red: bottom 20% of Trusts, Amber: middle 60% of Trusts, Green: top 20% of Trusts) All areas on this action plan have improved, 50% significantly.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to Trust Board

Date: Friday 23rd May 2014 **Enclosure: 10**

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 2013/14
Recommendation:	To note the Report

1.0	**Summary/Background** The Trust's strategy is to work towards meeting the government's target for carbon reduction by reducing its carbon footprint from our base year in 2006 by 10% by the year 2015. The Good Corporate Citizen's Group (GCCG) is the management group to oversee the drive to reduce carbon emissions on site.
2.0	**Detail** The GCCG is chaired by the Head of Estates and Facilities and meets bi-monthly. The Trust has around 30 'Green Champions' registered; attendance at the meetings continues to be patchy. Further notification has been sent out encouraging staff to attend/join the group; this will boast numbers and spread the message to save carbon/energy. It was hoped that a 'Green Champion' would be nominated in each ward/department to help promote energy/carbon reduction initiatives throughout all areas of the Trust. The 'Green Champions' endeavour to help reduce the Trust's carbon footprint through good communication and promotion. The strategy is aimed at encouraging all staff to participate in all aspects of good housekeeping which we consider will make a contribution in driving down the Trust's energy usage and carbon footprint.

The GCCG has focussed its efforts on raising the carbon footprint profile through the use of screen savers and local promotion. The group has also organised a number of external energy and green travel company events to raise the energy reduction profile.

The Trust continues to invest in saving carbon through energy saving investments such as LED lamps, better controls for our building management systems, etc.

The Trust was successful in its bid and was awarded £90,931.20 from the available national energy fund. This has enabled the Trust to install an insulated system to the roof of the building which accommodates our Paediatric and Therapy Services. The projected recurring energy savings have been calculated at £4,143.82 per annum.

We are currently reviewing other buildings such as Hydrotherapy to see if energy performance can be further improved.

In 2013/14 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 2011/12	Actual 2012/13	Target 2013/14	Actual 2013/14	National Target 2015
Gas (Tonnes)	1170	11471	1278	1528	1278
Electricity (Tonnes)	1512	1427	1385	1555	1385
Staff travel (Tonnes)	900	845	900	974	990
NEA (Tonnes)	Not available	Not available	74	Not available	84
Waste - landfill (Tonnes)	138	115	125	109	125
Water (M3)	20424	22314	22000	24691	26391

The local and national target for gas was missed by 250 tonnes; this is due to the opening of the new Admissions and Day Case Unit and the new Decontamination Unit as there are no carbon allowances for new developments on site.

The local and national target for electricity was missed by 170 tonnes; again this is due to the opening of the new Admissions and Day Case Unit and the new Decontamination Unit as there are no carbon

	allowances for new developments on site. The local staff travel target was missed by 74 tonnes however we are still achieving the 2015 national target of 990 tonnes. The figures for non-emergency transport was not available however we have seen a 7% increase on last year's transport activity at the Trust. The 'waste landfill' local and national target was achieved by 14 tonnes, the reported figure relates to compacted waste, the Trust continues to segregate its waste stream and the following figures are now available: Recycled waste: 28 tonnes Cardboard waste: 52 tonnes Skip waste: 39 tonnes Clinical waste: 141 tonnes The local water usage target was missed by 2691 cubic metres. This was due to the Admissions and Day Case Unit opening together with the new Decontamination Unit which is energy hungry. The Trust is achieving the national water usage target of 26391 m3. The 2013/14 figures will be used to set targets for future years. The size of the Trust's estate has increased due to the commissioning the new Admissions and Day Case Unit and the new Decontamination Unit. This has put further pressure on the Trust's ability to meet the national targets. Sustainability reporting in the NHS is mandatory from 2012/13; the NHS Manual for Accounts has been updated to reflect this. The Trust reports on sustainability both nationally and in its Annual Report.
3.0	**Timescale** To work towards achieving the national 2015 targets.
4.0	**Financial Considerations** There has been no published information on any financial penalties for not achieving the 2015 national 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. The insulating of block 37 has realised a recurring benefit of £4,143.82 per annum against the Trust's utility costs.
6.0	**Risk Considerations** Failure to meet the 2015 national target, currently there are no perceived financial penalties.
7.0	**Consultation** The work of the Good Corporate Citizen Group and its 'Green Champions' continues to keep carbon reduction in everybody's minds and promotes/consults with a wide audience across the Trust.
8.0	**Conclusion and Recommendations** The Trust's main focus for 2014/15 must be to reduce its gas and electrical consumption and strive towards meeting the national target of a 10% reduction in carbon by 2015. The Estates and Facilities Department are looking at further building insulating systems in its bid to reduce energy consumption across the site. The Estates and Facilities Department has launched another recycling campaign, this campaign is encouraging staff and visitors to dispose of waste in the appropriate waste bins which are provided. The correct segregation of waste will generate reductions in our compacted waste stream and reduce cost. 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 2014/15 will be discussed and proposed at the next GCCG meeting.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: Friday 23rd May **ENCLOSURE NUMBER: 11**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**Implementing the recommendations of the Francis Report and the government's response, 'Hard Truths'.**

SUMMARY

The following actions have been undertaken by the ROH in response to Francis Report:-

- Short life working groups
- Gap analysis based on the findings of the working groups
- Safe staffing programme commenced November 2013
- Website statement published December 2013
- December 2013 and March 2014 Trust Board summary papers
- March 2014 Trust Board workshop discussion
- NHS England stock take of Safe Staffing completed April 2014

This paper provides a summary of the recommendations specific to the Trust Board and the proposed reporting mechanism, management of risks and lead committee structure.

IMPLICATIONS

Patient safety and experience. Staff satisfaction. Organisational reputation. Financial and Contractual.

RECOMMENDATIONS

Trust Board is asked to:-

- Note the progress to date and proposed next steps
- Be reminded of the Trust Board responsibility for ensuring learning is applied to this organisation thereby providing safe, quality focused patient care in an open culture with trained, competent and compassionate, supported staff
- Provide ideas which will help the Board to fulfil its own requirements to meet the recommendations
- Approve the reporting mechanism, risk management and lead committee structure

Implementing the recommendations of the Francis Report

and the government's response, 'Hard Truths'.

Introduction

This paper outlines the responsibility of the Royal Orthopaedic Hospital NHS Foundation Trust Board as recommended within the Francis Reports into the failings at Mid Staffordshire NHS Trust. The Board are responsible for ensuring learning is applied to this organisation thereby providing safe, quality focused patient care in an open culture with trained, competent and compassionate supported staff.

Francis Recommendations and Trust Board

The details provided below highlight the subject matter and the specific recommendations that are applicable to the duties of Trust Board. The action plans will provide specific details of each recommendation (Appendix One as an example)

In addition, to meet recommendations 253, access to quality profile, and 173/177, principles of openness, transparency and candour/ openness in public, the quarterly report to the Trust Board should be made available on the Trust website as a separate document and located in an area of the site that is easily accessed by the public.

Risk management

A full risk assessment of the agreed recommendations, implementation and timescales of delivery has been developed in draft format, awaiting agreement by the Executive team. The risks will be managed within the appropriate committee with devolved responsibility from the Trust Board; escalation may lead to the risks being incorporated within the corporate risk register and BAF.

Summary of Actions

The Trust Board is asked to discuss and affirm the recommendations, confirm the reporting, escalation, risk management and committee ownership to ensure recommendations are implemented in a timely manner becoming usual organisational business.

recommendation number	Descriptor	Committee leading on work	reporting to board	Lead Director
Implementing the recommendations:				
2:	*Core values shared*	**Workforce and OD**	**Via quarterly workforce report**	**AC**
	Leadership all levels	**Workforce and OD**	**Via quarterly workforce report**	**“**
	System recognises + applies transparency, honesty and candour			
	Cultural barometer/tool to measure health of the system	**Workforce and OD**	**via quarterly workforce report**	**AC**
Fundamental standards of behaviour:				
9	*Code of conduct for NHS Managers*	**Workforce and OD**	**via quarterly workforce report**	**AC**
11	*Staff follow guidance & professional disagreement corrective action taken, led by MD and DoN*	**EMT/CDs**	**Via quarterly workforce report**	**HS/AP/AC/AM**
12	*Incidents patient safety, compliance of fundamental standards insisted upon*	**Clinical Governance Committee**	**Patient Quality report monthly**	**HS /AP**
A Common Culture made real throughout the system:				
13	*Standards divided into* *(1) Fundamental minimum safety and quality* *(2) Enhanced – commissioning* *(3) Development – larger term goals to effectiveness*	**EMT & Board**	**Quarterly**	**HS/AP/AC/AM**
14	Governance system	**CGC**	**Patient Quality report monthly**	**HS**
15	Governance info are comprehensive - Working system - Good effect	**CGC**	**Patient Quality report monthly**	**HS**

Responsibility for, and effectiveness of, healthcare standards :				
28	*Zero tolerance – fundamental standards health, actual harm or continuing risk, criminal liability, regulatory consequences*	**CGC**	**Patient Safety report monthly**	**HS**
37	• *Trust Boards should through Quality Accounts provide full and accurate information of compliance Made available on website, including detail* • *Fair representation – compliant / non compliance* • *Information of how we produce the information* • *Criminal offence to wilfully or recklessly give false statement with safety or essential standards –awareness only; this is awaiting legislation*	**CGC**	**QA goes to Audit Committee as part of Annual Report which is then signed off by Board**	**HS**
3	• CQC mandated return patterns of complaints, how dealt with and outcomes (narrative and data)	**CGC**	**Patient Safety report monthly**	**HS/JS**
44	• *Serious incident or avoidable harm CQC review of provider learning successfully implemented*	**CGC**	**Patient Safety report monthly**	**HS**
48	• *CQC letter, via provider, to each FT governor on appointment inviting to submit concerns to CQC - not yet enacted by CQC*			
Responsibility for, and effectiveness of, regulatory healthcare systems governance – Monitor functions :				
63	• *Improved transparency Monitor to publish side letters plus ratings as part of authorisation or licence*	**Monitor guidance is issued regularly and is reported to CGC and Board as appropriate by Company Secretary and then is implemented or used as guidance. CQC and Monitor have not yet issued guidance on recommendation 84. Code of Governance reviewed in April with recommendations agreed for improvement.**		
74	• *Enhancement of role of Governors. Monitor and CQC 'Governors principles of obligation'*			
79	• *Accountability of provider Directors. Fit and proper test Monitor /*			

	CQC code of conduct compliant • *Regulatory intervention to remove or suspend regardless of significant breach*	**Monitor formal governance reviews should elicit assurance on these matters.**		
84	• *Should Exec / NED be terminated on grounds of unfit and proper, reportable to CQC and Monitor*			
85	• *CQC and Monitor to provide guidance on Recommendation 84*			
86	• *FT's to have adequate programme for training and CPD for directors*			
Responsibility for, and effectiveness of, regulating healthcare systems governance – HSE in healthcare				
88	• Information sharing. SUI consistency of reporting death or serious incidents. SUI to patients or staff – death and serious harm – to HSE	**CGC**	**Patient Quality report monthly**	**HS**
Enhancement of the role of supportive agencies:				
91	• NHSLA – all providers (NHSLA / or not) to comply with risk management standards at least as rigorous as NHSLA	**CGC**	**BAF to Board monthly – workshop June 2014**	**HS/JS**
93	• *NHSLA requirements regarding observing guidance of staffing levels. Trusts evidence based guidance, benchmarks and risk assessments. Consider outcome based standards*	**EMT**	**Safe Staffing monthly report**	**HS**
98	• *NPSA adverse events not amounting to SUI but involving harm to be reported*	**CGC**	**Patient Quality report monthly**	**HS**
Commissioning for standards:				
123	• *GP's role monitoring patient acute provider care* • *GP to keep informed of standards of service provision of providers* • *Partnership patients seriously to be successful commissioners*	**Joint Clinical Commissioning Committee**	**Bi monthly**	**AM/PA/HS**

129	• *Ensuring assessment and enforcement of fundamental standards through contracts. Selecting indicators the focus should be on safeguarding patients to ensure expectations and concerns are addressed*	**Joint Clinical Commissioning Committee**	**Bi monthly**	**AM/PA/HS**
130	• *Commissioners, not providers, should decide what want to be provided and be willing to receive proposals from providers*	**ROH will respond as necessary and these matters will be discussed at commissioning meetings as appropriate.**		
131	• *Development of alternative sources of provision e.g. consortia*			
132	• *Monitoring tools by the Commissioner of the provider e.g. quality visits of fundamental and enhanced standards*			
133	• *Commissioner role in complaints – to intervene for individual patients*			
137	• *Intervention and sanctions for substandard or unsafe services*			
138	• *Commissioners have contingency plans to protect patients from harm where found service unsafe or substandard*			
Performance management and strategic oversight:				
139 - 144	• *Put patients first at all times*	**EMT/CGC/Board**	**multiple report sources**	**JC**
Patient, public and local scrutiny:				
145	• *Role of local Healthwatch*	**For response as necessary. Processes in place for complaints via MPs and preparedness for inspections.**		
150	• *Power to inspect providers*			
151	• *Complaints to MP's*			
Leadership				

214-221	• *Senior board level national and regional* • *Codes of conduct and ethics* *Accreditation*	**For response as issued**		
Information:				
249	• *Quality Account signed by all Directors – true account*	**CGC**	**Via Annual Report to Board – only CEO and Chair sign**	
250	• *Criminal offence to sign Quality Account if untrue or misstatement – awaiting decision/ legislation*			
Coroners and inquests:				
273-285	• D/W Trust Solicitors, NHSLA and Frances Kirkham	**Round table meeting needed and already discussed HS/FK**		
Department of Health Leadership				
266-290	**Not yet agreed but may require response from ROH.**	**Awaited**		

APPENDIX ONE – Trust Board. May2014

DRAFT Exec Team Action Plan - Francis Recommendation- Nursing

Executive Lead

Responsible for aligning projects/business plans/etc. to appropriate recommendation.

Responsible for updating/reviewing/delivery of recommendation within action plan folder.

Key - Level of Assurance	Colour
Completed	
No delays, expect to complete on time	
Slight delays, complete on time	
Slight delays, delayed completion	
Significant delays, delayed completion	
Activity not yet commenced	

Subject & Recommendation Number	Exec Lead	Op Lead	Current Position	Development Activities	Review Date	Timeline for delivery	Level
185 Culture of caring	HS		Mandatory training Competencies PDR Performance management KPI of services L&D support 6C launch & competition Recognition of achievement Feedback on performance Reporting culture	Continue to strengthen current activities Nurse leadership model Review competencies Review PDR of senior nurses L& D strategy linked		October 2014	
188 Aptitude test for compassion and caring	HS		Interview Incident follow up Patient Harm meetings	Values based recruitment -DWFOD Ward Values Welcome to Trust- DoN Staff nominations by patients		October 2014	
191Recruitment for values and commitment	HS		Senior Nurses Values agreed ROH draft values developed	ROH Values and standards - DWFOD Values based recruitment - DWFOD Ward Values		September 2014	
192 Strong Nursing voice - recommendation specific to national voice	HS		Nurses Forum DoN Patient Quality Report to EMT & Board 6C's@ROH programme	Nurse leadership development L&D TNA for Band 7 and above L&D		November 2014	

194 Annual learning portfolio, up to date nursing practice	HS		PDR &Portfolio	Standard portfolio – L&D Support to complete Launch		March 2015	
196 KSF linked to commitment, dignity and respect, leadership skills	HS			Review KSF with HR		March 2015	
197 Leadership training at every level	HS		Draft L&D strategy	TNA Band 7 and above Leadership training matrix		March 2015	
198 Cultural **Health** of front line staff	HS		MSB work	Explore cultural barometer		TBC	
199 Key Nurses for the shift	HS		Acuity pilot November 2013	Implement from 1st April 2014		May 2014	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD
ON
WEDNESDAY 30 JULY 2014,
8.30AM IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
07/14/91	**Apologies & Welcomes**	Dame Yve Buckland Rod Anthony	To Note	
07/14/92	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
07/14/93	**Patient Case – an illustration of the work we do** Director of Nursing and Governance			
07/14/94	**Minutes of Public Board Meeting held on the 23rd May 2014** Chairman		For Approval	Enc. 1
07/14/95	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
07/14/96	**Chairman & NED update** Chairman & NEDs		For Information	Enc. 3
07/14/97	**Chief Executive's Report** **-Including update on CQC visit** Chief Executive Officer		For Information and Assurance	Enc. 4
07/14/98	**Medical Director's Update** Medical Director		For Information and Assurance	Enc. 5
	Performance Management / Assurance Reports			
07/14/99	**Corporate Performance Report** Director of Finance		For Assurance	Enc. 6
07/14/100	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 7
07/14/101	**Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 8
07/14/102	**Board Assurance Framework** Director of Nursing & Governance		For Assurance	Enc. 9

07/14/103	**Quarterly Workforce Report** Director of Workforce and OD		For Assurance	Enc.10
07/14/104	**Quarter 1 Declaration – April to June 2014** Chief Executive		For Approval	Enc.11
07/14/105	**Revalidation Annual Report** Medical Director		For Approval	Enc.12
07/14/106	**Audit Committee Annual Report** Director of Finance		For Approval	Enc.13
	Strategy			
07/14/107	**Update on Five Year Strategic Plan** Chief Executive		For Information	Enc.14
07/14/108	**Constitution** Company Secretary		For Approval	Enc.15
	Board Committees			
07/14/109	**Audit Committee**		For Assurance	Enc.16
07/14/110	**Clinical Governance Committee** - to provide assurance on Adult safeguarding Annual Report		For Assurance	Enc.17 – **to follow**
07/14/111	**Remuneration Committee**		For information	Verbal
07/14/112	**Charitable Funds Committee**		For Assurance	Verbal
07/14/113	**Council of Governors**		For Information	Verbal
07/14/114	**Any Other Business**			
	Date of Next Meeting: Wednesday 24 September 2014 at 8.30am			

Confidential Matters

To resolve:

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

Enclosure 1

Minutes of the Trust Board Meeting held in public on Friday 23rd May 2014 in the Boardroom

Present:

Trust Board

Dame Yve Buckland (Chair)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director
Mr Mike Flaxman, Interim Non-Executive Director
Mr Tim Pile,Non-Executive Director

In attendance:

Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mrs Lisa Kealey, Public and Patient Services Manager (Agenda item 05/14/85 only)

Mr Andy Clark, Stakeholder Governor (University of Birmingham)
Ms Karen Hughes, Staff Governor
Ms Marion Thompson. Stakeholder Governor (BCU)
Ms Dia Martin, Governor
Mr Alan Last, Governor
Mrs Yvonne Scott, Governor
Mrs Stella Noon, Governor
Mr Rob Talboys, Governor
Ms Jean Rookes, Governor

Mr Julian Denney, (Preparing Board Minutes)

Apologies:

Ms Joy Street Company Secretary
Mr Roger Tillman, Deputy Medical Director
Ms Sue Arnott, Governor
Mr Paul Sabapathy, Governor
Mr Ronan Treacy, Staff Governor
Mrs Marion Betteridge, Governor

Agenda No.	Agenda Item	ACTION
05/14/72	**Apologies and welcomes** The Board welcomed Dame Yve Buckland in her first meeting as Chair. She introduced herself and thanked all Board members, Governors and staff for their contribution and in particular Tim Pile for acting as interim Chair and Mike Flaxman for acting as Chair of Audit . Apologies were received from Joy Street, Company Secretary, Roger Tillman, Deputy Medical Director and Sue Arnott, Governor, Paul Sabapathy, Governor, Mr Ronan Treacy, Staff Governor, Mrs Marion Betteridge, Governor	
05/14/73	**Declarations of Interest** No Declarations of Interest other than those registered previously.	
05/14/74	**Patient Case – an illustration of the work we do** This was presented by Anita Killingworth, Advanced Nurse Practioner, covering a very complex case which had been in general handled very well by the Trust and with important wider learning for example in relation to the handling of patient data regarding medication/ pain control with the potential for a greater use of IT.	
05/14/75	**Minutes of the Trust Board meeting held on 30th April 2014** In relation to page 9 (04/14/62) the Chair asked the CEO to ensure that the statement of compliance was independently reviewed given that Board members had queried a number of the areas of stated compliance at the previous Board and also that the Governors felt that the statement did not accurately reflect their experience; the CEO agreed to ensure this was discussed further. Regarding Page 10 (04/14/64) it was agreed that the words 'for weekends' should be removed and the investment figure should have been £230k not £300k. **Resolved:** With the above changes, the minutes were approved as a true record	**JC**
05/14/76	**Trust Board Action Points** The action notes were updated (see separate sheet). Regarding the compliance with annual leave policy – it was	

	agreed that there was a need to define more clearly what an appropriate exception is and to provide greater assurance that the learning from conferences and other absences is embedded within the organisation.	**AC**
05/14/77	**<u>Chairman and NEDs' update</u>** . The Chair made the following points : • She had been invited to the meeting of the Birmingham Heath Economy Chairs – it was agreed they would find a focus for every Chair to work on e.g. Health promotion •She had met a group of former staff and the ROHBOTs fundraising group and had been highly impressed by the enthusiasm and commitment of both groups •She had also attended a ROH nurses event at which a lot of suggestions for improvement made •She had reflected on her initial experiences of working with the Board and considered that it would beneficial to alternate development meetings and traditional formal Board meetings.	
05/14/78	**<u>Chief Executive's Report</u>** Jo Chambers introduced her report and made a number of supplementary points as follows and the Chair invited Board comment: **Monitor Feedback** - There had been feedback from Monitor that in general Trusts have been over optimistic in the Annual Plan submissions made particularly concerning their five year position. She had discussed a number of risks from Monitor's perspective including the stabilisation of the Board, engagement of staff, and the achievement of the CIP programme. The Trust specific letter from Monitor to ROH had not yet been received but informal feedback indicated that they had no specific areas of concern and the Trust was expected to remain in a low risk category **Commissioning** - There has been a tightening of service specifications in relation to specialist services. The Trust is now increasingly involved in helping inform commissioners' plans which should enable it to better predict how it may need to adapt its services in response to commissioners' evolving intentions. The financial challenge faced by commissioners is expected to be a major feature in the effort to change services for the future.	

	2015 Challenge Declaration - There is an opportunity for the Trust to become a co signatory to a letter covering seven key challenges for the NHS being sponsored by the NHS Confederation. It was felt that more time was needed to consider the report before deciding whether the Trust should become a signatory. The CEO will circulate the document for Board members to read as the weblink did not appear to be working properly. ***Board Comment*** - in general, the Specialist Orthopaedic Alliance was the most appropriate forum for wider presentation of the Trust's views, and care must be taken to avoid spreading limited resources too thinly **ROH Strategy** – this work is being progressed and its various components will be synthesized in due course **Academic Health Science Network (AHSN)** – She has now taken her seat on the AHSN Board and will take lead responsibility for the Central Spoke (Birmingham and Black Country) **Future directions for the NHS** - She has attended a dinner where the keynote speaker was Andy Burnham This is a part of a process to help the Trust to understand emerging polices from all political parties **Communications** - an expert has been engaged to support the Trust which will particularly valuable as the strategy is developed **NHS Partners** - She has met the CEO of Sandwell and West Birmingham Hospitals NHS Trust and, jointly with the Chair, the Chair and CEO of University Hospitals Birmingham NHS Foundation Trust; both organisations are key strategic partners of the ROH. There had been constructive discussions with each. **Medical Staff Committee** - She has had further discussions with the MSC and is developing deeper and more informal relationships with them. The CEO reported that the leadership of the MSC were keen for members of MSC to have the opportunity to meet with the Board. ***Board Comment*** -One opportunity to deepen the dialogue with the MSC could be via a lunch at a development meeting of the Board. It was important that ways to engage other staff groups	**JC**

	were also considered so that they could be made aware of the Board's thinking and strategy. This could be done in a variety of ways e.g. visits to theatre by Board members. **Executive Management Team** - Paul Athey reported that a key issue discussed was the IM&T strategy which will be brought back to the Board in June. Also considered was the OBC for the e-prescribing system which was approved to move forward to the specification and procurement stage of the project plan. **Resolved:** That the Chief Executive's Report be noted **External Governance Reviews –** The CEO had attended an event organised by Monitor to provide feedback on the pilot Trust's experience of the new external governance reviews that all foundation trusts would be required to undertake every three years. In discussion with the Chair, it had been agreed that as the Board has a number of new members including the Chair and CEO, it would be beneficial to commission a review now to establish a baseline and also support the organisational and board development plans. The guidance, published in the last couple of days would be circulated to Board members for information.	**JC/YB** **JC**
05/14/79	**<u>Medical Director's Update</u>** Andrew Pearson gave an update making the following key points: **CQC Inspection** - He had been invited to participate as an observer in a CQC inspection at the Royal National Orthopaedic Hospital NHS Trust. The inspection process is still evolving and there are still challenges in recruiting inspectors. The process focuses on five qualities and seeks to triangulate what has been declared in the pre inspection pack, what is available in the public domain and what is found in the inspection. There is a focus on theatres and theatre equipment, drugs, WHO checklist, record keeping, infection control and leadership. One of the ways leadership is considered is by assessing junior staff awareness of the organisation's strategy and their ability to handle critical incidents. The Chair invited a discussion as follows :	

	• The ROH is well prepared to host its own inspection which will start on Tuesday 3rd June with an offsite meeting and a listening event in the evening followed by onsite visits on Wednesday and Thursday the 4th and 5th of June •It would be worth providing a briefing regarding the ROH strategy to help prepare staff •Governors are welcome to come to the listening event in a capacity as patients or carers •CQC are taking a more sophisticated and nuanced approach to inspections, forming a view from a variety of sources. • The CQC lead inspector will speak to a number of Board members in advance of the inspection. It was agreed that both the Chair and Tim Pile will speak to CQC prior to their visit	**ALL** **YB/TP**
05/14/80	**<u>Corporate Performance report</u>** Paul Athey introduced his report and highlighted the following points: •All three 18 week treatment targets have now been achieved •ROH has overachieved in planned activity overall •There was a deficit in April of £189K associated with the low activity plan and case mix; this is typical at this position in the year •There has been a good early start for CIPs •Workforce has improved to an amber rating The Chair invited a discussion as follows : •Regarding theatres and anaesthetics CIPs it is planned to allocate CIPs linked to implant savings to directorates and consider innovative approaches to procurement to mitigate the risk of underperformance which has been experienced in the past. In addition work is being done to improve theatre utilisation and to drive harder non pay savings. The question of whether the CIP targets were too high was discussed , but overall the Board felt that they should be kept at their current level • R&D should be considered as having the potential for CIPs across the full extent of its budget •The Governors reminded the Board that it had been agreed that more information would be provided to the public regarding the use of car parking charges and requested that more information be provided regarding Café Royale and WRVS profits •Locum workforce costs will be reviewed at a further meeting **Resolved:**	**PA**

	That the Corporate Performance report be noted including the need for further scrutiny around the Cost Improvement Programme	
05/14/81	**<u>The Patient Quality Report</u>** Helen Shoker introduced her report and highlighted the following : •Conversations are continuing with Directorate teams regarding incident reporting , the use of the risk register, mitigating actions and any need to escalate to Executive Director or Corporate level •There has improvement nationally in incident levels reported; this explains an apparent relative decline in ROH performance. Work is being done to improve incident reporting at ROH. •A survey of staff members is being done regarding their understanding of incident reporting •'Days between harm' is now being included as a quality measure •So far this year there have been no patients with Grade 3 or 4 pressure ulcers which is a major achievement and a very positive step forward •ROH is on track to achieve regarding the WHO checklists measure •Charitable funds have agreed to purchase additional High Low beds to help prevent falls The Chair invited a discussion as follows : • WHO checklists are now considered to be based on robust data with previous concerns having been rectified •The majority of falls happen in Ward 3 which handles the most complex cases – the team are focusing on improvements including better planning and staff training • Areas of concern included care of patients with dementia or multiple comorbidities, and medical cover at the weekends The Chair said that in summary good progress had been made with some areas for further focus as noted above **Resolved:** That the Patient Quality report be noted	
05/14/82	**<u>Safe Staffing</u>** Helen Shoker introduced her report highlighting a number of issues including : •The work done on safe staffing risk assessment and the escalation process	

	•The use of incident reporting •The action plan that is now in place and is being implemented •The very effective fill rate for bank and agency staff when required - while acknowledging that the use of agency staff should be minimised •The intention that Safe Staffing be reported monthly to the Board The Chair said that good progress had been made but that the use of agency and bank staff needed to be kept under review **Resolved:** That the Safe Staffing report be noted	
05/14/83	**<u>Board Assurance Framework (BAF)</u>** Helen Shoker presented the BAF and the Chair invited a discussion as follows: **General Risks** • Regarding the Medical Records Scanning project it has now been agreed with the CD that some further Spinal medical records no longer required will be destroyed. All medical records will be located within the new medical records library by October 14 to enable demolition of wards 5 and 7 to take place in Q4. •The Clinical Director for Spinal has spent a great detail of his own time manually retrieving necessary data to ensure the outcomes CQIN was achieved following issues corruption of the Spinal database. The Board acknowledged his work with thanks •The RTT targets overall have been achieved with some concerns remaining around spinal deformity RTT which will be disaggregated as a risk on its own in future **Housekeeping and Cultural Issues** •There is a lot of work being carried out in theatres minimising the risks to contamination of equipment this is likely to be focus for CQC •There have been are also incidents involving staff leaving theatres in gowns •The Governors have identified some risks associated with the storage of linen on corridors •There have been a number of key staff and management changes which create the potential for improvement and a development programme is being created including the possible implementation of "Productive Theatre" •The Chair said this was a key issue to be taken off line with the right mixture of staff ownership , training and sanctions	**Executive Team** **YB/JC**

	being applied and urged all Directors and Governors to challenge everything they see that is not right **Strategic Risks** •An area for development of the BAF is to consider risks from the perspective of the Trust's ability to realise its strategic intent •This could be developed in a Board workshop which could also consider early warning signs regarding major or new risks **Resolved:** That the Board Assurance Framework be noted with a further review covering the strategic picture in June	
05/14/84	**<u>Annual Report and Accounts – including self certifications</u>** Paul Athey gave a presentation on the Annual Report and Accounts which had previously been scrutinised by the Audit Committee with no major areas of concern. The independent auditor's report confirmed that the accounts gave a true and fair view of the Trust affairs, and that there were no matters on which the auditors were required to report with regards to securing economy, efficiency and effectiveness in the Trust's use of resources. **Resolved:** •That the Board ratify the recommendation by the Audit Committee to approve the Annual Report and Accounts •That the Board authorise the CEO and Chair to sign Certifications G6 and CoS7 referring to "Systems for compliance with license conditions" and "Continuity of services condition 7 – Availability of Resources" respectively	
05/14/85	**<u>National Inpatient Survey</u>** The paper was summarised by Lisa Kealey. focusing on the evaluation of last year's action plan. In summary: • The Trust continues to perform strongly when compared to other organisations • The Trust is in the top 20% of best performing trusts in 5 out of 9 sections, compared with 7 out of 9 sections last year. • The section relating to operations and procedures has dropped into the middle 60% of trusts. • The Trust has further improved in 5 out of 9 sections overall from last year, (improvement in 7 out of 9 sections last year).	

	Key points raised in discussion: • It was noted that the Trust was working to learn more from the best performers •All items on the action plan are in hand • Board members would find more trend information helpful for the most significant categories Board members were interested to know why the Trust had dropped out of the top 20% of trusts for 2 areas and it was agreed that this would be reviewed and members advised. **The Chair's summing up:** •It would be helpful to identify what was needed to achieve all of the actions in the current year action plan and how long this would take •There is some more work to be done in terms of linking the this work to wider activities in the Trust for example in relation to Clinical Governance **Resolved:** That the Board note the results of the 2013 national inpatient survey	**LK**
05/14/86	**<u>Carbon Reduction Strategy</u>** Amanda Markall, presented the Carbon Reduction Strategy and detailed the progress being made notwithstanding the age of the estate Points made in discussion : • As a large user of energy the ROH should be a position to obtain support from utility providers to become more efficient e.g. around automatic systems to improve energy and water utilisation •Business cases for new assets need to reflect sustainability e.g. based on the building research sustainability criteria. •ROH should seek to learn from best practice elsewhere **Resolved:** That the Board note the Carbon Reduction Strategy bearing in mind the comments made above	
05/14/87	**<u>Francis Inquiry Update</u>** Helen Shoker presented the update and highlighted the importance of integrating this work within existing reporting	

	mechanisms, risk management processes and lead committee structures so as to embed the recommendations and to provide a clear audit trail regarding what is being done **Key points raised in discussion:** The core values for the organisation have been shared with staff and have been well received by them. This presents a potential issue in that previously the Board had agreed to review and approve the values in advance. The Board's view was that the next step would be for it and the Executive to reflect on whether any further evolution of the values was required. **Resolved:** That the Board : • Note the progress to date and proposed next steps • Agree to review whether further work is required regarding values as part of the Board development day • Confirm that Tim Pile is the Director for whistle blowing • Approve the proposed reporting mechanism, risk management and lead committee structure so as to embed the Francis recommendations with ROH core work and to provide a clear audit trail regarding what is being done	
05/14/88	**<u>Clinical Governance Committee</u>** Tauny Southwood highlighted a number of issues raised by the CGC including: •Leadership - e.g. high turnover of clinical audit committee chairs and over reliance on single individuals • Concerns regarding the accuracy of some data and its interpretation and use across the organisation • The need to establish the baseline of the issues The Chair requested an action plan to address these issues and the CEO commented that this should be covered as part of the governance and strategy review **Resolved:** That the Board :	**TS/ HS/AP**

	•Note the assurances provided by the CGC meeting subject to the action above	
05/14/89	**<u>Charitable Funds committee</u>** Frances Kirkham presented the report of the Committee and made the following comments : • The figure for the purchase of 10 High-Low beds in the report was an error – it should have been £36k not £336k • FK encouraged all to put forward ideas for consideration for funding – there were significant funds available which needed to be spent **Resolved:** That the Board : •Note the Charitable Funds Committee Report with the above amendment and endorsed the request for further bids	
05/14/90	**<u>Any Other Business</u>** Regarding the Volunteers' Summertime 'Pop-in' on Thursday 31st July 2014 Café Royale, 2.30 -3.30pm – the Chair encouraged Board members and Governors to attend The Chair thanked Mike Flaxman for his support to the Board as an interim NED	
<u>Date and Time of Next Trust Board Meeting</u> Wednesday 25th June 2014 at 8.30am in the Board Room.In addition there will be an informal meeting of the Board on Monday 9th June between 8-12 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

Enclosure 2

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 23rd May 2014

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
03/14/44 Corporate Performance Report (26.03.14)	FK asked that a report on paediatrics be given to a future meeting.	AM	End of June 2014		To be handled as part of Strategy Development
04/14/58	Data from patients on satisfaction with food should be disaggregated to see if satisfaction levels among oncology patients are as high as others	JS	End of May 2014		The team has been asked to disaggregate information from both Friends and Family and real time survey data. As these are held on paper-based systems the information is not yet ready, but may be for verbal update at the board.
05/14/75	Ensure that the statement of compliance is independently reviewed given that Board members have queried a number of the areas of stated compliance at the previous Board and also that the Governors have felt that the statement did not accurately reflect their experience	JC	End of June 2014	√	An independent review has been undertaken and advice is being sought.
05/14/76	Regarding the compliance with annual leave policy – it was agreed that there was a need to define more clearly what an appropriate exception is and to provide greater assurance that the	AC	End of June 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	learning from conferences and other absences is embedded within the organization.				
05/14/78	Regarding the opportunity for the Trust to become a co signatory to a letter covering seven key challenges for the NHS, the CEO will circulate the document for Board members to read as the weblink did not appear to be working properly.	JC	End May 2014		
05/14/78	Commission an external governance review to establish a baseline and also support the organisational and board development plans. Circulate guidance, to Board members for information.	JC/YB JC	End of June 2014 End of May 2014	√ √	Governance review commissioned. Circulated guidance discussed at Board Workshop in June 2014.
05/14/79	Provide staff with a briefing prior to the CQC Inspection. Speak to CQC in advance of their visit	ALL YB/TP	Before June 3rd 2014		
05/14/80	Provide more information to the public regarding the use of car parking charges and Café Royale and WRVS profits	PA	End of June 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
05/14/83	Consider approach to deal with cultural and housekeeping issues covering theatre equipment linen etc.	Executive Team	Review in July as part of post CQC visit debrief / part of strategy and values work		
05/14/83 **05/14/87**	Consider risks from the perspective of the Trust's ability to realise its strategic intent as part of a Board development workshop Review whether further work is required regarding values as part of the Board development day	YB/JC	End of June	√	Strategic risks identified in 5 year strategic plan.
05/14/85	Regarding the National Inpatient Survey, Board members were interested to know why the Trust had dropped out of the top 20% of trusts for 2 areas and it was agreed that this would be reviewed and members advised.	LK	End of June		
05/14/88	Create Action Plan to address issues identified by the CGC	TS/AP/HS	End of July		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: **30 July 2014** **ENCLOSURE NUMBER: 3**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Yve Buckland , Chair**
SUBJECT:	**Chair's Update**

SUMMARY

To provide an update to the Board from the Chair on her key activities since the last Board

IMPLICATIONS e.g. financial, operational, risk, etc

Developing a better understanding of operations within the Trust, observing patient safety issues from first hand conversations with staff and patients, updating the Board on any key external issues

RECOMMENDATIONS

That the Board note this report

During the last month there have been a number of matters in which I have been active and which are relevant to report to the Board.

1 External Relationships

1.1 Birmingham Women's Hospital

I have been liaising with the Chair of Birmingham Women's Hospital, on some areas of mutual interest. She is promoting an idea with the Nuffield Trust about a piece of collaborative work which is about demonstrating the added value of smaller, specialised provider Trusts and would like the ROH to be included. I think that this could be of benefit to us and have suggested that the CEO would be the right person to engage more fully in these discussions. We would also need to ensure that we were not cutting across any similar work by the Specialist Orthopaedic Alliance. I believe that Robert Jones and Agnes Hunt will also be involved.

Birmingham Women's Hospital has also been generous in providing us with information about their approaches to Governor Involvement and NED appraisals.

1.2 CQC Inspections

On the 8 July I attended a training event in London on the new style CQC inspections which focussed on how to plan for and respond to the outcome of Inspections.

The event used the experience of Trusts who had been inspected and some of the learning that had flowed from inspections. I came away with a much better understanding of the likely follow up in process terms from our inspection and in particular the importance of the Quality Summit that we will need to hold with key stakeholders when our report is published. The timing of this is still to be determined but I would like some of our NEDS to be present at the Summit if possible.

I was particularly impressed by a presentation from the Director of Governance of Salford NHS Trust which has an "outstanding" rating following recent inspections. The underlying messages from Salford had been how they had developed a culture of Quality Improvement and Engagement which reinforces the approaches we have set out in our own strategy. I would like to invite them to come and talk to us about their strategic journey on one of our development days.

2 Governors

2.1 Meeting with the Governors

On Thursday 3 June the Governors met to approve the Constitution which is here on the agenda today. At the meeting we continued the discussions with the Governors on how we might better support them to undertake their duties

and how we can develop better systems of reporting and accountability. There is a role for the Governors in holding NEDS to account and I would like to ensure an improved approach to this both through the attendance of NEDS at meetings with the Governors to report on their particular areas and through the appraisal process. I will bring forward proposals to discuss this with the Board in due course. Governor elections will be in September and our AGM will be on the 24 September.

2.2 Personal Objectives

I will be setting my objectives with the lead governor in September and will share these with the Board

3 Internal

3.1 Medical Staff Committee

On Friday 27 June I accompanied the CEO to a meeting with MSC .This was my first formal introduction to MSC although I have meet individual consultants in a variety of settings. The discussion went well and I have had good feedback that the Consultant Body feel positive about the management and leadership of the Trust and wish to engage and collaborate with the Strategy and new developments. There was however an issue raised about the need for clear lines of formal communication between the Board and MSC which has been the subject of previous correspondence. The CEO and the Chairman of MSC have agreed a way forward and there are plans to invite MSC to an informal session with the Board in September.

3.2 Visit to Theatres

I have had a good opportunity to spend time in theatres meeting theatre staff and spent a morning observing a consultant and his team performing operations in theatre. I found theatre staff to be highly motivated, very positive and well managed. I learned much more about the scheduling of patients through theatre and theatre productivity; the logistics of and problems that can occur in the supply of theatre equipment to perform operations; and got a better understanding of the impact on all staff of the theatre list particularly when it runs over. I saw at first hand the use of the WHO checklist and other good patient safety procedures. My presence in theatre had been cleared with all those patients whose procedures I observed. There is an obvious and ongoing issue about the problems with the flow of patients between theatre and ADCU which is having an impact on the patients and which needs to be resolved .On the day I visited this problem had resulted in a reported incident. This issue is being looked into by the Director of Operations. I have also met the new leadership team at HDU who are tackling some important issues there which were highlighted during the CQC visit.

3.3 Patient Feedback

My walks around the hospital have been helpful and illuminating and I continue to try and ensure I meet and speak with patients when I am in the Trust. Staff have been open and welcoming and I have enjoyed meeting many people who work for the Trust and who volunteer. A number of staff have shared with me that they appreciate visits from Board members and the opportunity to talk to them … not just when we have CQC visits or when there are problems.

The overwhelming feedback from patients has been very positive, particularly about their surgery, good and kind nurses and effective pain management. But some have shared with me their thoughts on areas where their experience has been less positive. I have shared this feedback with the Director of Operations who has followed it up but we are giving some thought to how we can capture my feedback in a more helpful way.

A number of staff and governors have also aired their concerns about the administration of appointments and customer interface difficulties. This is a problem which I believe we need to address quickly and collaboratively with all of those involved.

3.4 Next Steps

I am giving some thought about how better to structure and make more systematic my feedback from my walkabouts to achieve the right balance between getting an informal feel for what's happening in and around the hospital on a daily basis, being visible and reporting issues where necessary. I have also asked our Director of Nursing to establish from September a rota for NEDS to undertake ward visits periodically as we discussed at our last meeting.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 July 2014 **ENCLOSURE NUMBER: 4**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Chief Executive's Report**

SUMMARY

This report provides an update to Board members of key issues and activities since the last meeting.

IMPLICATIONS

To ensure Board members are aware of the context and policy framework in which the Trust is operating, and to highlight matters of interest.

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update the Board on national and local issues.
Recommendation	The Board is asked to note the contents of the report and discuss items as appropriate.

This report provides Board members with an overview of key issues in relation to the Trust.

1 Care Quality Commission Inspection – Pilot for new regime

The Care Quality Commission has re-visited the Trust to conclude the 'unannounced' component of its inspection under the pilot arrangements for the new regime. No feedback was provided to the Trust on this occasion and a draft report is expected to be received in the near future. A number of people were interviewed by were the inspectors and they were particularly keen to review improvements that we have made to the High-Dependency Unit equipment and weekend medical review of patients.

I am in close communication with the Royal National Orthopaedic Hospital NHS Trust, being the other pilot site for specialist orthopaedic inspections, with the aim of mutual benefit and learning from the process, the new approach and our responses to the inspection.

2 Strategy Development

The refreshed strategy and 5-year strategic plan was submitted to Monitor on 30 June 2014. A separate agenda item provides a detailed update on progress towards implementation.

3 Staff Engagement Activities

My CEO 'drop-in' sessions have been expanded to include sessions in theatres to make it easier for staff working in that environment to have direct access. I have also undertaken a briefing session on the strategy in 'recovery' and will continue to improve visibility in these areas of the hospital.

The new communication system and products are now in place and will develop over time. I am now writing a short 'journal' item once per month (or more as required), there is a bi-monthly newsletter ROH Life which has just had its first edition, and the team brief cascade system has run for two months. We are actively seeking feedback and monitoring attendance so that we can find any gaps or areas of the Trust where the cascade is not working well.

Additionally, staff briefings were undertaken to share the development of the strategy and the final plan was presented to staff at 'Question Time' at June's TBALD.

All material is either emailed to key briefers, or is available on the intranet.

It is intended that by strengthening and embedding these systems it will complement the broader engagement agenda that will be developed as part of implementing the strategic transformation initiatives.

4 ROH Charity

I have met with the in-coming Chairman of the Trustees of the ROH Charity, the separate organisation that raised significant funds to develop the Research and Teaching Centre some years ago and handed over ownership to the ROH. I have been invited to attend the next Trustees meeting on 29 July. The charity has funds available and is keen to work with the Trust to fundraise for another significant project. I intend to follow this opportunity up and am in discussion with a number of clinicians about the potential for us to strengthen our research capabilities in line with the Trust's strategic initiative.

5 Other External and Partnership Engagement

- I have had an introductory meeting with Stephen McCabe MP, who is keen to establish a regular opportunity to meet.

- I met with the Bourneville Village Trust Chief Executive in relation to the development of our interest in providing services from the new development on Bristol Road, which would see the ROH provide some services from a health centre situated on the housing campus. We are developing a business case with various options and see this as an important opportunity to extend our range of services particularly in relation to musculoskeletal health, well-being and prevention services, to support CCGs to better meet the needs of patients.

- I have met with the CEO of Birmingham Children's Hospital (BCH) in a routine partnership meeting. Our two trusts work in partnership in a number of different ways and this is a very important strategic alliance for the ROH. We enjoy a positive relationship and further discussions will be taking place to explore the opportunities for longer-term collaboration. There are some short-term challenges in relation to access to theatres at BCH and options are under consideration to address this as part of BCH's redevelopment plans; I will be observing a theatre session at BCH, used by our consultants, to better appreciate some of the current constraints and to help inform options going forward, which may involve joint investment.

- The Chief Officers 'Unit of Planning' meeting is due to take place on 24 July to progress longer-term system wide strategic considerations.

6 Executive Management Team – June and July 2014

6.1 18 June 2014

Key points to note:

- The strategy was discussed and risks considered.
- The consultation on the Trust's proposed new values was discussed.
- Corporate performance report and patient safety report were reviewed, with particular discussion on the need for directorate teams to manage the risk register more effectively and use incident reporting more consistently.
- Updates were received from Estates Programme Board, Clinical Programme Board and the IM&T Programme Board.
- The ROH/ Bourneville Village Trust Well-Being Centre business case was approved.
- EMT reviewed an initial scoping exercise against the seven day working 10 clinical standards put out by the NHS England Board. Further work will be required to assess the requirements specifically for an elective hospital without an A & E, however, the safety standards are of paramount importance for all patients in our care. Clinical Directors and the Clinical Programme Board were asked to review the standards further.
- EMT approved a business case to store 'archived' medical records off site and a procurement process will be initiated.
- EMT approved a business case to set up a direct access ultrasound service in line with requests from Birmingham Cross City CCG.
- EMT risks – noted decreasing risk in relation to spinal database and CQC outcome 4 (care and welfare of service users). New risks were added to the Board Assurance Framework:
    - 621 – Delays in MRI imaging and reporting
    - 636 – PAS system contract expires in 2016 – successor arrangements
    - 7 - Long waiting times for spinal deformity (re-opened)

  All other risks considered to be managed appropriately.
- An updated Email Policy was approved subject to a minor amendment.
- A new policy for the early detection, management and control of PE was ratified subject to two amendments.
- The interim policy on the Management and Transfer of Level 3 Patients which had been approved using 'Chair's action' was ratified.

6.2 23 July 2014

A verbal update will be provided at the meeting.

7 Recommendation

The Board is asked to note the contents of this report and discuss as appropriate.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 July 2014 **ENCLOSURE NUMBER: 5**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Andrew Pearson** **Medical Director**
SUBJECT:	**Medical Director Board Report July 2014**

SUMMARY eg. what you want the Board to consider/make decision on

Concerns:

1. Outcomes & Evidence
2. Infection Rates
3. Appraisal and Revalidation Process
4. Caldicott Guardian Issues

IMPLICATIONS eg. financial, operational, risk, etc

The risks of not addressing the raised concerns are a combination of financial and reputational

RECOMMENDATIONS

I ask the Board to accept this report noting my concerns and continue supporting the Medical Director in his role and in particular in addressing the raised concerns.

Activities

1. King's Fund Senior Clinical Leaders

In June I completed module 3 of this residential course with one final module to complete in September. Once again this was a very valuable 3 days constituting a mixture of lectures, problem solving and small group learning. Already I am finding the skills I am learning on this course are translating into the day to day work I do as Medical Director.

2. Standards

I have been working on a set of clinical standards that I believe are both desirable and necessary for the Royal Orthopaedic Hospital to adopt. I have already shared these with the Executive and at the Clinical Directors meeting. I have attached these standards to this paper for you to see and I welcome your comments (Appendix 1).

Concerns

1. **Outcomes**
2. **Infection Rates**
3. **Appraisal & Revalidation process**
4. **Caldicott Guardian – Personal Databases**

1. Outcomes

We have for some time had difficulty evidencing the quality of what we do at the ROH. This has been a problem that many clinicians have raised in different forums on many occasions. It was evident when the Patient Reported Outcome Measure (PROMS) information was first sent the us. It was clear that although surgeons had been providing their individual patient outcome data to the organisation, the first they knew of outlier status for the PROMS was when informed by an external organisation.

The problem 'came to a head' when during the recent CQC inspection when challenged to evidence the claims on quality the ROH was making, we were unable to achieve this without a surgeon coming out of theatre and opening his personal laptop to show the CQC his own database.

Solutions

It is clearly an entirely unsatisfactory situation that as a leading orthopaedic hospital that we are unable to properly evidence the quality of the surgical and medical care we provide. This will impact on our CQC rating and may well impact on our ability to be commissioned locally and nationally.

The Trust is currently looking at a bespoke outcome system which should address the concerns of both clinicians and the executive allowing us to know how we are doing before others do and enabling us to provide evidence when requested.

2. Infection Rates

The Trust participates in surgical site infection (SSI) surveillance with Public Health England and has for the first time ever been informed that in the period January-March 2014 for primary total knee replacement we were above the national 90th percentile with a SSI rate of 1.6%.

Because the Bone Infection Unit (BIU) monitors the SSI rate for all hip and knee arthroplasty patients, we were aware of this issue and had already conducted an investigation. However, we were unable to find any specific pattern to account for this outlier position. I can confirm that we are no longer in an outlier position and it would appear that this was a 'blip' which does occur from time to time.

On a positive note, the BIU set itself the target of reducing SSI rates by 50% three years ago and has achieved a 65% reduction.

We do however have an unacceptable readmission and 'return to theatre' rate because of infection in our patients with the negative impact this has on patient experience, organisational reputation, financial and strategic risk.

Solution

The Trust and all clinicians must be made aware of the impact that their action or inaction has on infection rates and we should be aiming for a 0% SSI, accepting that it is unlikely that we will ever get there. The extensive data that the BIU has on individuals SSI and deep infection rates, individual theatre infection rates and adherence or otherwise to proven best practice will be shared widely in the organisation to ensure full engagement from all groups.

3. Appraisal & Revalidation

As Responsible Officer I have a statutory obligation to ensure that the appraisal process within the organisation is a robust process.

I have been concerned that the robustness of appraisals at the ROH is in a minority of cases not up to the standards I or the GMC require. My annual Responsible Officer report to Board gives more detail.

Solution

I am arranging for all 14 medical appraisers in the organisation to undergo 'refresher' appraiser training and I am working to develop an 'in-house' appraiser group to ensure that standards are maintained.

4. Caldicott Guardian Issues – Personal Databases

As a result of the lack of an appropriate integrated outcome collection and reporting system within the organisation, a number of consultants have developed their own personal databases on mobile devices or at home. As Caldicott Guardian I have concerns that these devices have patient identifiable data on them and this may not be held in a secure encrypted format. This presents a risk to the organisation.

Solution
I have written to all clinicians reminding them of their professional and legal responsibilities and the fact that they are in breach of the data protection act if they hold any patient identifiable data on devices off site and that in the event of any data breach as a result of this they could be at risk of prosecution by the Information Commissioner and would not be indemnified by the Trust.

Andrew Pearson
Medical Director
July 2014

Appendix 1

Clinical Standards - How do we raise them at The Royal Orthopaedic Hospital?

Patients must be at the centre of everything that the Royal Orthopaedic Hospital does. In light of the findings of the Francis Inquiry, we need to look at how improving patient experience and outcomes must be central to our purpose.

The principles of high standard patient care for me are:-

1. **Fundamental standards of care are met every time**
   Treatment with kindness, respect and dignity. Treated in clean and comfortable surroundings with the minimal risk of procedure or hospital acquired infection.

2. **Patient experience is valued as much as clinical effectiveness**
   Patients' experience of care should be measured with reference to the NICE quality standard on patient experience and the findings of this acted upon at all levels of the hospital

3. **Responsibility for each patient's care is clear and communicated**
   Clear lines of communication with each patient's care led by a named consultant working closely with the ward manager.

4. **Patients have effective and timely access to care**
   Waiting time for appointments, reduction of appointment changes, tests, POAC and admissions.

5. **Robust arrangements for transfer of care**
   The handover of care between shifts for doctors and nurses must be robust, particularly for the higher risk patient. We also need to ensure that the transfer of care between the hospital and community and from referring hospitals becomes simplified and seamless.

6. **Good communication with and about patients is the norm**
   Effective communication with patients is a fundamental element of medical professionalism. There has to be good communication with and about patients. Patients must also be able to access advice from secretaries in an easy and timely way.

7. **Care is designed to facilitate self-care and health promotion**
   Empowering patients is a fundamental aspect of medical professionalism and shared decision making between doctors and patients should be common practise. Patients should be able to make decisions in an informed manner such that the decision is made with their best interests in mind.

8. **Services are tailored to meet the needs of individuals patients, including vulnerable patients**

   All the services we provide need to be tailored to the individual, whether they are older and frail, young, cognitively impaired or have mental health problems. The environment we care for patients must be suitable for all patients.

9. **Staff are supported to deliver safe, compassionate care and are committed to continuously improve quality**

   We must support all staff to take ownership both collectively and individually in the care of individual patients and in their own contribution to the overall standard of care delivered by the Trust.

   So if these are my principles of high clinical standards of care, how do we achieve these and deliver consistently high quality care for all of our patients?

   The Francis Inquiry Report and the work of the Future Hospital Commission (FHC) frequently refers to 'putting the needs of the patient at the centre of what we do' and using this principle to drive new ways of working for clinicians.

   I think that many of the challenges that we perceive to enabling us to do the work we do could and can be resolved if we put ourselves in the shoes of the patient and ask ourselves would we be happy with the care we are receiving.

   If the answer to that question is no, then it is our professional duty to work with the organisation and others to rectify the situation so as to raise the standard of care. Merely commenting on it or worse 'walking past' it is professionally negligent and will do nothing to raise the care we provide and so the standing of the organisation locally, nationally and internationally.

   We must move away from treating patients by their hospital number, moving through the organisation in an, at times, random manner having returns to the Trust for appointments because it suits us rather than what is right for them. Waiting for lengthy periods of time on admission before their operation, because it suits us. Changing clinic appointments numerous times, cancelling operations for lack of communication etc.

   Some of the most common specific issues that patients raise in surveys and in their contact with the Patient Advice and Liaison Service (PALS) are:-

   Lake of clear communication:

   1. Appointment changes at short notice
   2. Leaving hospital without knowing when their follow-up will be

3. Lack of information and detail about their condition/operation
4. Lack of senior medical review post-operatively
5. Lack of a clear point of contact to make an enquiry regarding care

Some of these issues require resources, which the Board is addressing. However many of these issues can be addressed by clinicians looking at the way they conduct their practice.
I believe that these measures will raise the standard of care we provide by raising the standard of patient experience.

1. **Consent Process**
   There is on-going work I am conducting around the process of obtaining informed consent, by the right person (the operating surgeon) at the right time, with the patient suitably equipped with appropriate information to make an informed decision in their best interests.

2. **Direct Booking of Operation Date**
   Where possible (and there should be few exceptions), the patient should have an agreed date for their surgery when they are placed on the waiting list.

3. **Minimum of six week's notice when booking annual, study and professional leave**
   Apart from in exceptional circumstances which have been discussed and agreed with the clinical director and directorate manager, there should be no circumstances where this fails to occur. Only by having this degree of 'forward look' can operating lists and clinics be arranged to minimise inconveniencing patients.

4. **Pre and Post-op review of patients by the operating surgeon and anaesthetist**
   I cannot think of a situation where a patient would not wish to be seen by the surgeon performing their operation and anaesthetist both beforehand and afterwards. I as a patient would also expect my consultant to have at least one formal ward round a week when I might see them so they could discuss my recovery.

Staff wellbeing and clinical engagement will be a priority to promote good outcomes for patients and doctors and nurses will need to be supported to embed these principles of medical and nursing professionalism.

There will be a move to not tolerating professional behaviours which fall below these standards. To accept anything less will mean that The Royal Orthopaedic Hospital fails to regain its place as the centre of

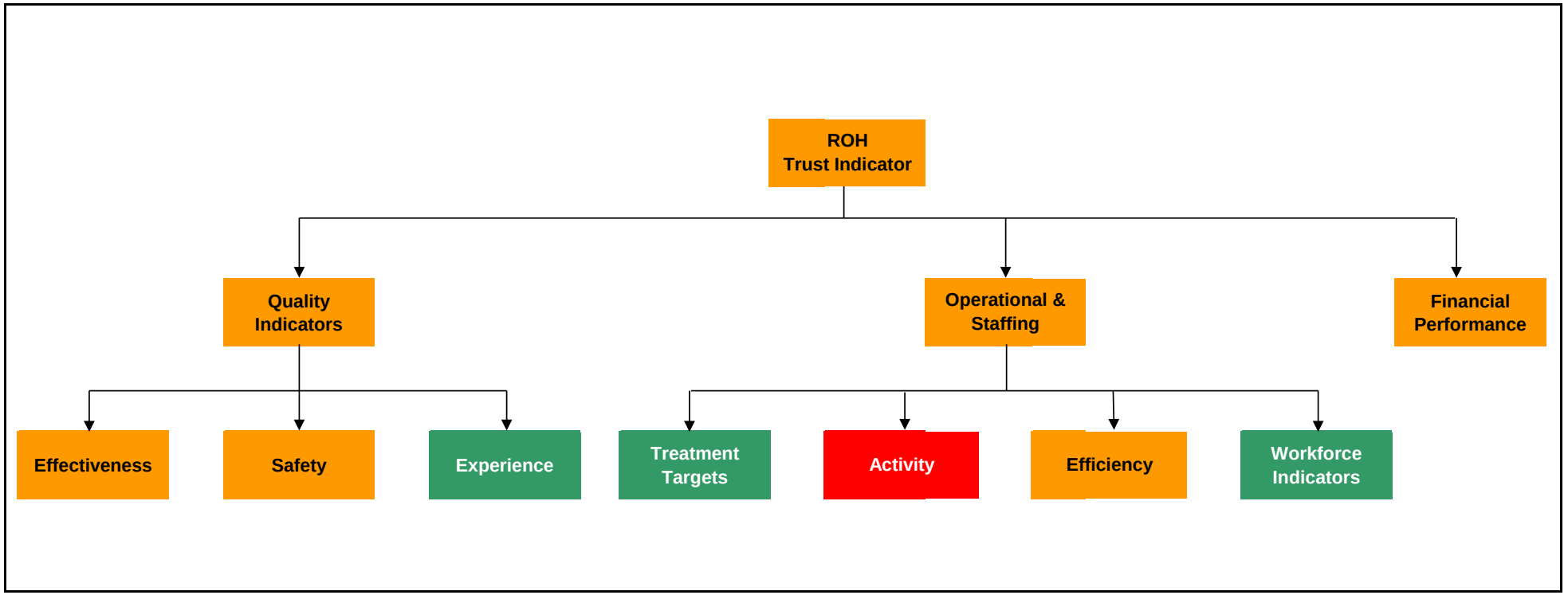
patient care excellence and as a consequence will become increasingly irrelevant in the future healthcare system.

There is no doubt that care is going to become more and more consultant provided as well as led. This requires us to think how we can align what we do with best patient focused care. We can do this and the only thing stopping us at the moment is ourselves.

I invite you all to join me in delivering a specialist provider hospital which is the envy of our competitors, the place where patients want to be care for and where staff feel valued and rewarded because of the excellent care they provide.

Andrew Pearson
Medical Director
June 2014

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending June 14



Quarterly Detailed Report
Executive Summary as at June 2014

Headlines

- For the month of June the Trust made a surplus before impairments of £83k compared to a planned surplus of £125k.
- All 3 RTT targets have been met.
- The backlog has reduced by 40 in month

Monitor Compliance Framework Targets	Jun-14 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.15%	95.32%	0	6
Referral to treatment time - Admitted %	90%	91.74%	91.79%	0	6
Referral to treatment time - Incomplete Pathways %	92%	95.10%	94.76%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	100%	100%	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
Avoidable Clostridium Difficile cases	0 (Full Year)	0	0	0	5
MRSA cases	0 (Full Year)	0	0	0	5
Other risks impacting on Governance Risk Rating	None				

Indicative Monitor Governance Risk Rating	Green
Indicative Continuity of Services Rating	4

Key Trust Targets		Jun-14 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	2		3
	Complaints	<=12	7		4
	CQUINS	100%	100%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<400	364		6
	Incomplete 14 - 18 Week Waiters	<450	547		6
	Total Admitted Patient Care Patients vs Plan	100%	84.7%		7
	Unused Theatre Sessions	<44	46		8
	Sickness	3.7%	3.8%		9
Financial	Surplus before impairments	£125k	£83k		10
	CIP	£365k	£551k		10
	Agency Expenditure	£91k	£186k		11
	Locum Doctor Expenditure	£46k	£75k		11

Trust Summary

The Trust has met all Referral to Treatment Targets for the month of June, and the backlog has reduced by 40 in month primarily in non-admitted.

For the month of June the Trust made a surplus before impairments of £83k against a planned surplus of £125k.

Elective and non elective activity are behind plan and red rated. Day Cases met plan, and follow up outpatients and outpatient procedures performed in excess of plan.

All RTT targets are expected to have been met.

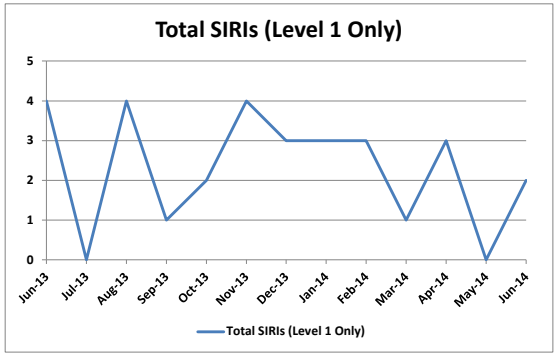
Sickness absence remains green for the third month.

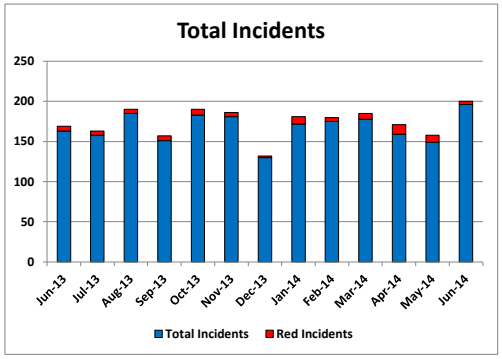
Quarterly Detailed Report
Safety Indicators as at June 2014

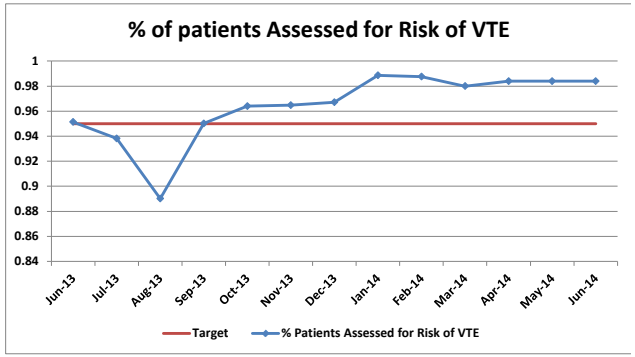
Headlines

- Medicine incidents reduced, and have become amber rated from red.
- Total incidents have increased which is positive, and red incidents have decreased.
- Patient falls are still red rated, but have decreased from prior month.

	Monitor	National	CQC Standard		Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	14/15 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)	4	0	4	1	2	4	3	3	3	1	3	0	2	5
			4,16	SIRI per 1000 bed days	1.32	0.00	1.27	0.36	0.62	1.39	1.01	0.90	0.85	0.27	0.89	0.00	0.59	0.48
			4,16	Total Incidents	163	158	185	151	183	181	130	172	175	178	159	149	196	504
			4,16	Incidents per 1000 bed days	53.95	47.07	58.96	54.12	56.82	62.70	43.61	51.71	49.30	47.94	46.96	41.98	57.92	48.84
			4,16	Red Incidents	6	5	5	6	7	5	2	9	5	7	12	9	4	25
			9,16	Total Medicine Incidents Reported	15	15	23	18	21	16	8	11	18	18	19	17	12	48
			9,16	Medicine Incidents Reported per 1000 bed days	4.96	4.47	7.33	6.45	6.52	5.54	2.68	3.31	5.07	4.85	5.61	4.79	3.55	4.65
				Medicine Incidents with Harm	3	2	1	4	1	3	2	1	3	3	3	2	4	9
		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	95.13%	93.82%	89.02%	95.02%	96.40%	96.48%	96.71%	98.87%	98.76%	98.00%	98.40%	98.40%	98.40%	98.39%
			9	Incidence of Hospital Related VTE	1	1	0	1	1	0	1	1	1	1	1	0	1	2
			4	Patient Falls - Inpatients	6	4	9	2	4	8	6	3	6	12	6	7	5	13
			4	Patient Falls per 1000 bed days	1.99	1.19	2.87	0.72	1.24	2.77	2.01	0.90	1.69	3.23	1.77	1.97	1.40	1.26
				Avoidable Patient Falls with Harm											0	0	TBC	TBC
			4,16	% Harm Free Care	97.94%	98.90%	97.85%	98.70%	97.00%	98.90%	97.50%	97.41%	100.00%	97.71%	89.90%	99.02%	96.91%	95.97%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

There have been 2 SIRIs reported in month, compared to 0 in May.

Total incidents have increased from 149 in May to 196.

There have been 4 red incidents in month, compared to 9 in May.

Medicine incidents have reduced from 17 to 12, and as such have become amber rated

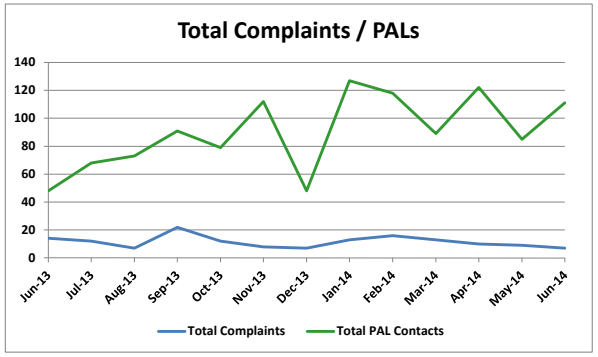
Additional information on all of the above is included in the Quality Report.

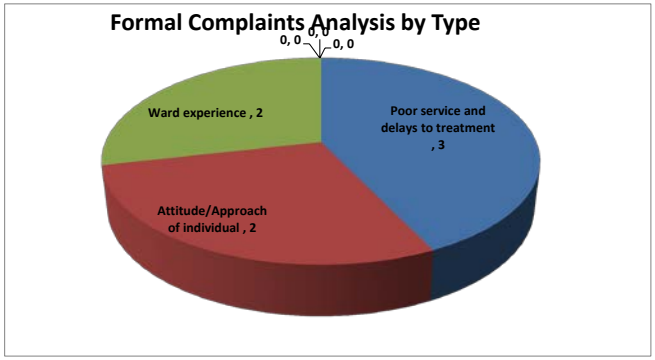
Quarterly Detailed Report
Experience Indicators as at June 2014

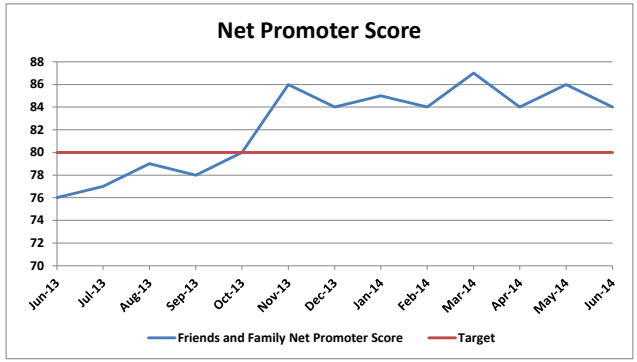
Headlines

- Complaints are down from 9 in May to 7 in June, the lowest since December 2013.
- PALs contacts increased from 85 in May to 111 in June.
- The real time food survey results increased from 90.60% last month to 97.70% satisfaction.

	Monitor	National	CQC Standard		Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	14/15 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:29	1:32	1:46	1:14	1:34	1:16	1:63	1:37	1:27	1:42	1:46	1:48	1:60	**1:51**
			17	Total Complaints	14	12	7	22	12	8	7	13	16	13	10	9	7	**9**
			17	Complaints reverted to informal <48 hrs	1	1	3	3	0	1	0	0	0	0	0	0	0	**0**
			17	Formal	13	11	4	19	12	7	7	13	16	13	10	9	7	**26**
			17	Complaints per 1000 bed days	4.63	3.57	2.23	7.89	3.73	2.77	2.35	3.91	4.51	3.50	2.95	2.54	2.07	**2.52**
				Complaints Response Time (Average No of Days)	37	53	39	30	35	53	49	45	53	25		46	59	52.5
			17	Total PAL Contacts	48	68	73	91	79	112	48	127	118	89	122	85	111	**318**
			17	PALS Contacts per 1000 bed days	15.89	20.26	23.27	32.62	24.53	38.80	16.10	38.18	33.24	23.97	36.03	23.95	33.08	**30.27**
				Total PALS Concerns								65	65	56	80	59	49	188
			17	Total Compliments	404	386	320	298	409	124	440	481	439	552	455	436	423	**1314**
			17	Compliments per 1000 bed days	133.72	114.99	101.99	106.81	127.00	42.96	147.61	144.62	123.66	148.67	134.38	122.85	118.42	**125.06**
				Food - Real Time Patient Survey	86.67%	90.48%	92.40%	90.00%	90.60%	92.00%	96.60%	95.00%	93.00%	98.20%	97.20%	90.60%	97.70%	**95.17%**
			17	Friends and Family Net Promoter Score	87	84	80	83	88	90	86	83	84	85	81	76	81	**79**
				Friends and Family Response Rate	68.0%	56.0%	54.0%	54.0%	49.0%	51.0%	44.0%	40.0%	43.0%	46.0%	53.0%	39.0%	40.0%	**44.0%**







* Please note that complaints response time will be reported a month in arrears.

PALS
Number of contacts this month was 111, which is more in line with average, but is still high.
Of the contacts, 49 were concerns (43%), down from 69% in May.

COMPLAINTS
The number of complaints received this month is 7, down from 9 in May, and the lowest since December 2013.

COMPLIMENTS
The number of compliments received this month is 423, which is down from last month's total of 436.
Real time patient food survey at 97.7% shows consistent and strong performance

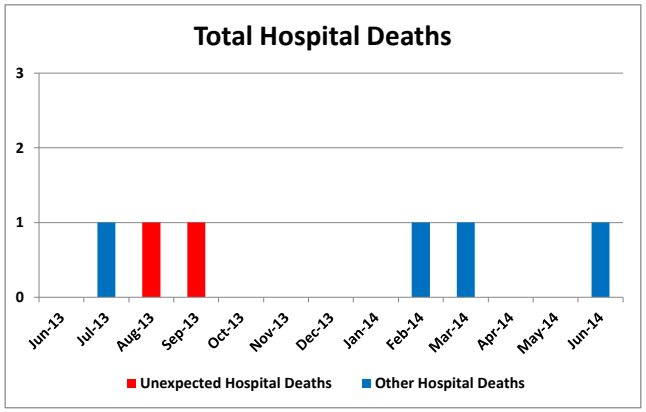
Further information on experience is included in the Quality Report.

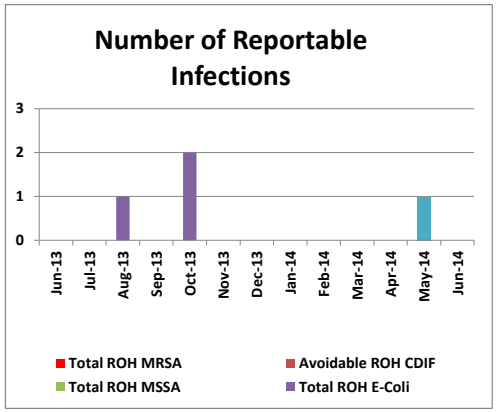
Quarterly Detailed Report
Effectiveness Indicators as at June 2014

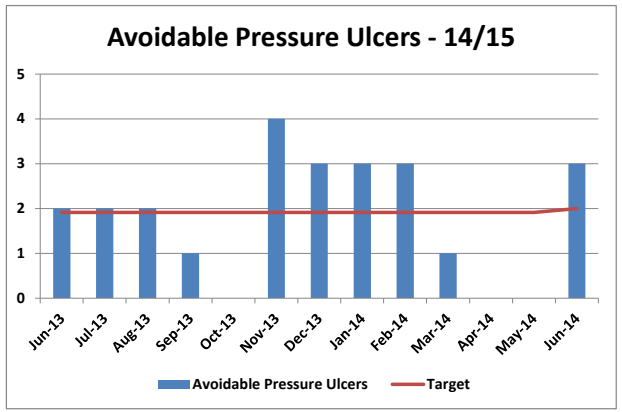
Headlines

- WHO checklist completion has improved in month, but is still amber rated.
- There were 3 patient deaths in month.
- There were 3 avoidable grade 1 and 2 pressure ulcers, up from 0 in prior month.

	Monitor	National	CQC Standard		Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	14/15 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	1	1	1	0	0	0	0	1	1	0	0	3	1
			4,18	Hospital Deaths per 1000 bed days	0.00	0.30	0.32	0.36	0.00	0.00	0.00	0.00	0.28	0.27	0.00	0.00	0.84	0.29
			4,18	Unexpected Hospital Deaths	0	0	1	1	0	0	0	0	0	0	0	0	0	0
				Other Hospital Deaths	0	1	0	0	0	0	0	0	1	1	0	0	1	1
			8	MRSA % Screened	140.59%	145.53%	127.51%	146.00%	132.00%	114.30%	100.10%	135.40%	102.00%	109.00%	115.00%	118.00%	126.00%	120%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
				Avoidable ROH CDIF												0	0	0
				Unavoidable ROH CDIF												1	0	1
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	1	0	2	0	0	0	0	0	0	0	0	0
			8	HCAIs not attributable to ROH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	1	0	0	2	1	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	2	2	1	1	0	2	2	3	3	1	0	0	3	3
			4	Avoidable Pressure Ulcers per 1000 bed days	0.66	0.60	0.64	0.36	0.00	1.39	1.01	0.90	0.85	0.27	0.00	0.00	0.89	0.29
				% Completion of WHO Checklist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.69%	96.88%	97.88%	97.82%







Effectiveness Commentary

There were 3 avoidable grade 1 & 2 presure ulcers this month, up from 0 in prior month.

There were no reportable infections this month.

There was three patient deaths in month. One remains under investigation.

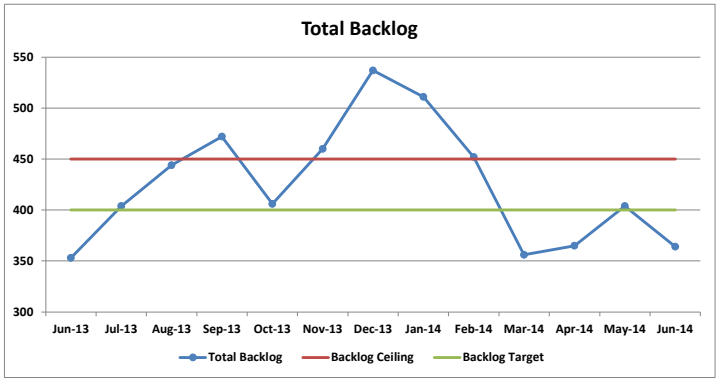
Further information on effectiveness is included in the Quality Report.

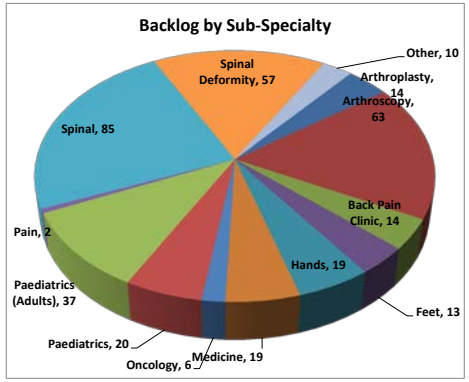
Quarterly Detailed Report
Treatment Targets as at June 2014

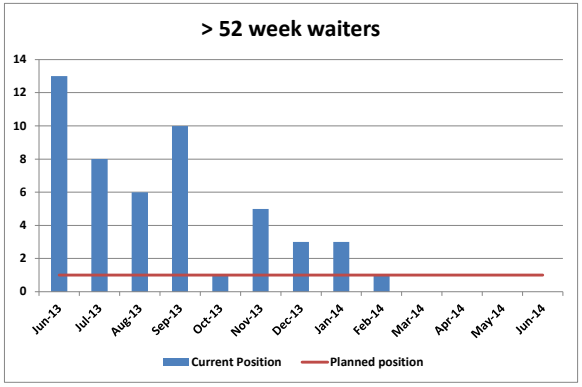
Headlines

- The backlog has reduced by 40 in month
- All 3 RTT targets have been met.
- All cancer targets continue to be met.

	Monitor	National	CQC Standard		Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	14/15 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	13	8	6	10	1	5	3	3	1	0	0	0	0	**0**
				Referral to treatment waits over 45 weeks	20	13	15	16	7	9	6	6	5	7	5	4	5	**5**
	M	N	4	Referral to treatment time - Non Admitted %	95.35%	95.29%	95.78%	95.42%	95.24%	95.13%	95.12%	95.13%	95.00%	95.01%	95.32%	95.48%	95.15%	**95.40%**
	M	N	4	Referral to treatment time - Admitted %	91.37%	92.05%	90.33%	90.19%	90.09%	88.12%	83.25%	83.65%	88.76%	88.37%	91.12%	92.51%	91.74%	**91.82%**
	M	N	4	Referral to treatment time - Incomplete Pathways %	94.77%	94.18%	93.71%	93.33%	94.00%	93.33%	87.49%	92.71%	93.21%	94.63%	94.75%	94.43%	95.10%	**94.59%**
			4	Non admitted Backlog - Pathways waiting >18 wks	110	131	159	163	160	167	259	260	199	152	156	211	174	**170**
			4	Admitted Backlog - Pathways waiting >18 wks	243	273	285	309	246	293	278	251	253	204	209	193	190	**190**
			4	Total Backlog - 18 week pathways waiting >18 wks	353	404	444	472	406	460	537	511	452	356	365	404	364	**360**
			4	Incomplete 14 -18 Week Waiters	504	477	630	654	565	640	721	721	520	475	379	574	547	**547**
				Non Admitted Median Wait (Weeks)	8	8	8	9	9	8	8	9	9	8	8	8	9	**8**
				Admitted Median Wait (Weeks)	10	9	9	10	10	10	11	11	11	10	9	9	9	**9**
				Incomplete Median Wait (Weeks)	6	6	7	7	6	7	7	7	6	6	6	7	6	**6**
	M	N	4	Cancer 2 week (all cancers)	100.00%	100.00%	100%*	100.00%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100% *	**100.0%**
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.00%	100.00%	100%*	100.00%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100% *	**100.0%**
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.00%	100.00%	100%*	100.00%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100% *	**100.0%**
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	66.67%	80.00%	100%*	83.30%	100.00%	85.7%	66.7%*	81.8%*	100.0%	100.0%	100.0%	100.0%	100% *	**100.0%**
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.52%	99.20%	99.09%	99.70%	99.43%	99.36%	99.37%	98.90%	99.82%	99.57%	99.15%	99.58%	99.15%	**99.3%**
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	1	0	0	0	0	0	0	**0.0%**
			1,21	Data Quality on Ethnic Group - Inpatients	96.43%	94.86%	95.22%	98.35%	95.65%	95.70%	95.47%	96.19%	96.16%	96%	95.58%	95.50%	95.73%	**95.3%**







Treatment Targets Commentary

The Trust has met all Referral to Treatment Targets for the month of June. There were no Diagnostic breaches and the Cancer pathways were fully compliant.

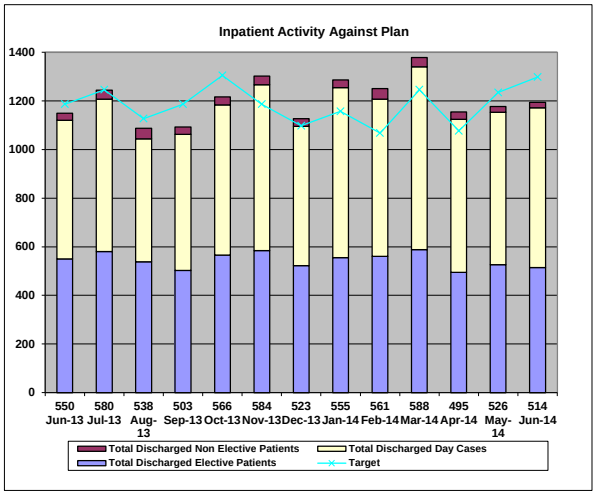
The total Backlog reduced by 40 in month primarily in non-admitted.

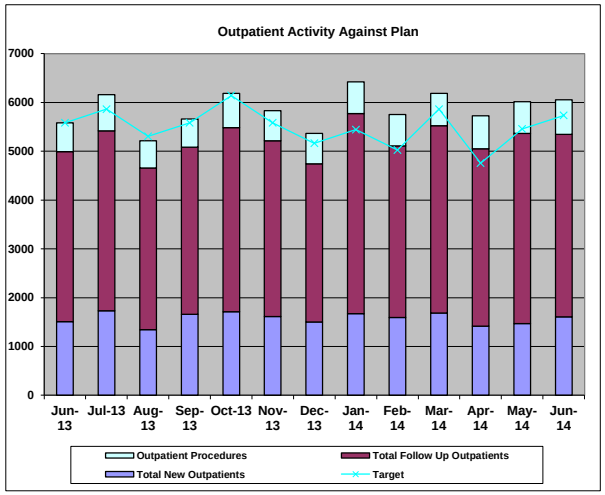
Quarterly Detailed Report
Activity Targets as at June 2014

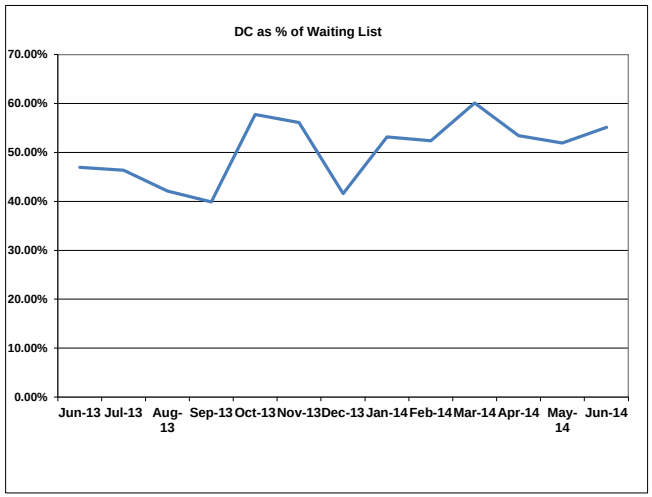
Headlines

- Elective activity is red rated for June, and is only 85% of plan. Tha majority of this underperformance relates to large joints and oncology. Management are considering options for increasing activity in other directorates for the remainder of the year.
- Non elective activity continues to be red rated for the second month at 65% of plan.
- Day Case activity and outpatient activity is positive.

	Monitor	National	CQC Standard		Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	14/15 Full Year Position
Activity			4	Total Discharged Elective Patients	550	580	538	503	566	584	523	555	561	588	495	526	514	**1535**
			4	Total Discharged Non Elective Patients	30	38	44	30	33	35	31	32	43	38	31	23	22	**76**
			4	Total Discharged Day Cases	570	627	506	560	618	683	573	700	647	753	629	628	658	**1915**
			4	Total New Outpatients	1508	1728	1343	1659	1709	1614	1503	1672	1593	1682	1415	1467	1606	**4488**
			4	Total Follow Up Outpatients	3481	3691	3314	3428	3778	3600	3237	4101	3519	3840	3636	3902	3743	**11281**
			4	Outpatient Procedures	594	743	560	575	697	618	627	652	643	663	675	646	707	**2028**
				DC as a % of WL	46.95%	46.34%	42.10%	39.86%	57.76%	56.08%	41.58%	53.15%	52.39%	60.10%	53.40%	51.94%	55.11%	**53.48%**
			4	Elective as % Against Plan	91.0%	91.4%	93.7%	83.2%	85.1%	96.6%	93.5%	94.2%	103.1%	92.6%	98.4%	91.2%	84.7%	**91.0%**
			4	Non Elective as % Against Plan	78.1%	94.3%	120.6%	78.1%	78.1%	91.2%	87.3%	85.5%	124.5%	94.3%	110.7%	71.9%	64.7%	**80.9%**
			4	Day Cases as % Against Plan	104.8%	109.8%	97.9%	103.0%	103.3%	125.6%	113.9%	132.0%	132.2%	131.9%	115.2%	100.3%	100.0%	**104.6%**
			4	% New Outpatients Against Plan	106.5%	116.2%	99.8%	117.2%	109.7%	114.0%	114.8%	121.1%	125.0%	113.1%	107.9%	97.5%	101.5%	**102.0%**
			4	% Follow Up Outpatients Against Plan	99.1%	100.1%	99.3%	97.6%	97.8%	102.5%	99.6%	119.7%	111.3%	104.1%	124.8%	116.8%	106.5%	**115.5%**
			4	% Outpatient Procedures Against Plan	90.6%	108.0%	89.9%	87.7%	96.7%	94.3%	103.4%	102.0%	109.0%	96.3%	127.0%	106.0%	110.3%	**113.8%**







Activity Commentary

Activity is behind plan for electives and non-elective at the end of Quarter 1. This is driven largely by underperformance in large joints and oncology (c.230 cases behind plan), offset by some overperformance in small Joints, paediatrics and spinal (c105 cases above plan).

Management are currently considering reducing the plan for large joints, along with reducing theatre capacity, and transferring both capacity and activity to directorates who are or are able to, over perform.

Quarterly Detailed Report
Efficiency Indicators as at June 2014

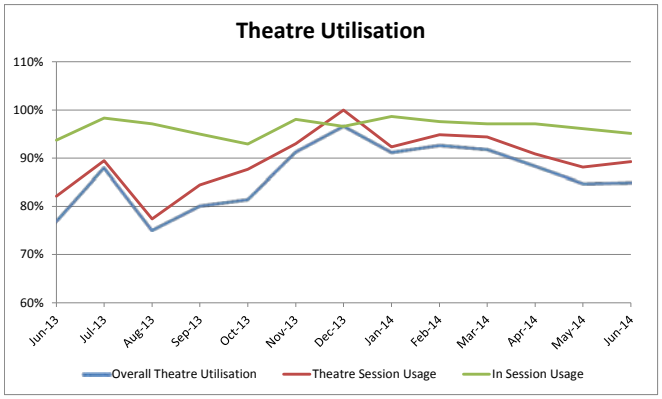
Headlines

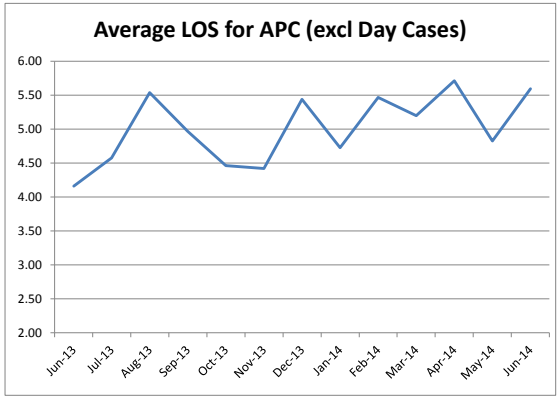
Whilst overall cancelled operations remain red rated, the proportion as a percentage of activity remains relatively static.

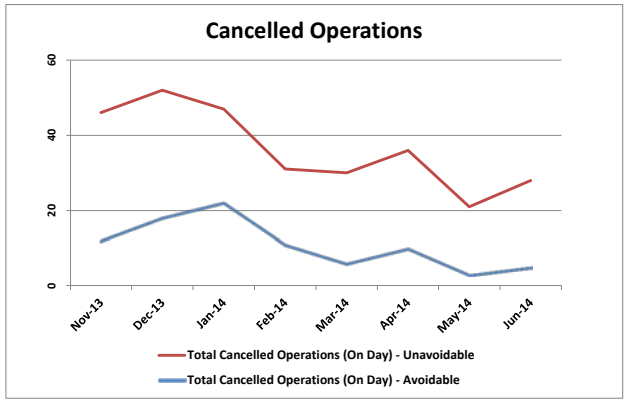
AVLOS remains red rated, and is the highest it has been for at least a year. This is partly driven by a long stay patient.

There were 46 unused theatre sessions in June, a reduction on May, but still amber rated.

	Monitor	National	CQC Standard		Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	14/15 Full Year Position
Efficiency			4	Overall Theatre Utilisation	76.95%	87.98%	75.15%	80.19%	81.51%	91.23%	96.58%	91.13%	92.59%	91.74%	88.30%	84.76%	84.98%	**86.01%**
			4	Theatre Session Usage	82.09%	89.50%	77.38%	84.42%	87.73%	93.02%	100.00%	92.37%	94.88%	94.44%	90.88%	88.17%	89.30%	**89.45%**
			4	In Session Usage	93.73%	98.31%	97.11%	94.99%	92.92%	98.07%	96.58%	98.66%	97.59%	97.14%	97.16%	96.14%	95.16%	**96.15%**
			4	Unused Theatre Sessions	77	50	102	67	61	30	0	36	21	25	33	51	46	**43**
			4	Number of Cases per Theatre Session	3.08	2.79	2.95	2.91	2.67	3.09	2.97	2.83	3.10	3.11	3.31	2.98	2.94	**3.06**
			4	Total Cancelled Operations (On Day or Day Before)	63	88	58	62	82	120	84	78	71	58	67	53	61	**181**
			4	Total Cancelled Operations (On Day) - Avoidable						12	18	22	11	6	10	3	5	**18**
			4	Total Cancelled Operations (On Day) - Unavoidable						34	34	25	20	24	26	18	23	**67**
			4	Total Cancelled Operations by Hospital (On Day)	5	11	14	4	2	11	10	9	3	5	5	8	6	**6**
			4	% Cancelled Operations by Hospital	0.46%	0.93%	1.36%	0.38%	0.17%	0.89%	0.94%	0.73%	0.25%	0.38%	0.46%	0.71%	0.53%	**0.57%**
			4	Total T&O Review-To-New Ratio (including Spinal)	2.55	2.25	2.54	2.36	2.33	2.35	2.30	2.58	2.44	2.50	2.75	2.74	2.46	**2.65**
			4	Pain Review-To-New Ratio	2.90	4.02	4.24	1.89	3.59	2.70	3.38	3.72	3.85	3.64	4.55	4.16	3.79	**4.17**
			4	Outpatient DNAs	9.23%	8.70%	9.33%	8.49%	8.46%	8.51%	8.61%	9.59%	8.18%	8.65%	8.42%	8.40%	8.40%	**8.41%**
			4	Bed Occupancy - Adults	71.91%	76.53%	76.26%	71.19%	83.58%	86.36%	79.80%	83.60%	88.61%	80.72%	80.32%	81.21%	86.15%	**82.52%**
			4	Bed Occupancy - Paediatrics	55.00%	42.71%	46.77%	40.28%	58.60%	59.72%	53.18%	63.80%	65.87%	82.80%	69.26%	50.87%	54.44%	**58.04%**
			4	Bed Occupancy - HDU	81.44%	82.76%	85.15%	77.01%	90.67%	85.92%	84.62%	87.45%	86.89%	91.40%	69.88%	75.10%	77.05%	**74.00%**
			4	Bed Occupancy - Private Patients	39.29%	66.96%	63.13%	66.19%	71.89%	77.62%	64.94%	80.28%	68.88%	78.80%	65.52%	81.57%	83.25%	**76.89%**
			4	Admissions on the Day of Surgery	403	418	374	371	417	405	386	421	415	445	358	383	390	**1131**
			4	AVLOS for APC (excl day cases)	4.16	4.58	5.54	4.97	4.46	4.42	5.44	4.72	5.47	5.20	5.71	4.83	5.59	**5.38**







Efficiency Commentary

46 theatre sessions were not used in June with an associated underperformance in activity. Discussions with Directorate teams are underway to transfer theatre sessions from directorates who are underperforming to those with high demand (please see activity tab).

LOS continues to be high (in part due to discharge of a patient with a LOS of 206 days, but also related to an increase in bone infection patients. A new work stream is being established via CPB to address this.

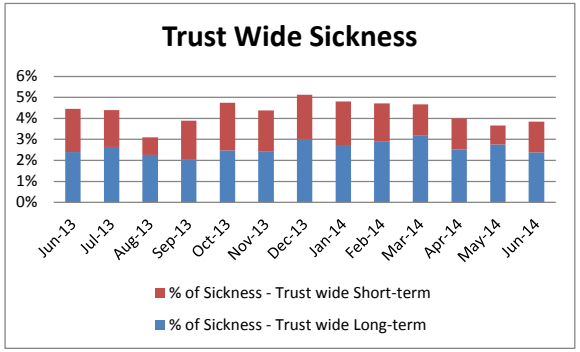
Cancelations as a percentage of total in month activity remained relatively static. 3 of the hospital cancellations are as a result of consultant sickness.

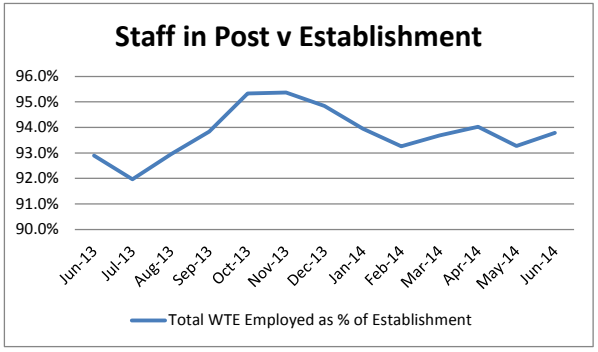
Monthly Report
Workforce Indicators as at June 14

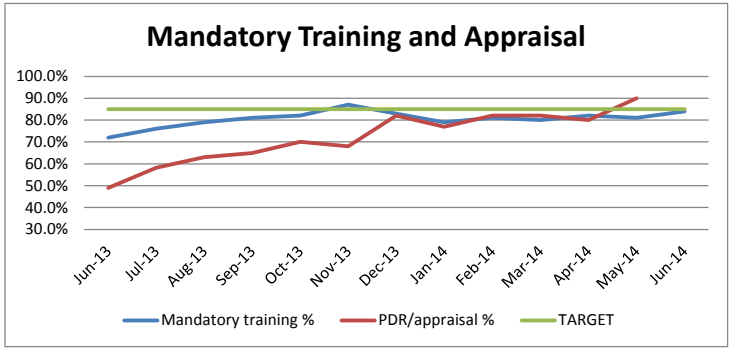
Headlines

- Sickness absence still below 4%
- PDR completion is down to 81% from 90% in previous month.
- Turnover up - but no obvious underlying reason

	Monitor	National	CQC Standard		Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	14/15 Full Year Position
Workforce				Total WTE Employed as % of Establishment	92.9%	92.0%	92.9%	93.8%	95.3%	95.4%	94.8%	94.0%	93.3%	93.7%	94.0%	93.3%	93.8%	**93.7%**
				Staff Turnover (%) - Unadjusted	12.6%	12.5%	12.5%	12.7%	12.8%	12.9%	13.1%	12.2%	11.8%	11.3%	11.6%	11.3%	11.9%	**11.6%**
				Staff Turnover (%) - Adjusted	9.1%	9.1%	8.6%	8.8%	8.7%	8.4%	8.6%	8.0%	7.4%	7.1%	7.7%	7.7%	9.5%	**8.3%**
				% of Sickness - Trust wide	4.5%	4.4%	3.1%	3.9%	4.8%	4.4%	5.1%	4.8%	4.7%	4.7%	4.0%	3.7%	3.8%	**3.8%**
				% Staff received mandatory training last 12 months	72%	76%	79%	81%	82%	87%	83%	79%	81%	80%	82%	81%	84%	**82%**
				% Staff received formal PDR/appraisal last 12 months	49%	58%	63%	65%	70%	68%	82%	77%	82%	82%	80%	90%	81%	**84%**
				Staff Friends & Family Test - Care & Treatment														
				Staff Friends & Family Test - Great Place to Work														







Workforce Commentary

Sickness absence was green in June for the third consecutive month, with the moving annual average reducing for the fifth consecutive month.

The vacancy position taken from the ledger suggests an acceptable level of just over 6%.

The standard turnover figure increased on the May position but is lower than the June 2013 position.

Mandatory training increased slightly to 82% in month and PDR completion is at 81%.

Monthly Report

Finance Dashboard as at 30th June 2014

	Surplus before impairments £'000	Cash £'000	Capital spend £'000
Plan	125	16,280	1,312
Actual	83	18,507	1,077
Forecast for next month (YTD)	577	18,511	1,745

	Year to date		
	Actual	Plan	Risk Rating
Capital Servicing Capacity	1.9	2.0	3
Liquidity Ratio	67.5	67.1	4
Overall Continuity of services ratio			4

NOTE: The waterfall is based on a revised plan rather than the plan submitted to Monitor. This was amended to reflect the differences between the actual and planned outturn for 2013/14, and allows the Trust to provide a clearer picture of the actual variations in balances against where they would be expected to be.

The current capital servicing capacity rating is a 3, driven largely by the Q1 deficit. As the liquidity ratio is a 4, this gives the Trust an overall continuity of services ratio of 4, the highest rating.
Although the deficit is slightly higher than plan, both the individual and combined ratios are as expected, and as built into the Monitor 5 year plan.

Activity was behind plan for June for Electives and Non-electives.
When offset by the richer case mix, this has resulted in a c.£200k impact on the Trust's finances.

The pay expenditure is below the Monitor plan by £84k. This is due to some of the organisational development funds and the growth reserves being allocated against pay in the Monitor plan, but they have yet to be used.

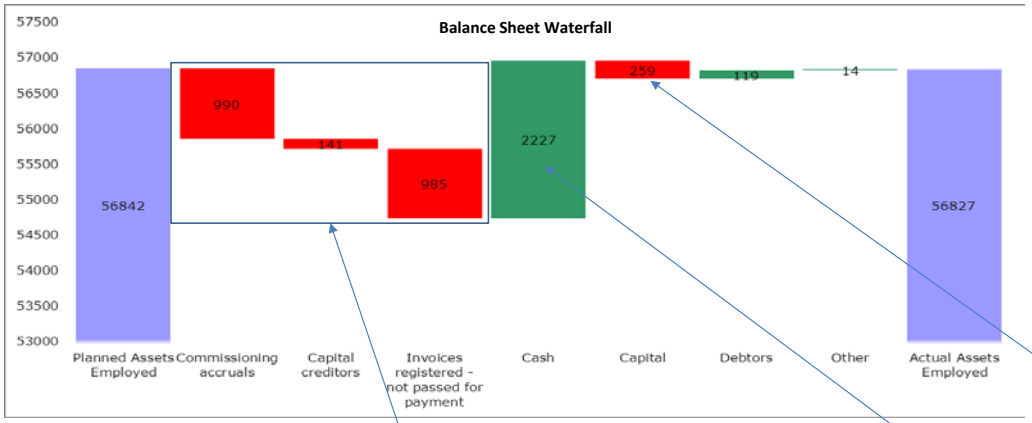
When compared to base budget, the underlying pay is higher than expected (budget does not include the above funds). Agency pay (£186k) and locum pay (£75k) are both high, but have reduced from prior month, whilst bank pay has increased slightly to £202k.

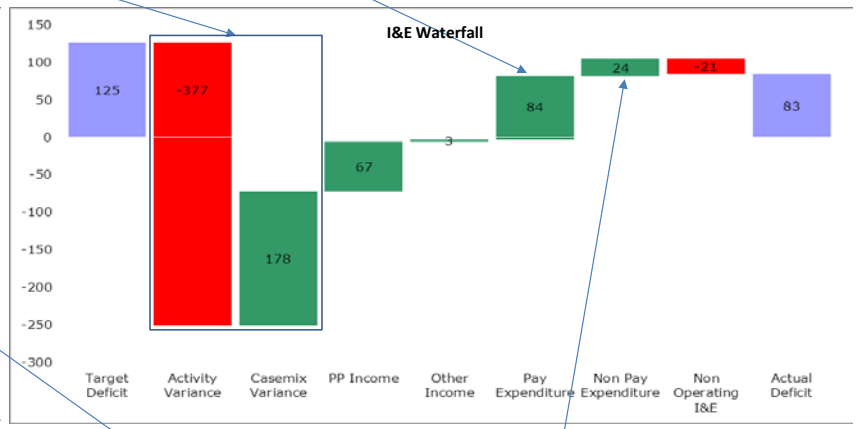
The predicted impact of impairments in the year was calculated for the Monitor plan, and spread throughout the year.

The planned and actual results include the first quarter's element of the expected impairment (£242k).

The underlying plan was therefore a surplus of £125k, compared to an actual of £83k.

	Plan	Actual
Surplus before imp.	125k	83k
Impairments	(242k)	(242k)
Deficit after imp.	(117k)	(159k)





Creditors are higher than plan as a result of a number of reasons, and this has been divided for clarity on the waterfall. All of the significant differences are as a result of timing differences rather than spend being significantly higher than expected;
1. Commissioning accruals: The planned balance sheet had made an assumption over the timing of clearance of underperformance against contract with the commissioners. However, the timing of this clearance is likely to be later in the year and is largely out of the control of the Trust.
2. Capital creditors: The Trust is yet to receive the invoices for some of the capital spend on Ward 11 and the Short Stay Ward, although we know that the liability exists, and we have therefore accrued.
3. Invoices registered and passed for payment: There had been a delay in receiving invoice approval for a number of large invoices (accounting for c.£700k) out in the organisation. However, as of 15th July £469k of those large invoices have now been received back into the department and paid. It is therefore considered that this was timing rather than an indication of a wider controls issue.

Cash is higher than expected largely as a result of creditors being higher than plan for the reasons explained.

Capital spend is lower than plan largely due to equipment and building works in relation to the mobile scanner. Further detail is provided on the Quarterly finances tab.

Non pay expenditure is lower than Monitor plan by £24k.

This is being driven by a oncology implants being lower than expected by c.£60k in addition to a number of other small underspends being offset by overspends on drugs of c.£30k and orthotics of £50k.

Monthly Report

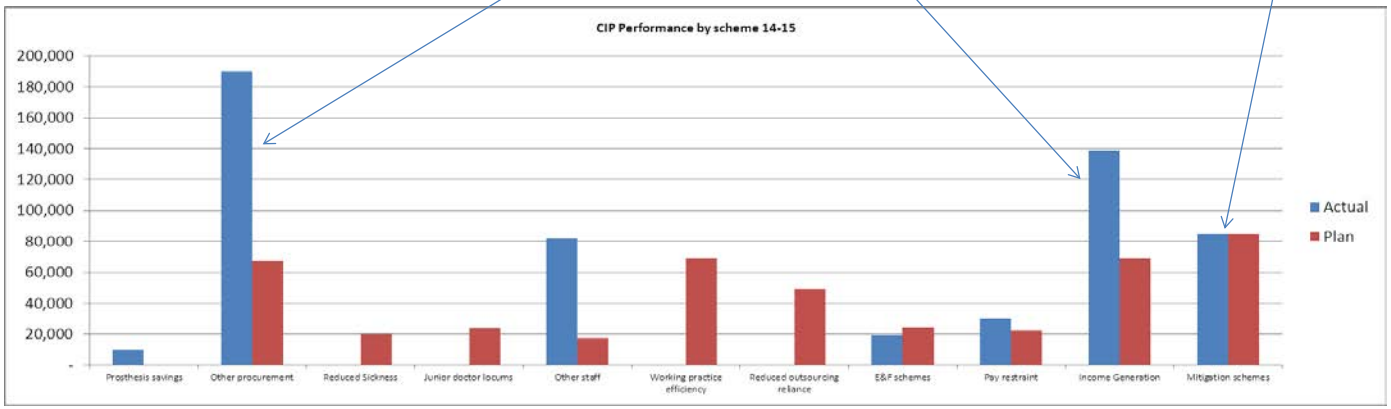
CIP Dashboard as at 30th June 2014

Plan for YTD	£365k
Actual for YTD	£551k
Difference	£186k

Negotiation of better rates on SLAs accounts for the majority of this performance, with £58k of the £186k relating to agreeing a lower PACs service contract, and £47k relating to the Orthotics contract.

A significant proportion of the performance in this area is as a result of the increase in car parking and catering charges.

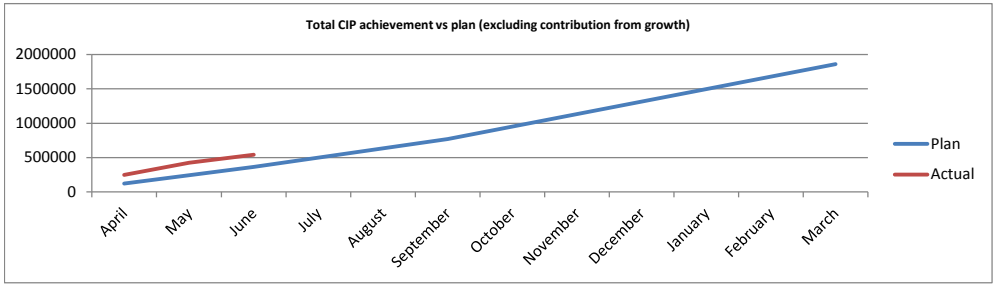
The mitigation CIP recognised to date relates to improvements in cancellations, in addition to pay restraint savings.



Overall performance against plan has remained positive in M3, with the strongest performance in 'other procurement', 'income generation' and the 'mitigation schemes'.

While some other schemes are behind plan, discussions have been taking place in CIP programme board around getting detailed plans in place, whilst also ensuring Quality Impact is assessed appropriately.

85% of schemes have been QIA assessed, with all those in the 'completed' categories having been QIA'd. The Director of Nursing and Governance and the Medical Director held a meeting on the 18th June to challenge the content of the QIAs with the relevant Directorate Managers. Actions from that meeting are currently being progressed, and directorates have been asked to complete their QIAs by 31st July.



Overall performance by category

	£'000
Completed recurrent	333
Completed non-recurrent	123
Completed mitigation scheme	85
Planning/Implementation	375
Scheme Ideas	398
Mitigating Schemes	548
Total CIP target	**1862**

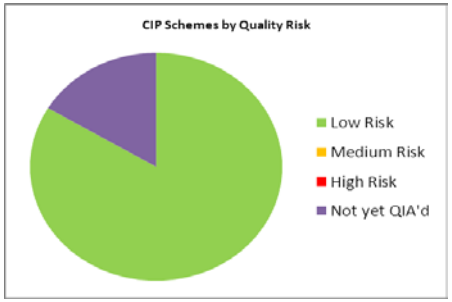
CSS and estates and facilities continue to have the strongest performance to date in terms of completed schemes, with theatres still having the largest unidentified balance.

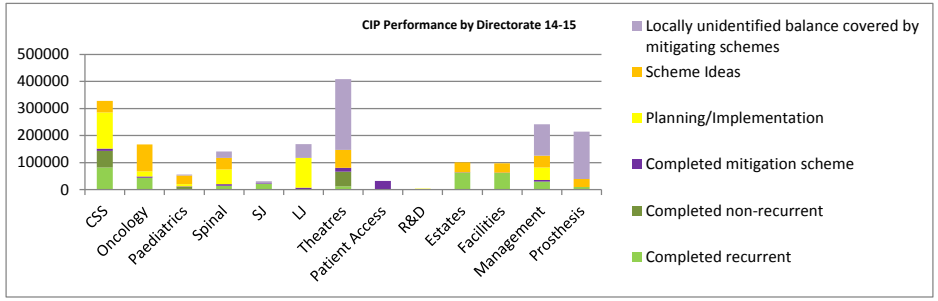
Management are still working with the Directorates to encourage local target delivery. In conjunction, the Trust has identified a number of Trust wide schemes which it is actively pursuing to identify further savings.

Such schemes include;
- reducing cancellations;
- savings on prostheses; and
- reduced reliance on outsourcing to facilities such as West Heath.

Where Directorates have not been able to meet their targets, these 'mitigating' schemes will be used to ensure that the Trust meets its overall CIP target for the year.

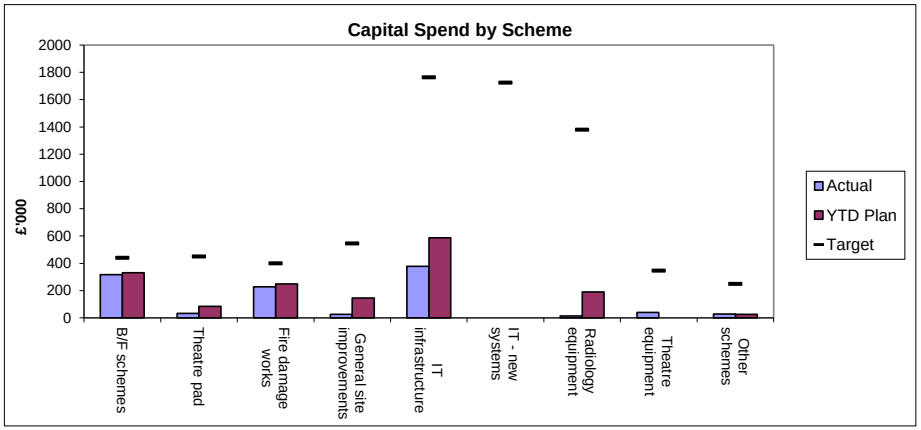
The finance department are working on methods of accurately measuring performance against these schemes. To date, performance against the pay restraint and reduced cancellation schemes have been able to be measured and recognised.





Quarterly Report

Quarterly finances as at 30th June 2014



Capital spend is lower than plan largely due to equipment and building works in relation to the mobile scanner.

Although works on the site commenced in July, there has been some slippage. However, all works are expected to be completed in year and on budget.

IT infrastructure is also showing an underspend due to the timing of invoice receipts.

The radiology spend to date has been in relation to the building works which are underway on the mobile MRI pad. The underspend is due to the plan assuming that the digital X-ray machines would be purchased in Q1. These will actually be on site in August.

The remaining underspend is in relation to general site improvements. This is made up of a number of smaller areas, with lifts having the largest underspend. This is due to slippage as a result of the lifts taking longer to procure than expected. They are expected to now be purchased in Q2.

It is still expected at this stage that the funding allocated will be fully utilised within the year. However, Monitor expects capital spend to be within a 15% tolerance of plan. The current spend is less than 85% of the plan at the end of Q1, and as a result, a capital reforecast will be required to be submitted as part of the Q1 return. This will update the phasing of the spend in line with current expectations.

Theatres has the largest overspend at present (£297k, with paediatrics having the biggest underspend (£40k).

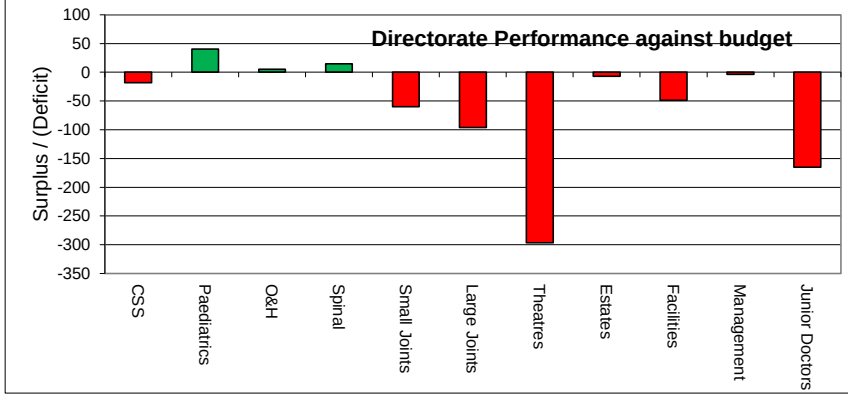
The theatres overspend is driven largely by individual overspends against anaesthetists (£62k), theatres main (£51k) and HDU (£67k). The latter two overspends are driven by the use of agency.

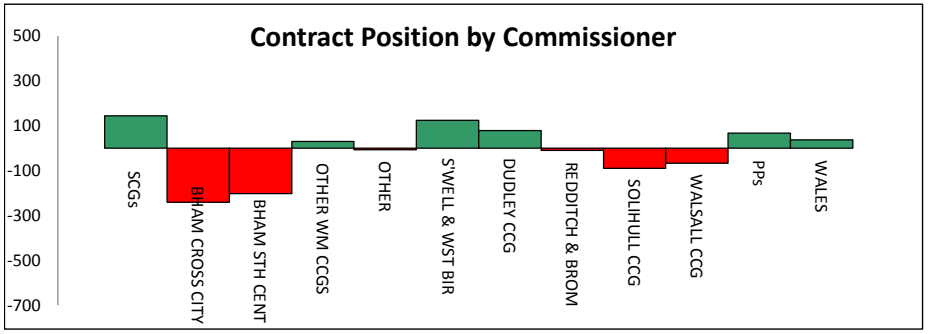
Small joints also has an overspend (£60k), which is driven by spend on ADHs. Work is ongoing to measure what aspect of this overspend is as a result of increased activity.

The overspend in Large Joints (£96k) is due to a number of factors; a £43k overspend on junior doctors as a result of using locums to cover vacant Clinical Fellow posts, in addition to overspends on a number of wards.

The facilities overspend of £49k is due to overspends on domestics, catering and portering. A review of rotas is currently being undertaken.

Finally, there is also a significant overspend against Junior Doctors of £165k.





There is mixed performance against contracts at present.

The largest overperformance is with Specialist Commissioners (£145k), which is predominantly in relation to increased reconstructive procedures and soft tissue sarcoma work.

The largest underperformances are with Birmingham Cross City (£241k) and Birmingham South Central (£202k). These are largely due to lower than expected hip and knee surgeries, which is in line with the underperformance in Large Joints and Oncology Arthroplasty.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th July 2014 **Enclosure:** 7

DIRECTOR LEAD:	Helen Shoker, Director of Nursing & Governance
AUTHORS:	Lisa Pim, Interim Deputy Director of Nursing & Governance Alison Braham, Governance Manager
SUBJECT:	Patient Quality Report – June 2014

SUMMARY

This paper provides an update on patient quality, safety and experience activity during June 2014 and sets out the 2014/15 national, regional contractual and ROH NHSFT quality standards.

The quality of care we deliver, our patient's safety and their experience remains a high priority for the organisation and it is anticipated this report will assist the Trust Board in bringing together key quality issues for debate, assurance and information.

Proposed areas for future reporting:

- More detailed information on safeguarding adults and paediatrics including types of referrals made.

Key areas of note this month:-

- CQC Intelligence monitoring report – This replaces the former CQC Quality Risk Profiles. The latest report received indicates two areas as an amber risk relating to staff sickness in two areas, see below:
  - Proportion of days sick due to stress in the last 12 months (01-Apr-13 to 31-Mar-14)
  - Proportion of days sick in the last 12 months for other clinical staff (01-Apr-13 to 31-Mar-14)
- There were 3 patient deaths during this month.
- To date, the majority of falls have resulted in no harm or low/minor harm; however one of the falls sustained in June has resulted in the patient sustaining moderate harm, (Fractured distal radius).
- Public and Patient Services in collaboration with Ward 11 collect Friends and Family data on all children admitted to the Trust, including those who are under the age of 16. Themes identified include, children feel they are kept up to date with progress, their pain is well controlled and they would like more written information.
- There were 3 Grade 2 Avoidable Pressure Ulcers noted in June. All Pressure Ulcers occurred on the same ward.

RECOMMENDATIONS

The Trust Board are asked to:

- **discuss** the Patient Quality Safety and Experience report
- **identify** areas of risk requiring further assurance
- **Note and accept**

1 PATIENT SAFETY

REPORTING REQUIREMENT:
National Incident Reporting Requirement & Quality KPI Contractual Requirement

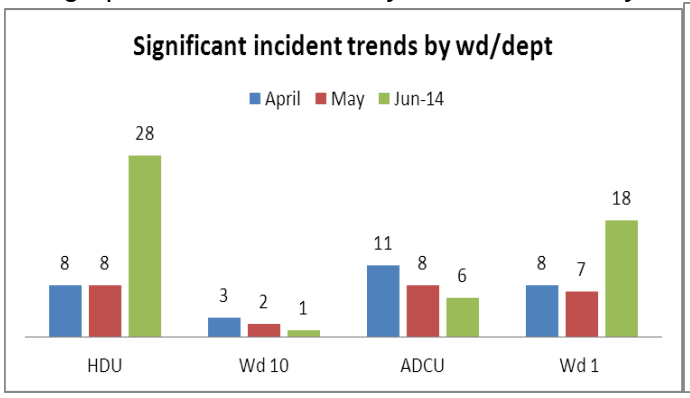
1.1 Serious Incidents - June 2014
There were 2 Serious Incidents reported during June 2014.
Appendix 1 outlines details of all current open Serious Incident investigations.

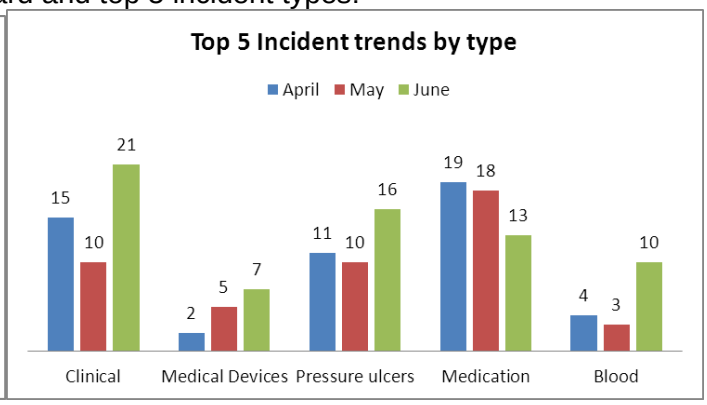
1.2 All other incidents requiring an investigation
4 additional incidents were reported that subsequently required an RCA investigation to be undertaken (See Appendix 2).

1.3 Deaths
There were 3 Patient deaths reported in June 2014, details are as follows:

- An expected death of a terminally ill oncology patient. The patient was under the care of the ROH prior to death and has since been referred to the Coroners.
- One patient was reported as having attended for an injection by an Extended Scope Practitioner (ESP), and died two days later. This was referred to the Coroner who was has since confirmed that the injection performed at the ROH did not detrimentally impact upon the patient's health and unfortunate death.
- Following treatment at the ROH on ward 2 (Large Joints) a patient died 20 days post-discharge from a Deep Vein Thrombosis (DVT). An investigation is currently being undertaken.

1.4 Incident trends
A total of 196 incidents were reported during June, compared to 149 incidents reported during May.
The graphs below indicate key incident trends by ward and top 5 incident types:





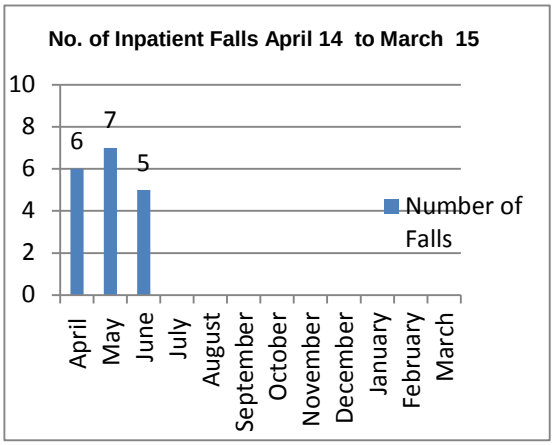
1.5 CQC Intelligence monitoring
The latest CQC Intelligence monitoring report highlights the following two areas as an amber risk relating to staff sickness in two areas:

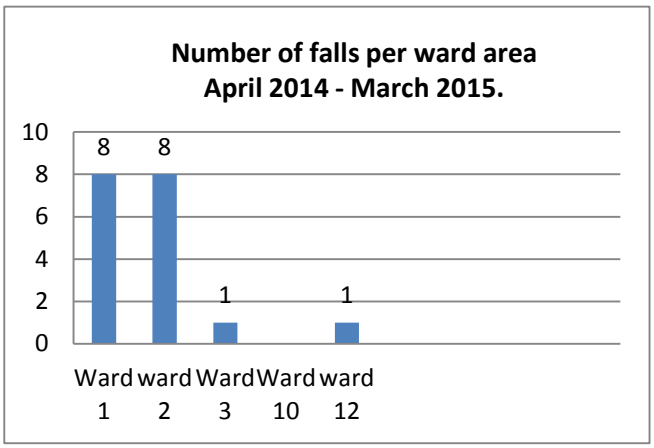
- Proportion of days sick due to stress in the last 12 months (01-Apr-13 to 31-Mar-14)
- Proportion of days sick in the last 12 months for other clinical staff (01-Apr-13 to 31-Mar-14)

There has been one risk improvement since the March Intelligent monitoring report, this relates to **PROMs EQ-5D score: Knee Replacement (PRIMARY).** This is no longer highlighted as a risk on the July report.

1.6 Falls
There have been **5 (adult)** inpatient falls reportable incidents for the month of June 2014**.** 2 falls incidents are currently under investigation and 3 falls have been deemed unavoidable.
All reportable falls have been individually reviewed.

- 2 reportable falls were sustained by the same patient; 1 of which has resulted in moderate patient harm.
- 3 of these incidents occurred in patients who were suffering with delirium/confusion
- All 5 falls had the correct nursing metrics in place as per each patient's individualised plan of care





Falls Risk Assessments & Care Planning - Quality indicator requirements

Qu1.	Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	June 2014	100%
Qu2.	If the patient is identified as high risk is a care plan in place? Yes/ N/A	June 2014	100%
Target = 91% compliance per ward			

Actions for Improvement:

- Funding has been approved for 10 high-low bedframes
- June 19th saw our first Falls Awareness Day in collaboration with Birmingham Age UK.
- Work has commenced on the Throne Project within wards 12, 1 and 2.
- Ward 1 will pilot the "Tuft Box" from August

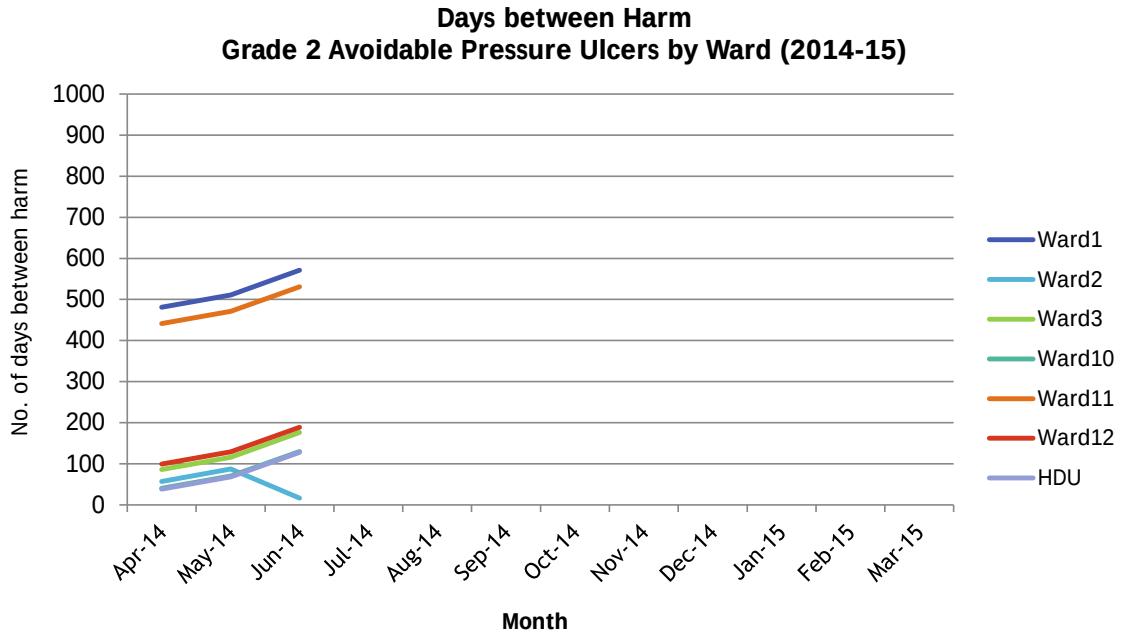
1.7 Infection Prevention and Control and Tissue Viability

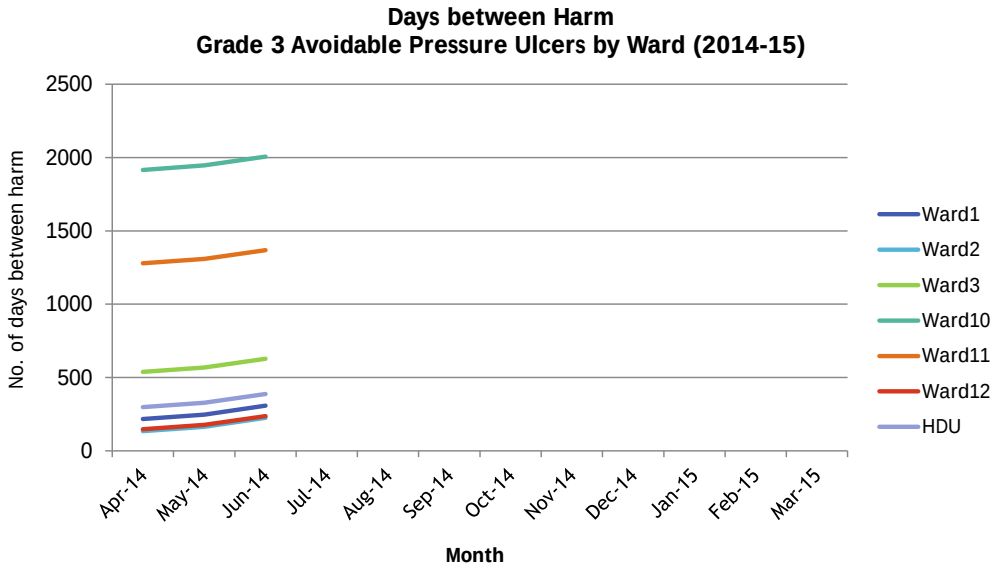
REPORTING REQUIREMENT:
Contractual Quality KPI requirement, National Safety Thermometer CQUIN and National Reporting requirement.

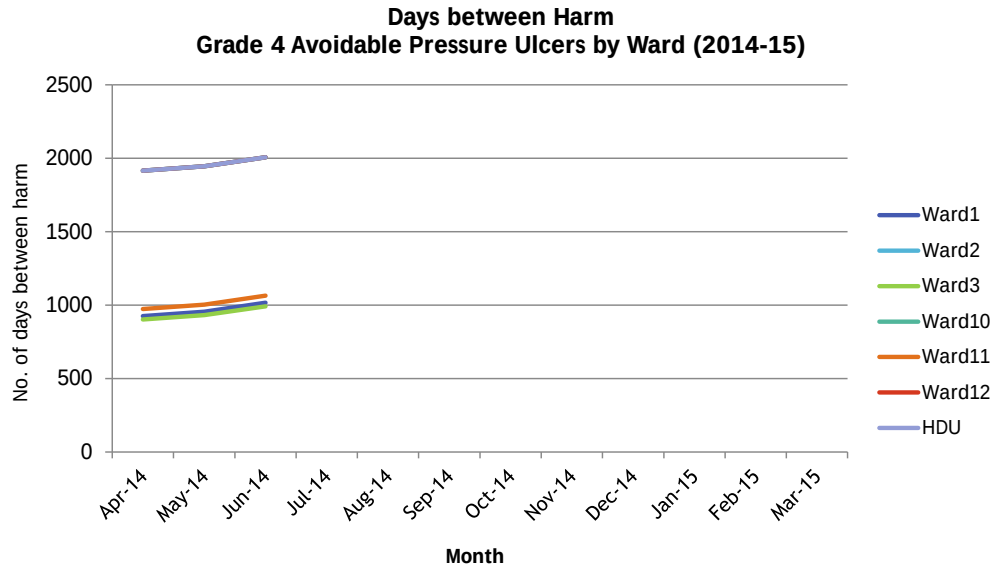
CQUIN

1. Safety Thermometer

A database has been developed to record days between harm by ward, a new requirement of the scheme.







This information along with the root cause analysis and patient harm meetings are utilised to ensure practice is scrutinised and improved wherever possible.

2. SSI surveillance

The Trust is about to extend surveillance for arthroplasty patients from 30 days post operatively to 1 year as part of a locally agreed CQUIN. A clear protocol has been developed for the surveillance criteria. The audit criteria utilised is that produced by Public Health England to enable benchmarking to take place with other Trusts. Deviation from this criteria will make benchmarking inaccurate, therefore the standard protocol will be utilised.

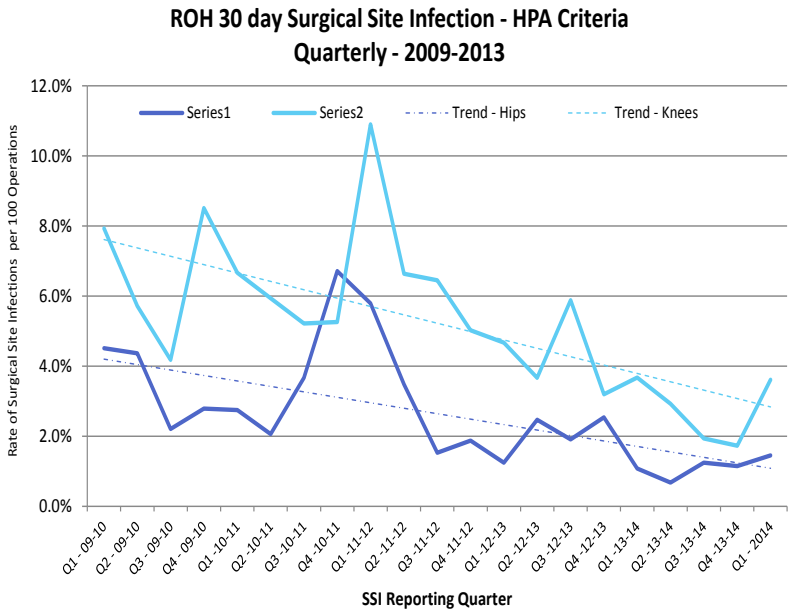
Tissue Viability

There were 3 avoidable pressure ulcers (grade 2) during June, all cases occurred on Ward 2 and have been investigated. The actions required by the ward team relate to the need for early intervention - to escalate patients onto the correct type of mattress, or implement the correct use of equipment as soon as any issues with tissue integrity is noted. Poor documentation can lead to pressure ulcers being deemed avoidable if there is no record of the appropriate action being taken at the appropriate time.
New pressure ulcer prevention documentation has been well received. Although reported audit results are very positive, spot checks of documentation indicate some inconsistencies in documentation.

Nutrition

Quarter 1 (April – June 2014) the results for completion of MUST within 6 hours of admission demonstrate that Wards 3, Private Patients and ADCU fall below the standard. The Matron and Senior Sisters of these areas should ensure this does not continue into quarter 2.

Surgical Site Infection
A report investigating a possible cluster of infections within Arthroplasty was discussed at the Infection Control Committee in May along with a further review of a possible cluster of spinal infections. Neither review identified any link between organism, theatre, surgeon or other personnel. The spinal service has produced a thorough action plan following the recommendations made by IPC in the report. Feedback from Arthroplasty is awaited.
A significant reduction in SSI has been seen at ROH over the past 5 years with a reduction of 65% in both primary Hips and Knees, the following graph details the downward trend:



A spike was noted in Jan – March 2014 – this was carefully investigated and no obvious cause has been identified. Close monitoring has continued and the following Quarter (April – June) has seen a reduction, although the 30 day data for that period will not be completed until the end of September.

Exception Report
The following indicators have not been met:
Indicator: Percentage of relevant emergency cases MRSA screened.
MRSA screening for all emergency patients has been in place at ROH for over a decade.Trust policy states that all emergency admissions must be screened for MRSA, a significant amount of emergency admissions were screened on admission during June although the target was not met.
Indicator: IPC Training Programme – staff attendance
Learning and development monitor the attendance of all staff at mandatory training and attendance for May was at 81%.

1.8 Safeguarding Adults and Children

Contractual Quality KPI requirement and National Reporting requirement

The information outlined below provides an update of Adult and Children Safeguarding Training as of June 2014:

Adult Safeguarding Training

- Level 1 Safeguarding Adults (includes SG, MCA, DoLs, Learning Disabilities) MC 86.95%, DOLS 87.5%
- Level 2 – Enhanced (External provider) – 88%
- Level 3/4 – For Lead /Named Nurse & Doctor = 75%

Key learning: Application and recording of capacity assessments formally in medical/nursing notes, and evidence reasonable adjustments clearly.

Children Safeguarding Training

- Children's Level 1 (Basic Awareness) - 100%
- Level 2- Enhanced Child Protection – 91%
- Level 3/4 – For Lead and Named Nurse/Doctor – 100%

1.9 Patient Safety Alerts

REPORTING REQUIREMENT:
National Reporting Requirement & Quality KPI Contractual Requirement

A total of 13 Patient Safety alerts were closed during May and June 2014, requiring no further action by the ROH. The following alert was closed with all actions completed.

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
NHS/PSA/W/2014/009	Risk of using vacuum and suction drains when not clinically indicated	NHS England	06-Jun-14	Action Completed	04-Jul-14

Patient Safety alerts currently being assessed for relevance – June 2014

Reference	Alert Title	Originated By	Issue Date	Response	Deadline
NHS/PSA/W/2014/012	Risk of harm relating to interpretation and action on PCR results in pregnant women	NHS England	23-Jun-14	Assessing Relevance	31-Jul-14
MDA/2014/023	Adaptors for Shelfpak humidifier and Aquapak sterile water. Manufactured by Teleflex Medical.	MHRA Medical Device Alerts	17-Jun-14	Assessing Relevance	17-Sep-14
EFA/2014/002	E-cigarettes, batteries and chargers	DH Estates and Facilities	16-Jun-14	Assessing Relevance	08-Sep-14
MDA/2014/022	Central venous catheters: various pressure injectable, multi-lumen and multi-lumen.	MHRA Medical Device Alerts	12-Jun-14	Assessing Relevance	10-Jul-14
NHS/PSA/D/2014/010	Standardising the early identification of Acute Kidney Injury.	NHS England	09-Jun-14	Assessing Relevance	09-Mar-15

1.10 WHO compliance
REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement
The total number of WHO Checklists that met the 100% Standard for patient safety was 97.88%. **This fails to meet the expected contractual requirement of 99%. Quarter 1 Directorate reviews will explore this and seek assurance of achievement in the coming months.**

1.11 CQUIN Schemes
REPORTING REQUIREMENT: National and Local CQUIN Requirement

Please find below a table indicating this year's CQUINs and their financial value. All evidence for Q1 has been submitted to the Commissioners within prescribed deadlines. No immediate concerns have been raised for Q1 achievement.

CCGs	% of 2.5%	Weighting within Category	Financial Value
National	**0.500%**		**£ 222,599**
Friends and Family Test (FFT)	0.167%	33%	£ 74,200

NHS Safety Thermometer	0.167%	33%	£ 74,200
Dementia	0.167%	33%	£ 74,200
Local	**2.000%**	**100%**	**£ 890,394**
Telephone follow up for Pain Management Injections	0.400%	20%	£ 178,079
AHRQ Patient Safety Culture Survey	0.400%	20%	£ 178,079
Reviewing the patient Journey	0.500%	25%	£ 222,599
Conservative and exercise treatment for knee conditions	0.400%	20%	£ 178,079
SSI Surveillance - Telephone follow up	0.300%	15%	£ 133,559
Total CQUIN Value	**2.500%**	**100%**	**£ 1,112,993**
£ 1,112,993			

Specialised Services	% of 2.5%	Weighting within Category	**Financial Value**
National	0.500%		**£ 89,698**
Friends and Family Test (FFT)	6.67%	33%	£ 29,899
NHS Safety Thermometer	6.67%	33%	£ 29,899
Dementia	6.67%	33%	£ 29,899
Local	2.000%		**£ 358,792**
Highly Specialised (PMBTS) Network Audit Workshop	20.000%		£ 89,698
Specialised Spinal Dashboard	5.000%		£ 22,425
Specialised Orthopaedics Dashboard	5.000%		£ 22,425
Specialised Orthopaedics Network MDT	50.000%		£ 224,245
Total CQUIN Value	2.500%		**£ 448,489**
£ 448,490			

2 PATIENT EXPERIENCE

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

2.1 PALs contacts, Complaints and Compliments

Directorate	PALS	Complaints	Compliments
Clinical Support	26	3	17
Corporate	12	0	18
Small Joint	7	0	7
Large Joint	19	2	120
Oncology	12	0	27
Paediatrics	6	0	31
Spinal	22	1	115
Theatres	7	1	88
Total	**111**	**7**	**423**

PALS contacts this month was 111 - up on last month's volume of 85. This is an increase of 26 or 30% however we do not believe this should be a cause for concern as the volume of formal complaints has reduced in month by 22%. Of the 111 contacts, 28 were general enquiries (30%) and 83 were concerns (70%).
Greatest areas of concern were:

- Parking – lack of space, charges, received ticket here onsite and on Bristol Road
- Across most directorates – what's happening with care and treatment plans; lack of info/clarity; chasing update and progress
- Unsure of who to ask for advice - clinical concern or queries post-surgery and discharge

Highest volumes of general enquiries were:

- Medical records
- PP enquiries

The number of complaints received this month is 7 down from 9 last month, a decrease of 22%.
Areas of concern:

- Poor service and delays to treatment x 3 (1 each for spinal, x-ray, and pain management)
- Attitude/Approach of individual x 2 (Anaesthetist and OPD receptionist)
- Ward experience x 2 (different wards and not able to categorise as simply nursing care as multi-factorial)

% of complaints resolved within timeline was 82% (9/11) against KPI of 80%.
Average length of time to close complaints due in June was 43 days reduced from last month's average of 46.

The number of compliments received this month is 423, slightly down from 436 last month, a decrease of -13 or 3%.

2.2 Patient Friends and Family Test

The Score for the patient Friends and Family Test for June is 81 with a 40% return rate. This meets the CQUIN requirements for the month. The detractor rate for the month is 2.5% which is below the national average.
The test is reliant on volunteer activity to ensure the compliance is met. Work will continue to be undertaken with wards and departments to ensure that greater ownership within areas is achieved.
New national guidance was published in July 2014, we are undertaking analysis to understand the implications for the ROH NHSFT, however early indications are that we already undertake best practice within FFT.
The Director of Nursing is meeting her counterpart from The Royal National Orthopaedic Hospital NHS Trust to explore how they have achieved consistently high levels of FFT promoter and return rate.

2.3 Child Patient Experience

Public and Patient Services in collaboration with Ward 11 collect Friends and Family data on all children admitted to the Trust, including those who are under the age of 16 (currently not a national requirement) The June FFT Score for Ward 11 (under 16) is 93 (compared to a Trust-wide score of 81).
Information from the comments section are evaluated and sent to the Senior Sister and Matron in the same manner as the national requirement scoring.
In addition, patient satisfaction surveys are conducted using a child friendly patient experience data collection method, called Fabio Frog. The surveys and points at which questions are asked is currently being reviewed by the Matron, the Senior Sister and the Public and Patient Services Manager.
The general themes for July are as follows:

- Children feel that their pain is well controlled
- Children feel that what is happening is clearly explained to them
- Children would like more written information that is written specifically for them.

2.4 LITIGATION

REPORTING REQUIREMENT: ROH NHSFT Good Practice

June 2014 update - New Cases

Clinical Negligence Cases: potential claims			
Ref	**Date of Incident**	**Details**	**Directorate**
T451	Dec-12	Patient told there was a 'problem with scrub sinks' on day of surgery - subsequently developed serious infection.	theatres/ paeds (adult patient)
T450	2008 to present	Surgical outcome - inserting screws in neck & spine	spinal
T449	Mar-13	THR, bone fragment inside knee, further procedure required	large joints

Progress with Existing Cases

A formal Letter of Claim was received in the following case

Ref	**Date of Incident**	**Directorate**	**Description**
T420	Mar-13	large joints	surgical outcome - THR, dislocation, revision surgery

Closed Cases

Clinical Negligence Claims – liability admitted				
Ref	**Date of incident**	**Directorate**	**Details**	**Settlement**
T360	Jan 2013	theatres/ anaes	awareness under anaesthesia	damages £10k; claimant costs £19k; defence costs £621
T375	Dec 2012	large joints	nursing care – pressure sores, fluid balance, catheterisation, mobilisation, nutrition	damages £10k; claimant costs £25k; defence costs £5.6k
T406	June 2008	oncology	retained suture in chest drain causing infection, delayed recovery and scarring	damages £7k; claimant costs £13k; defence costs £2k
T257	Nov 2008	large joints	acetabular component failed requiring further surgery during which sciatic nerve damaged leading to left foot drop	damages £135k; claimant costs £83k defence costs £23k

Coroner's Inquests: None

2.5 Single Sex Compliance

REPORTING REQUIREMENT: National Reporting Requirement & Contractual Reporting Requirement
There were no single sex compliance breaches during June.

2.6 Patient Reported Outcome Measures (PROMs)

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice
During June the 90% target compliance rate for completed questionnaires for both hip (99.0%)and knee (98.4%) replacement surgery was achieved. The figures are based upon the actual theatre activity according to ORMIS and are checked against the patient details in PAS.

2.7 National Joint Registry (NJR) Update

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice
NJR Compliance Progress June 2014

	Jan 14	Feb 14	March 14	April 14	May 14	June 14
% Compliance	88%	92%	90%	89.8%	91%	85%

Note: All missing/incomplete forms are sourced and sent to be completed by the relevant clinician.

NJR Consent Progress January to June 2014

	Jan 14	Feb 14	March 14	April 14	May 14	June 14
% NJR Consent	29%	45%	51%	52%	76%	61%
% NJR Consent after retrospective follow-up letter	73%	75%	76%	N/a	N/a	N/a

Note: All patients not consented through POAC are written to retrospectively. Following the start of a new process in POAC for NJR patient consent, starting in June, the whole process for NJR process will be re-audited in late July**.**

3. EFFECTIVENESS OF CARE

3.1 Safety Thermometer

REPORTING REQUIREMENT: National Reporting Requirement

2014-15		April 2014	May 2014	June 2014	Quarter 1
Pressure Ulcers	Old	2.02%	0.98%	2.06%	1.69%
	New	0%	0%	0%	0%
Falls		4.04%	0%	1%	1.68%
Total Harm Free		89.09%	99.02%	96.91%	95.01%

3.2 Matron KPI
Reporting Requirements - ROH NHSFT Good Practice

Large/Small Joints Directorate
Ward 2 – Amber overall rating. Slight decrease in performance noted due to pressure ulcers.

Increased levels of sickness and decrease in completed appraisals. There has been 1 complaint. There have been 4 falls and 3 pressure ulcers in this month.

Ward 10 - Green overall rating. Good performance. Low incident reporting numbers noted.

Ward 12 - Amber overall rating. Slight decrease in performance from May noted. Poor attendance at link meetings noted, and some decrease in safety checks.

Theatres/Anaesthetics and Critical Care Directorate

HDU - Amber rating overall. Slight reduction in performance is noted. Small decrease in mandatory and resus training numbers. No observations of care or patient stories undertaken. Good levels of incident reporting. 4 medication incidents noted, and some decrease in safety checks also observed.

ADCU – Green overall rating. Sustained good performance. Some reductions in safety checks noted. Increase in sickness levels also noted.

CCO - Amber overall rating. Sustained performance.

Theatres - Amber overall rating. Sustained performance. Sickness levels are increasing in some theatres. Appraisal figures are decreasing slightly in some theatres. Safer use of Insulin E Learning remains static at red. Low levels of incident reporting noted in some theatres. Theatre 2 KPI was incomplete.

Support Services Directorate

OPD - Green overall performance. Improved performance noted this month. Hand Hygiene requires improvement.

ROCS - Green overall performance. Sustained good performance. Manual handling training has moved into amber this month.

POAC - KPI not completed at time of writing report

Pain – KPI not completed at time of writing report.

Spinal Directorate

Ward 1 remains at an overall amber rating this month with sustained performance noted. Mandatory training figures are improving month on month. 1 medicines incident reported this month.

Paediatric Directorate

Ward 11 has sustained an amber rating but looks to be moving into overall green. Sickness levels are decreasing. There are low levels of incident reporting in this area.

Oncology Directorate

Ward 3 remains as an overall amber performance, with slightly improved metrics in certain areas. VTE/Manual handling is noted as red, as well as poor discharge lounge utilisation.

APPENDIX 1

1.1 New Serious Incidents Requiring Investigation (SIRI) - June 2014

Ref	Incident date	Date raised to commissioners	Description	Level of harm (prior completion of RCA investigation)	Directorate	Progress	Final RCA due
12746 STEIS 2014/18047	10/04/14	03/06/14	Grade 3 pressure ulcer	Minor harm	Paediatrics	Investigation underway	05/08/14
13017 STEIS 2014/19042	09/06/14	11/06/14	Fracture following fall	Moderate harm	Large Joints	Investigation underway	13/08/14

1.2 Ongoing/Submitted SIRIs:

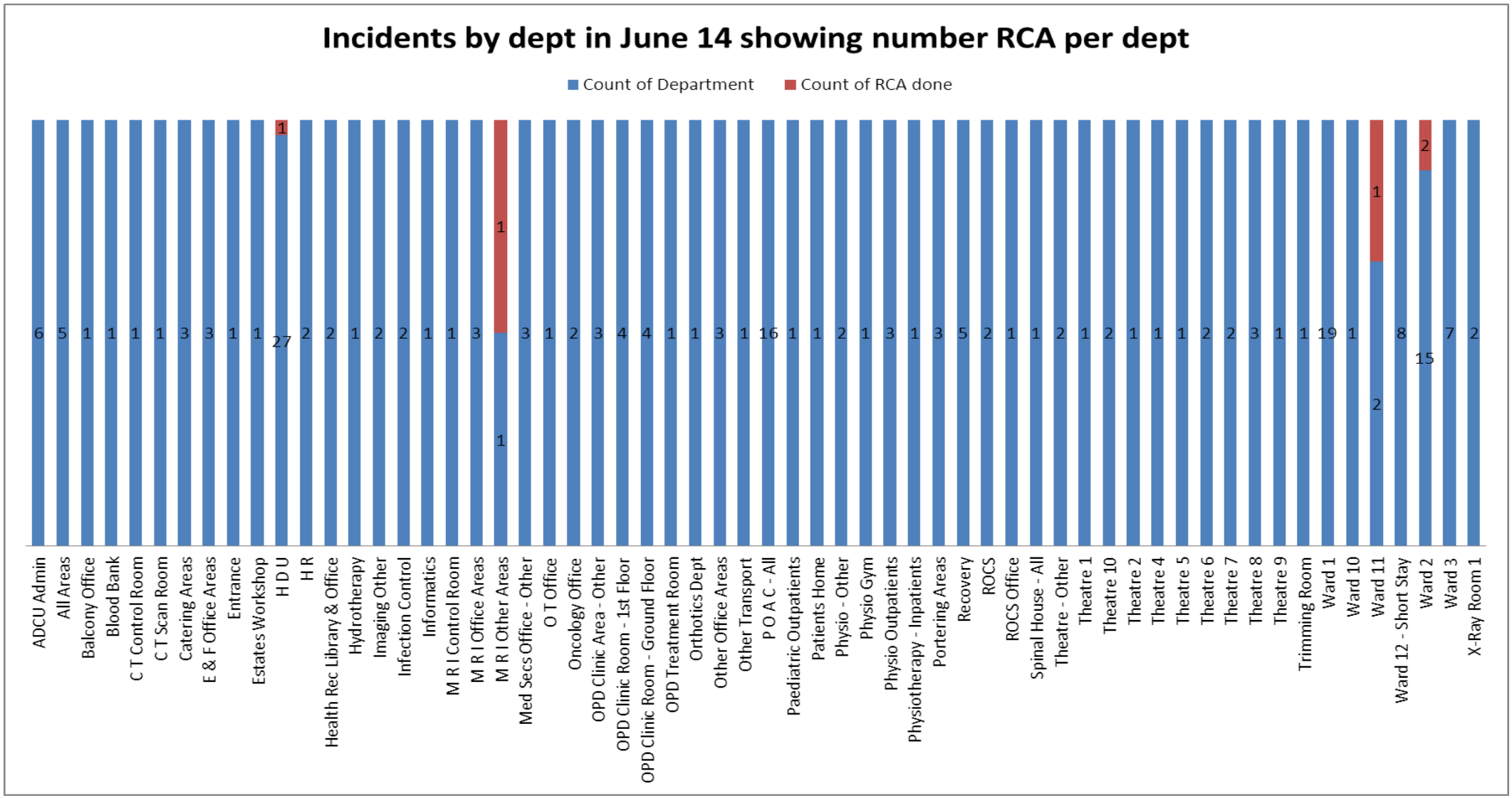
Ref	Incident date	Description	Directorate	Progress/ date submitted	Date report due
12412 STEIS 2014/5869	11/02/14	Pt transfer	Theatres & Anaesthetics	Investigation underway..	It is anticipated the RCA investigation will be completed and submitted by mid-July 2014.
12645 STEIS 2014/10793	28/03/14	Hickman line issues	Theatres & Anaesthetics	Report submitted.	10/06/14
12640 STEIS; 2014/10893	28/03/14	Wrong side Anaesthetic block	Theatres & Anaesthetics	Report submitted.	11/6/14

Quarterly summary of findings from SIs

Ref	Incident date	Description	Directorate	Date report due/submitted	Outcome of review
12383 STEIS 2014/4895	10/02/14	Confidentiality breach	Corporate	16/4/14 (submitted 16.4.14).	**Lessons Learned/Findings** • No formal registered audit or information sharing agreement. • No risk of identity theft and no harm to patients. • Procedures and guidance have been implemented to avoid a reoccurrence.
12532 STEIS 2014/8553	10/03/14	Delayed diagnosis	Oncology	20/5/14	**Lessons Learned/Findings** • Consultant Radiologists to agree a pathway for escalation of abnormalities on x-rays which is robust and ideally electronic. • Trust Policy for the Management of clinical diagnostic tests/screening procedures awaiting agreement and dissemination.
12645	28/03/14	Hickman line	Theatres/Anaesthetics	10/06/14 (submitted on time).	**Lessons Learned/Findings** • Staff to be competency assessed and undertake reflection. • Ensure that all pharmacy endorsements are clear. • Further review needs to take place as to whether Hepsal should be available as stock on HDU as well as heparin 1000units/ml. HDU is the only ward that stock Heparin 1000units/ml as the only ward where pts requiring heparin infusions will be treated. • Availability of TEG equipment needs to be reviewed
12640 STEIS; 2014/10893	28/03/14	Wrong side Anaesthetic block	Theatres	11/6/14 (submitted on time).	**Recommendations:** • Amendment, presentation and re-circulation of the ROH SOP on Wrong Side Block. • The Standard Operating Procedure (SOP) wording should be amended to make the calling 'out loud' of the safety checks explicit.

Appendix 2:

Please note, 1 RCA was reported as an incident in a previous month and is not included in the June figures within the table below



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Board: 30th July 2014 **ENCLOSURE NUMBER: 8**

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**Safe Staffing – Summary - June 2014**

SUMMARY

In June there was ONE incident reported relating to safe staffing.
For a second month an incident relating to a single shift of HDU OOH bleep holder was raised- Incident Number 13085.

Matrons are confident that safe staffing is maintained.

Twice weekly Matron/Senior Nurse Quality Debriefs continue.

ROH NHSFT completed the NHS England Safe Staffing UNIFY data uplift on for the month of June on time .

Safe Staffing data has been published for all NHS providers within NHS Choices website since May 2014. For a second month ROH NHSFT has received a GREEN rating.

The Safe Staffing tool continues to be completed by Senior Sisters, checked by Matrons and submitted to the DoN on a weekly basis.

The data collection methodology is now embedded, reporting at ward level commences in July.

IM&T are supporting the transfer of paper based, labour intensive mechanism to an electronic solution in late summer/early autumn.

The action plan shows good progress for the organisation against the national recommendations. Appendix One.

IMPLICATIONS

Patient safety and experience, Staff satisfaction, Organisational reputation

RECOMMENDATIONS

Trust Board asked to:-

- Note the continued progress made by ward teams, Matrons and project lead
- Recognise and acknowledge the importance to ROH NHSFT of the national guidance in regards to our patient welfare and future strategy
- Be assured

APPENDIX ONE – EMT & Trust Board July 2014

Safe Staffing – Ward Review- Action Plan

Key - Level of Assurance	Colour
Completed	
No delays, expect to complete on time	
Slight delays, complete on time	
Slight delays, delayed completion	
Significant delays, delayed completion	
Activity not yet commenced	

Subject& Recommendation Reference	NQB Ref No CQC Ref	Lead	Current Position	Review Date	Timeline for delivery	Level
The Board receives a report every six months on staffing capacity and capability which has involved the use of evidence based tool. **This report:** **• Draws on expert professional opinion and insight into local clinical need and context** **• Makes recommendations to the Board which are considered and discussed** **• Is presented to and discussed at the public Board meeting** **• Prompts agreement of actions which are recorded and followed up on**	**1,3,7** **CQC A**	**HS Matron**	**Board received paper in May** **EMT and CGC receive monthly reports**	**Monthly**	**Six Monthly**	
Clearly display information about the nurses present and planned in each clinical **setting on each shift. This should be visible, clear and accurate.** **Significance of**	**8** **CQC B**	**HS SL Matron**	**Staffing boards on display within wards in place, stating staff on duty and Nurse in Charge** **Posters of staff uniforms displayed on wards** **Entrance to ward notice boards in place** **ROH standard format of ward entrance notice boards designed by Matrons/Senior Nurses**	**~~June~~ August**	**~~June~~ July**	

different uniforms and titles used. To summarise, the displays should: • Be in an area within the clinical area that is accessible to patients, their families and carers • Explain the planned and actual numbers of staff for each shift (registered and non-registered) • Detail who is in charge of the shift • Describe what each role is			**ROH ward entrance notice boards data trial on Ward 3, aim for all wards by end of July**			
The Board receives an update containing details and summary staffing • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap • Evaluates risks associated with staffing issues • Seeks assurances regarding contingency planning, mitigating actions and incident reporting • Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly area of the website	**1,7 CQC C**	**HS**	**EMT and CGC paper to July Committees Twice weekly Quality Debrief continues Active shift management by Senior Sisters, Sisters and ward staff Bank and Agency use report received each month**	**May Monthly**	**Monthly ongoing**	
The Trust will ensure that the published monthly update is available to the public via not only the Trust's website but also the relevant	**1,7 CQC A, D**	**HS WP Comms**	**Report to be published following May Trust Board UNIFY data uplift completed in July for June data with assistance from Informatics Date to be published on NHS Choices, ROH NHSFT rated as Green**	**Monthly**	**June**	

hospital(s) profiles on NHS Choices.			**for second consecutive month Website publication to be developed**			
The Trust: • Reviews the actual versus planned staffing on a shift by shift basis • Responds to address gaps or shortages where these are identified • Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care	**2 CQC E**	**Matron HS**	**Wards & HDU completed daily acuity and staffing tool, commenced 1st April Project Manager support for data collection, inputting and analysis (WP) Weekly analysis Bi weekly Quality Debrief continues Matrons and Senior Sisters proactive management of each shift daily Two safe staffing incidents reported in May, HDU GREEN rating Bank and Agency monthly report provided to DoN/Matrons showing fill rate and RN/HCA usage**	**Bi weekly**	**April**	
Safe Staffing Policy, to include escalation process	**N/A**	**HS**	**Draft policy completed in April Circulation and comments through May & June to stakeholders To EMT and Trust Board in August for approval**	**June**	**~~July~~ ~~August~~**	
Ward based safe staffing risk assessments	**N/A**	**Matron**	**Safe staffing and minimum staffing levels confirmed**	**Quarterly**	**April**	
Acuity Tool, Safer Nursing Care Tool development	**CQC A**	**HS AG WP**	**Initial development of the tool undertaken in January Trialled by wards March Officially commenced 1st April Feedback from Senior Sisters and Matrons received Refinements to tool undertaken in May Final version commenced use in mid May**	**Monthly**	**June**	
Staff awareness	**N/A**	**HS Matron WP LP**	**National Quality Board report circulated to all Matrons and Ward Teams Nurse Leaders Forum discussions 6C's@ROH events programme commences May EMT and Trust Board monthly reports Audit Committee presentation July and October**	**Monthly**	**Ongoing**	

Quality Debrief	**N/A**	**HS LP Matron AM**	**Bi weekly Quality Debrief continues (commenced January)** **Provides forum to reflect and plan over the week for matters associated with the day to day patient safety/experience and safe staffing** **Summary email sent to all Senior Nurses and DOps** **Provides forum to escalate issues to DoN & DOps**	**Six monthly review of effectiveness**	**Bi weekly**	

HS	Helen Shoker
SL	Stuart Lovack
WP	Wendy Prestage
AG	Alex Gilder
LP	Lisa Pim
AM	Amanda Markall

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30th July 2014 **ENCLOSURE NUMBER: 9**

NAME OF DIRECTOR	Helen Shoker, Director of Nursing and Governance
SUBJECT	EMT Risk Register and BAF Report
AUTHORS	Lisa Pim, Deputy Director of Nursing and Governance; Alison Braham, Governance Manager; Jane Moore, Litigation Assistant and Governance Facilitator

SUMMARY

EMT have taken the following actions this month:-

1. Reviewed the non-BAF risks managed via the EMT committee
2. Reviewed the BAF themes and updates of which no new risk(s) added to the BAF/TRR, Closed risk(s) 29 compliance with CQC outcome 4 (care & welfare of service users), no increasing risks noted and decreasing risk(s) 178 WHO checklist compliance,621 MRI delays,51 Medical records

Trust Board are asked to note the changes in yellow in line with Internal Audit recommendations within both (appendix 1) and the Trust Risk Register progress report (appendix 2).

Work continues to develop the external risks and those of the BAF themes.

The Governance team has reviewed all Directorate Red Risks and a discussion was had at EMT in regards to the mechanism of escalation to TRR and Trust Board. Work shop events are planned in August-October to support learning across the Directorates of how to manage risk, risk registers, TRR and BAF.
The directorate teams were asked to familiarise themselves with the detail of their risk(s) and adequacy of controls with a view to escalating their risk(s) if appropriate or providing assurance that the risk(s) can be managed at directorate level.

I.D	Area	Description
329	X-ray	Outsourced MRI
387	Theatres	Blood traceability
587	Theatres	Old diathermy machine
477	Matron	Drug errors
561	Estates	Theatre 4 compliance with HTM regulations

IMPLICATIONS

Patient Safety, Contractual, Legal, Reputational

RECOMMENDATIONS

Trust Board is asked to:

- Note the paper
- Discuss

BOARD ASSURANCE FRAMEWORK 2013/14 (updated: 14.7.14)

This table maps all Trust-wide high level (red) risks against the 8 new 2013/14 BAF themes. Details of the 8 strategic BAF themes are given on the attached summary sheets.

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
32	Higher than expected rates of 30 day SSI within arthroplasty		16	Medical Director (As DIPC)	Lead Committee				Supporting Committee			
33	Insufficient assurance around robust implementation of infection prevention strategies in theatres.		16	Medical Director (as DIPC)	Lead Committee				Supporting Committee			
27	Inability to control the use of unfunded medical temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2	lack of continuity of patient care; On going locum and agency costs. potential successful banding claims Pre-monitoring exercise has highlighted potential breaches of national New Deal standards.	20	Medical Director	Supporting Committee			Lead Committee		Supporting Committee	Supporting Committee	Supporting Committee
582	Risk of non-delivery of strategic objectives due to poor staff perception of the need for change and ineffective implementation of change in the recent past.	Care for patients that is less than the best; Lack of organisational sustainability	16	Director of Workforce and OD	Supporting Committee					Lead Committee		
7	Re-opened June 2014. Long waiting times for spinal deformity	Risk to patients of deterioration in condition whilst waiting. Increased complaints & litigation. Risk of Financial penalties levied by Commissioners for breach of 52 weeks	12	Director of Operations				Lead Committee				

New or Recently Upgraded Risks July 2014

none

Risks downgraded in last month (to be removed from the BAF): assurance to be sought from Lead Committee(s) that the risk is de-escalated

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			RAG status	Exec Lead								
I.D.	RISK	CONSEQUENCES										
621	New June 2014. Delays in MRI imaging and reporting	potential delay in diagnosis and treatment. Ineffective outpatient consultations . Repeat visits. Potential complaints/claims	12	Director of Operations (changed from Director of Finance)	Lead Committee							
51	Medical Records: Non compliance with Information Governance/ data protection regulations.Retention of records unnecessarily. Insufficient destruction of medical records in line with policy. Mitigation: policy updated with justification for retention of records; policy to follow ratification process	Potential financial penalty due to data protection/IG breaches.	12	Director of Operations	TBC							
178	Poor completion of WHO safety procedure. Mitigation: Working partly in place, reviewing whole process. Daily WHO Audits undertaken and published. Poor Practice highlighted	Patient safety through their their experience of the operating department may be compromised, at the mosts severe a never event may occur	12	Director of Nursing & Governance	Lead Committee							
Risks previously downgraded (to be removed from the BAF): awaiting assurance from Lead Committee(s) that the risk is de-escalated												
625	Spinal database relating to outcomes and CQUINS held in R& T - data corrupted.	Adversely impacts upon delivery of quarter 4 CQUINS report and potential financial loss to Trust	12	Director of Finance					Lead Committee			
636	New June 2014. PAS system contract expires July 2016 - successor arrangements	Threat to delivery of patient services	10	Director of Finance				Lead Committee				
275	Inability to consistently demonstrate learning from serious events/ claims/ complaints is embedded in practice	poor quality patient experience	9	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee		Supporting Committee

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
269	Failure to deliver activity targets	creates a lower in year surplus and a lower base to contract from in 2013/14 thus shrinking the organisation. Lack of ownership at Directorate level Processes not working efficiently enough to generate required throughput Lack of consultant job plan flexibility Poor activity management on a day-to-day basis	8	Director of Operations (changed from Director of Finance)	Supporting Committee			Lead Committee				Supporting Committee
12	Contractual KPIs: Trust is required to sign up to SLA contracts with our material commissioners, including performance clauses in line with national and local requirements	Quality of care reduced leading to fines and financial loss. Reputational damage.	8	Director of Nursing & Governance (changed from Director of Finance)	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			
414	ROH shows low position for health improvement as measured by PROMs on national Information Centre figures	Patient experience Reputational damage	12	Medical Director	Lead committee			Supporting Committee	Supporting Committee			Supporting Committee

Risks closed or downgraded In Quarter 4 2013/14 - assurance to be sought from the Lead Committee(s) that the risks have been de-escalated

30	Non-compliance with CQC outcome 9 "management of medicines"		8	Director of Nursing & Governance	Supporting Committee							
13	Failure to deliver contractual CQUINS			Director Finance	Supporting Committee				Supporting Committee			
8	Current clinical workforce unable to meet the needs of increasingly complex patients with multiple co-morbidities			Medical Director								
31	Absence of risk assessments on which to base a Health surveillance programme:			Director WFOD								
29	CQC outcome 4 "care and welfare of people who use services". Inadequate documentation. Concerns over the environment on Ward 11. Additional psychology support services required	Breach of CQC essential standards of safety and quality	6	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			
28	Accuracy and timeliness of prescribing of medications on admission and reduction of missed doses of critical medicines		12	Director of Nursing & Governance	Lead Committee							

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
35	Risk of ineffective patient administration due to the impact of organizational change (admin review)	Patient experience is adversely affected due to confusing/duplicate communication concerning their care. Ineffective utilisation of resources eg Clinic capacity.	16	Director of Operations	Supporting Committee			Lead Committee		Supporting Committee		

Appendix 2

Trust Risk Register Update – July 2014 (date updated: 24th July 2014)

Date added to BAF	BAF Theme	Risk	Consequence	Lead Director	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
March 2014	Staff Engagement	(i.d.582) Management of Change	Sub-optimal patient care; lack of organizational sustainability	Dir WFOD	• Well led	16	16	n/a – risk rating unchanged	Leadership behaviours agreed by SMT. Diagnostic to be developed to understand the barriers and enablers to increasing engagement of medical staff in leadership roles and activities	EMT
June 2014	Standards of Care	(i.d.7) Long waiting times for spinal deformity	Risk to patients of deterioration in condition whilst waiting. Increased complaints & litigation. Risk of Financial penalties levied by Commissioners for breach of 52 weeks	Dir of Ops	• Safe • Effective	20	12	Managed via risk 12 on 'KPIs' until escalation and re-opened as single risk Retained on BAF as 'high' Amber until update on mitigation received..	Re-opened June 2014.	EMT

Date added to BAF	BAF Theme	Risk	Consequence	Lead Director	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
May 2014	Standards of Care	(i.d.621) Delays in MRI imaging and reporting	Potential delay in diagnosis and treatment. Ineffective outpatient consultations. Repeat visits. Potential complaints/claims	Dir of Ops	• Safe • Effective	16	12	Additional resources secured for equipment and staff	Regular weekly review and escalation of outsourced examinations turnaround times Recruitment underway. Procurement for mobile van underway.	CGC
March 2014	Standards of Care	(i.d.178) WHO checklist compliance	Potential compromise to patient safety, possible never event	DNG	• Safe • Effective	16	12	Weekly reports continue Directorate, Theatres team and CD's aware of failure to meet 100% WHO checklist compliance	Assurance to be sought from CGC that this risk should be de-escalated from the BAF	CGC

* If risk increased, state why; if decreased, give evidence; if closed give date of closure and link to relevant minutes

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: 30 July 2014 **ENCLOSURE NUMBER: 10**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Anne Gynane** **Director of Workforce & OD**
SUBJECT:	**Workforce Report – Quarter One 2014/15**

SUMMARY

This is the quarterly workforce report to the Board. The report indicates some of the work that has now commenced concerning embedding values into core people management processes and activities to develop the leadership strategy. The report also provides information on the first set of staff Friends and Family Test results. The workforce indicators are detailed in the Corporate Performance report and indicate improvement.

RISK & IMPLICATIONS

Staff engagement and leadership remain BAF risks and this report details the actions that have and will be taken to mitigate and address these risks.

RECOMMENDATIONS

Trust Board is asked to note the content of this report.

Quarter One Workforce Report

1. **<u>Workforce Development</u>**

a. Development of staff in pay bands 1-4

As a result of funding allocated by Charitable Funds Committee, a number of non-clinical staff, including those in paybands 1-4 are now being supported to pursue additional learning:

- Nine staff will pursue academic learning programmes in the autumn as part of their personal development in subjects from Touch Typing to a BSc (Honours) in Computing and IT Practice.
- Thirty seven staff are in the process of enrolling on NVQ qualifications through apprenticeships in subjects such as customer service, health and social care and team leading/management.

Further updates will be provided to Charitable Funds Committee later in the year.

b. Diversity

In June, a further six Contact Officers have been appointed and trained, increasing the total number to ten. This includes two staff members from the Theatre and Anaesthesia directorate, an area of concern with regard to bullying and harassment in the last National Staff Survey. Contact Officers have been established in the Trust for several years and their role is to support staff who believe they have been bullied or harassed. To raise awareness of the role and new people appointed there will be some internal publicity during August.

Following a deeper review of the staff survey outcomes for 2013, we have noticed a difference in the responses from staff of black and minority ethnic origin in relation to some specific questions:

- Percentage of staff agreeing their role makes a difference to patients
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion

In order to further understand the experience of staff in this regard, all staff from a BME background will be invited to make contact with either the Director of Workforce and OD or Head of Learning and OD, either in person or anonymously, to share more information about their experiences.

2. **<u>Organisational Development</u>**

a. Values based recruitment and appraisal

Following agreement of the Trust's values, discussions have begun with trade unions concerning incorporating these into the performance and development review policy for staff

and it is expected the new approach will be agreed by the end of September 2014. There will be a need to also incorporate the values into the appraisal of medical staff and this will be progressed by myself and the Medical Director.

Values based recruitment is already in place for nursing roles in the Trust and in collaboration with NHS Elect, a revised approach for all recruitment will be developed with a view to implementation in October 2014.

b. Leadership Strategy

Work is underway to finalise the Trust's leadership behaviours. These are based on the national leadership model and will describe the Trust's expectations of individual leaders, in addition to their role specific knowledge, skills and experience. These are expected to be finalised in the next month with support from OPM who have facilitated the Executive team development. In addition an external partner will be commissioned in August to identify the barriers and enablers to increasing participation in medical leadership roles and activities at the Trust.

In order to develop the leadership strategy it will also be essential to undertake:

- A gap analysis of our current leaders, at an individual level, concerning their learning and development needs with regard to the Trust values and leadership behaviours
- An organisational review of future leadership requirements in terms of the number and nature of leadership roles required, the balance of skills within the leadership community, diversity and a succession plan for specific roles.

There will be a regular report to EMT and discussion at Trust Board on development of the approaches and strategy as the strategy develops.

c. Medical Workforce Model

An initial discussion took place in early July with some consultants, ANPs, members of the HR team and the Medical Director to discuss the current medical cover out of hours and potential alternative models that could provide safe care for patients in a sustainable way by an available, competent workforce. Two potential models are emerging which will require significant work to finalise and to engage a wider range of internal and external stakeholders in their development to ensure ownership by the medical, nursing and clinical workforce. It is envisaged that a final decision and recommendation will be made to EMT and the Board in September/October 2014.

3. HR Evolution

a. Outsourcing

During 2013, it was agreed with the Interim Chief Executive that the feasibility of outsourcing recruitment and HR admin to an external provider would be explored.

In conjunction with colleagues from Procurement, potential delivery options were explored which included outsourcing to an NHS shared service centre and private providers. In late 2013, it became clear that there were two credible providers with NHS contracts under existing framework agreements. As a result of a commercial acquisition these providers

became one business and discussions have taken place with them concerning the feasibility of outsourcing ROH recruitment services to them.

The quote submitted was for £159.5K which is £66.8K more expensive than the current in-house provision including the non-recurrent additional resource agreed for 2014/5. In addition the following activities would need to be retained within the Trust:

- The issuing of smartcards would need to be retained, potentially transferring to the IT department.
- Recruiting managers would need to take responsibility for checking the identity of all successful applicants and advising recruitment service provider of the checks undertaken.
- Directorates would need to take responsibility for organisation of Advisory Appointment Committees (consultant recruitment interviews).

The service would be provided from an existing service centre in north west England and therefore the existing ROH staff employed in this work would need to either be redeployed into suitable alternative roles or if this was not possible, be redundant.

The potential benefits of outsourcing would be:

- Additional HRM capacity (0.3WTE) to support directorates with operational HR matters
- Increased standardisation of processes to reduce variation.

The potential provider would commit to sustain, but not further improve the recruitment times currently in place (average of 8 weeks post-employment offer for substantive appointments)

It was agreed at EMT that data would be shared concerning the improvement over the year in performance of the current recruitment team and that the Director of Workforce and OD would meet with two members of the Committee who were concerned about the proposal to not proceed to a full business case for outsourcing. This matter will be considered by EMT in either August or September.

b. Streamlining

The Trust is one of 28 Trusts within the region participating in a project, sponsored by NHS Employers, to streamline 4 elements of pre-employment procedures – mandatory and statutory training, occupational health screening, junior medical screening and general recruitment. The aim is to reach region-wide consensus on standards of information, pre-employment checks and training to allow all NHS staff to move easily from one organisation to another without unnecessary duplication of processes or checks. The project builds on existing work undertaken in London where significant savings have been made in the ‘time to fill’ vacant posts and reduced duplication. Members of the HR team are participating in this project as service users. The dedicated project staff are currently being recruited and further information concerning timescales are expected in September.

External Matters

a. Friends and Family Test

The Friends and Family Test for staff was implemented during quarter one with a third of staff (380) asked to complete an on-line survey. The response rate was 19%, 72 people which we understand from our survey provider is consistent with other Acute Trusts. However these results represent only 8% of the total workforce and therefore the Board is asked to consider the results in that context.

In relation to the question " How likely are you to recommend the Trust to friends and family if they needed care or treatment?" the net recommender scores is 53%.

In relation to the question " How likely are you to recommend the Trust to friends and family as a place to work" the net recommender score is -8%. The free text comments for this question highlight issues that are known to the Board as staff concerns, namely confidence in senior management, communication, excess working hours, few opportunities for progression due to size of the organisation and slow pace of change. These issues are being addressed through improved engagement, communication and transformational work and it isn't surprising that these results have been received at this stage.

NHS England are re-considering how the net recommender data is presented on their website and NHS Choices. It is expected to be published in September 2014.

Quarter Two Priorities

- Distilling the inputs from the Board and Stakeholder day into a formal People Strategy.
- Completing the review by an external partner on the barriers and enablers of participation by medical staff in leadership roles and activities
- Communicating details of the Contact Officers and their role
- Communicating the new Whistleblowing Policy and Speak out Safely Champions
- Finalising the Performance and Development Review Policy to include the revised values and the link to pay progression from April 2015 onwards

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 July 2014 **ENCLOSURE NUMBER: 11**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Jo Chambers, Chief Executive**
AUTHOR(S)	**Jo Chambers**
TITLE	**Governance Declaration – Quarter 1 2014/15**

SUMMARY

To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 1 2014/15 to Monitor.

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 Continuity of Services risk rating of at least 3 over the next 12 months.

For Governance that:
"The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

Report To	Trust Board
Report Of	Jo Chambers, Chief Executive
Report Presented By	Jo Chambers, Chief Executive
Purpose of the Report	To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 1 2014/15 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 Risk Assessment Framework. The Q1 submission is due on the 31st July 2014.
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 of the Trust's financial performance for the 3 months from the 1st April 2014 to 30th June 2014 is contained in the Trust's Corporate Performance Report. 2. <u>Service Performance Targets</u> The table of Monitor requirements and evidence is Appendix One of this report. The Trust has been able to sustain the delivery of all waiting time targets throughout the quarter. All other targets have been met. 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 Trust's Governors appointed a new chair with effect from May 1st 2014 and a new Chair of Audit (NED) from 1st June 2014. This completed the NED group on the Board. • The Director of Operations has resigned and will leave the Trust in September 2014. Recruitment for a substantive replacement is underway. • The board has considered the capacity of the current executive team to deliver its future strategy and has agreed to appoint a Director of Strategy and Transformation. • There have been no governor elections during the period. • 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. • The Clinical Governance Committee has met once during the quarter and reviewed the relevant assurances that risks to compliance are being managed. The Committee intends redesigning its processes of receiving reports from other executive committees in order to further mitigate risk. • The Audit Committee met once during the period in respect to this declaration and can offer the following assurance: o Having updates on the work of the external audit and internal audit the Board is assured that work remains on plan and there are no material issues or problems to report; o External Auditors presented a risk assessment benchmarking report which rated the Trust as a strong performer for EBITDA, cash and CIP delivery in comparison to Deloitte's client base. o The committee was assured that appropriate management and mitigation of key organizational risks was taking place, and noted the recommendations made by internal audit to improve the use of the Board Assurance Framework as an effective management tool. o The committee received an update on delivery against the action plan regarding waiting list management and were assured that significant improvements have been made in all areas of the process.

APPENDIX ONE

The Trust provides financial information reflected in the CPR as assurance.

The Trust provides performance and quality information as set out in CPR and Patient Safety Report as assurance.

In Quarter 1 there was a CQC inspection. Verbal comments have been received but formal written feedback is not due until August. The trust believes, however, that the CQC will identify some areas for improvement and is already working to improve these.

In Quarter 1 no elections took place.
.

The Trust can confirm that there are no exception reports to be provided in quarter 1
with regard to:

- Continuity of services
- Financial Governance
- Governance

Targets and indicators with thresholds for 2013/14

	Inicator	**Threshold (A)**	**Weighting (B)**	Source of evidence	Commentary
Access	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted **(C)**	90%	1.0	CPR	Achieved.
	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted **(C)**	95%	1.0	CPR	Achieved
	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway **(C)**	92%	1.0	CPR	Achieved
	All cancers: 62-day wait for first treatment **(E)** from: urgent GP referral for suspected cancer NHS Cancer Screening Service referral	85% 90%	1.0	CPR	Achieved
	All cancers: 31-day wait for second or subsequent treatment **(F)**, comprising: surgery anti-cancer drug treatments radiotherapy	94% 98% 94%	1.0	CPR	Achieved
	All cancers: 31-day wait from diagnosis to first treatment **(G)**	96%	1.0	CPR	Achieved
	Cancer: two week wait from referral to date first seen **(H)**, comprising: all urgent referrals (cancer suspected)	93%	1.0	CPR	Achieved
Outcomes	Clostridium (C.) difficile – meeting the C. difficile objective **(M)**	DM* ROH target is 2	1.0	CPR	Achieved

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 July 2014 **ENCLOSURE NUMBER: 12**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Andrew Pearson** **Medical Director & Responsible Officer**
SUBJECT:	**Responsible Officer Report**

Quality Assurance Annual Report of Responsible Officer

SUMMARY

Revalidation of doctors by the General Medical Council (GMC) commenced on 3rd December 2012. This report confirms that Trust achieves the requirements of the GMC and the Revalidation Support Team (RST) in maintaining an appropriately appraised and revalidated medical workforce. It also outlines where further action needs to take place to fully comply with all the necessary requirements.

IMPLICATIONS

Failure to comply with revalidation requirements results in loss of licence to practice. In this event there could be operational and financial implications for the Trust

RECOMMENDATIONS

1. I ask the Board to accept this report noting that I am required to share it, along with the annual audit, with the Level 2 Responsible Officer at NHS England. I ask that the board continues its support of the Responsible Officer and the appraisal process at the ROH in terms of financial and time resource.
2. I ask the Board to approve the Statement of Compliance confirming that the organisation, as a designated body, is in compliance with the regulations.

Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officer (RO) in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisation
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors
- Ensure that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed

At the heart of revalidation lies the GMC's core guidance for doctors, *Good Medical Practice*. This sets out the standards expected of the medical profession. These standards have been used, as the foundation to develop the guidance on appraisal and the supporting information doctors will have to collect from clinical governance systems within the Trust.

Governance Arrangements

The governance of the appraisal and revalidation process has been managed by the RO supported by his Personal Assistant. The RO has regular (monthly) meetings with his PA to discuss the process and any issues. He also regular meetings with the GMC Employer Liaison Advisor (ELA) and is a member of the RO Network (4 meetings a year) overseen by NHS England.

Via GMC Connect an accurate list of prescribed connections is maintained with a timeline of appraisals and due dates for revalidation recommendation for each connection. Using the NHS Alert System it is possible to inform and be informed about any doctor for whom concerns have been raised to inform any recruitment process. Revalidation Pre-Employment Checks are performed by communication from one RO to another.

The recent adoption and introduction of ™Equiniti RMS, a paperless appraisal system, supported by the Board will allow a more coordinated and assured process. It is anticipated that this will be the default process used by the ROH by the end of September 2014. At present during the transition to the paperless system, the old style, time consuming paper stem is used.

Policy and Guidance

'Policy for Responding to Concerns about Responsible officers with a prescribed connection to NHS England' – May 2014 (available on request)

A required internal policy '*Responding to Concerns. Reskilling, Rehabilitation and Remediation for Doctors'* is currently in development and will be in place soon.

Medical Appraisal

a. Appraisal and Revalidation Performance Data

Number of Doctors

The ROH has 73 doctors who have a prescribed connection with the Trust for revalidation purposes. The breakdown is as follows:

60 consultants
7 specialty doctors
6 clinical fellows

Sub-speciality split:
Anaesthetic Directorate – 22 doctors
16 consultant
6 specialty doctor

Oncology Directorate – 10 doctors
8 consultant
2 clinical fellow

Large Joint Directorate – 14 doctors (RO appraised and revalidated externally)
12 consultant
1 clinical fellow
1 specialty doctor

CSS & OPD Directorate – 6 doctors
6 consultant

Paediatric Directorate – 4 doctors
4 consultant

Small Joint Directorate – 8 doctors
5 consultant
3 clinical fellow

Spinal Directorate – 9 doctors
9 consultant

Number of completed appraisals

Total – 67

2 not completed by consultants:

- Consultant A - new starter first consultant post
- Consultant B - new starter first consultant post

4 senior clinical fellow not completed

- Fellow A – appraisal booked for 28 July 2014
- Fellow B – appraisal booked for 11 August 2014
- Fellow C – new starter
- Fellow D – new starter

Directorate	Appraisal Complete	Appraisal Outstanding	Total
Anaesthetic	22	0	22
Oncology and Histopathology	10	0	10
Large Joint	13	1 (fellow)	14
Small Joint	5	3 (fellow)	8
Paediatric	3	1(consultant)	4
Spinal	8	1(consultant)	9
CSS & OPD	6	0	6
Total	**67**	**6**	**73**

Number of doctors in remediation and disciplinary processes

Total – 0

Previous concerns:

Doctor	Concern	Outcome
Consultant 1	Conduct/Capability	Remediated
Consultant 2	Capability	Remediated/Rehabilitation
Consultant 3	Capability	Resignation Tendered

b. Appraisers

The Trust currently has 15 appraisers who have all undergone full training:

Doctor	Directorate
Mr Carter	Oncology & Histopathology
Mr Waldram	Small Joints
Mr Thomas	Large Joints
Dr Vries	Anaesthetics
Mr Grainger	Spinal
Dr Shinner	Anaesthetics
Dr Blunt	Anaesthetics
Dr Balachandar	Anaesthetics
Nikki Mason	CSS & OPD
Mr Dunlop	Large Joints
Mr Tillman	Oncology & Histopathology
Mr Gaffey	Paediatrics
Mr McBryde	Paediatrics
Mr Sian	Spinal
Mr Pearson	Large Joints

c. Quality Assurance

Appraisal folders and portfolios are reviewed to give assurance on inputs (pre-appraisal declarations and supporting information) and outputs (PDP, summary and sign off to appropriate standard)

d. Access, Security and Confidentiality

All appraise and appraiser and patient identifiable information is securely held in a locked cabinet. With the introduction and rollout of the electronic RMS this should ensure further security of data.

e. Clinical Governance

The data collected by the Trust and made available to the appraisee and appraiser to inform the appraisal discussions is shown in the attached document.

Revalidation Recommendations

Number of recommendations April 2013-March 2014

Recommendations completed on time	16
Positive recommendations	16
Deferral Requests	4
Non engagement notifications	0

There have been 4 deferral requests, all were made due to insufficient appraisee supplied information being available to support a recommendation.

Responding to Concerns and Remediation

One doctor is currently under remediation regarding concerns around capability. Since being informed of the remediation process the organisation requires followed, the doctor has tended his resignation with a view to leaving the UK and not returning. The doctor's resignation has been accepted by the organisation.

Risk and Issues

1. Continued appraiser commitment with embedding of enhanced standards of appraisal.
2. Roll out of ™Equiniti RMS

Corrective Actions, Improvement Plan and Next Steps

1. Refresher appraiser training
2. Appraiser update sessions
3. Completion of *Policy – Responding to Concerns: re-skilling, Rehabilitation and Remediation.*

Recommendations

I ask the Board to accept this report noting that I am required to share it, along with the annual audit, with the Level 2 Responsible Officer at NHS England. I ask that the board continues its support of the Responsible Officer and the appraisal process at the ROH in terms of financial and time resource.

I ask the Board to approve the Statement of Compliance confirming that the organisation, as a designated body, is in compliance with the regulations.

Andrew Pearson
Responsible Officer
July 2014

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 July 2014 **ENCLOSURE NUMBER: 13**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Rod Anthony**
AUTHOR(S)	**Paul Athey**

TITLE	**Audit Committee Annual Report 2013/14**

SUMMARY

This annual report is the culmination of the work of the Audit Committee in relation to the 2013/14 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 attached report outlines the key issues discussed by the committee and the evidence and assurance offered by the committee to meet its terms of reference.

It should be noted that the current Chair of Audit Committee was not in post during 2013/14. The Chair of Audit Committee role was undertaken by Andrew Meehan from April 2013 to January 2014, and by Mike Flaxman for the remaining months of the financial year.

RISK & IMPLICATIONS

There are no risks arising from this report

RECOMMENDATIONS

The Board are asked to note the 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 2013/14 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.

Attendance at the Committee is shown in Appendix C.

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 Audit Committee has provided assurance to the Trust Board quarterly and in summary for the 2013/14 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;

- Following an internal audit review into the management of the 18 week referral to treatment pathway, Audit Committee have reviewed the progress made against the 12 recommendations made and have concluded that good progress is being made by the Trust in addressing these recommendations. The Committee will continue to review progress in 2014/15.
- Improvements to the structure of the Board Assurance Framework have been debated and agreed by the Committee in 2013/14. This included commissioning a piece of internal audit advisory work to support the development process.
- Audit Committee were required to approve the process for the calculation of the Trust's annual Reference Costs for 2012/13 on behalf of the Trust Board, and concluded that a robust process existing to ensure that these costs were accurate and produced in line with national guidance.
- Audit Committee approved the re-appointment of Baker Tilly to provide Internal Audit and Counter Fraud services to the Trust.
- There are no significant matters arising from the committee that have not already been brought to the attention of the Trust Board by the Chair of the Audit Committee during in-year reports

APPENDIX A

Audit Committee Work Plan for April 2013 to April 2014

	18 Apr 13	28 May 13	16 July 13	Nov 19 13	25 Feb 14
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			√		√
Declarations of Interest 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 - 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					√
Quality Accounts - Draft	√				
- Final		√			
- Consultation on future years					√
Review the effectiveness of audit services – Internal			√		
- External			√		
- LCFS			√		

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 2013-14

TITLE	NAME	18/04/13	28/05/13	16/07/13	19/11/13	10/03/14
Non-Executive Director (Chair)	A Meehan	Y	Y	Y	Y	
Interim Non-Executive Director (Chair)	M Flaxman					Y
Non-Executive Director	R Millinship	Y		Y		
Non-Executive Director	E Mountford	Y	Y	Y		Y
Non-Executive Director	T Pile	Y	Y	Y	Y	
Interim Director of Finance	P Taylor	Y	Y			
Director of Finance	P Athey			Y	Y	Y
Internal Audit	G Palethorpe	Y		Y		Y
Internal Audit	N Tomkys	Y	Y			
Internal Audit	S Mallinson				Y	
External Audit	G Miah	Y		Y	Y	Y
External Audit	M Ramzan	Y	Y			
External Audit	J Turton		Y			
Counter Fraud Specialist	G Ball		Y	Y	Y	
Counter Fraud Specialist	M Elcock		Y	Y		

TITLE	NAME	18/04/13	28/05/13	16/07/13	19/11/13	10/03/14
Counter Fraud Specialist	B Vaughan				Y	Y
Director of Nursing & Governance	L Webb			Y		
Company Secretary	J Street	Y	Y	Y		
Acting Chief Executive	G Bragg		Y			
Deputy Director of Finance	P Athey	Y	Y			
Head of Financial Accounting	H Wright	Y	Y			
Deputy Director of Nursing	H Peakman		Y			
Deputy Director of Nursing	L Pim				Y	
Interim Risk Manager	B Ellison		Y			
Governance Manager	A Braham				Y	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 30 July 2014 **ENCLOSURE NUMBER: 14**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Strategy Update**

SUMMARY

This report provides and update to the Board on the development and implementation of the Trust's strategy.

IMPLICATIONS

The Trust Board approved a new 5 year strategic plan in June 2014. An implementation plan is being developed and resources mobilised to support the changes required. The Trust is continuing to engage in external stakeholder and commissioning activities.

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update the Board on the implementation of the new strategic plan.
Recommendation	The Board is asked to note the contents of the report and discuss items as appropriate.

1 5 year Strategic Plan – Submission to Monitor

The Board approved a new 5 year strategic plan on 25 June and the final version was submitted to Monitor on 30 June comprising a full plan, a 20-page summary of the plan and detailed financial plans. Monitor will review the plan and provide formal feedback in the autumn; an initial review will take place by teleconference at the end of August.

Final documents were circulated to board members.

2 Communication of the Strategic Plan

The 20-page summary of the plan has been placed on the Trust's website and is available to members of the public. A stakeholder summary document is being produced for staff and stakeholders and a small public leaflet will provide a very high-level view of the key points of the plan; final copy is being proof read.

A presentation has been made to staff and the 20-page summary document and the powerpoint slides used at 'Question Time' have been uploaded onto the Trust's intranet. The Team Brief system has also been used to provide a briefing which will cascade throughout the organisation.

The Council of Governors have also received the final version of the summary plan and were briefed at a meeting on 3 July.

3 Local Health Economy 'Unit of Planning'

The Birmingham, Sandwell and Solihull 'Unit of Planning' is continuing to consider the longer-term position and is in the process of developing a 15 year vision for services. The Trust is fully engaged in this process.

The Clinical Commissioning Groups are separately working with organisations on clinical redesign of services and a clinical director has been in attendance at all meetings arranged to date; these are organised in smaller geographical groups within the unit of planning footprint.

4 Implementation Update

July has been a short month due to annual leave and the following actions have been put in place to commence the mobilisation of resources around the implementation of the strategic plan initiatives; recruitment activities will have a lead time to select candidates and for them to work notice periods:

- Director of Strategy and Transformation recruitment – interviews due 1 August
- Final strategic transformation budget has been agreed in line with the Board's delegated authority – other recruitment processes will now commence.
- Interim support has been commissioned to cover some elements of current gaps and to assist in the set-up of the programme structure.
- The baseline quantum for all corporate services and clinical leadership roles is being identified to support further consideration of the Trust's structure and alignment of it to support the plan – due for completion end of July. Structure alignment will take place between September 2014 and March 2015.
- Baseline stocktake of all current research, evaluation and outcome activities requested to support alignment and start point for the 'Integrated Research, Evaluation and Outcome capability' workstream.
- Executive leads are mapping current programmes of work into new strategic transformation initiative workstreams to enable a managed transition, streamlining and re-prioritisation of activities.

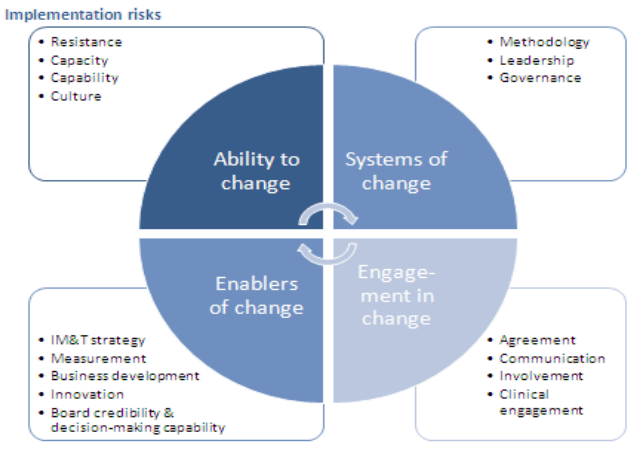
5 Stakeholder Strategy Day – Quick Wins

At the stakeholder strategy day in April, a number of 'quick wins' were identified by stakeholders which were roughly organised into 30 day and 90 day categories. Attached to this report is an update on progress made and actions taken, together with an update on additional quick wins identified by the Executive Team.

A significant number of the identified areas for action are now embedded in more substantial pieces of work within transformational workstreams.

6 Implementation Risks and Mitigation

The Board identified a number of risks to implementation and agreed that investment funding should support risk mitigation as well as enable transformational change. The principal risks include the Trust's ability to change, the systems of change, engagement in change and enablers of change. The investment proposals include developments intended to



mitigate the implementation risks identified in the diagram below. Once the Programme Board is established a risk register will be fully developed.

Investment proposals include change management capability and capacity, project management support, enhanced professional communication capacity and support for culture change.

Additionally there will be investment in board development and leadership, including clinical leadership development. A number of pieces of work will be commissioned to support diagnostic reviews to inform future investment and development decisions.

The largest investment in any one area is the IM&T strategy to include a trainer, implementation costs and licenses for systems.

The Board agreed to establish a new committee under the chairmanship of Tim Pile, to oversee the implementation of the transformational initiatives and the governance arrangements for this will be established over the next two months.

7 Future Reporting

Updates will be provided to the Board to advise periodically on the changing external context and development of commissioners' plans.

The new Board committee will oversee implementation of the transformation initiatives and report in summary to the Board of Directors.

8 Conclusion

The refreshed strategic plan has now been approved and there is much to do to align resources and enhance current capacity and capability to deliver sustainable transformation. Work is underway to get the necessary resources in place, which clearly has a lead time and some interim support will be commissioned to support the transition. Engagement continues with external partners and stakeholders. The plan is being communicated widely and new products are being designed for the benefit of different audiences. The formal programme structure is being developed.

8 Recommendation

The Board is asked to note the contents of this report and discuss as appropriate.

25 April 2014 Stakeholder Strategy Day 'Quick Wins'

Position Statement as at 24 July 2014

Overall priority	30 day actions	Lead Director	Comment	90 day actions	Lead Director	Comment
Improving and developing processes **Tables 5, 9 and 11**	• IMT strategy agreed • oncology – read referral letter in clinic	Paul Athey	Information Management Technology (IMT) Strategy agreed at Executive Management Team (EMT) in May and signed off at Trust Board in June	• Electronic Prescribing and Medicines Administration (EPMA) procurement • Strategy approved • Digital dictation • Records scanning • The Trust Integration Engine (TIE) procurement	Paul Athey	EPMA business case was approved by EMT in May. Procurement phase is now underway with planned contract award by 31st March 2015 TIE business case has been written. Digital Dictation business case is being developed IMT Strategy was agreed at EMT in May and signed off at Trust Board in June
	• EPMA business case – EMT • Identify opportunity for bids - Technology fund - Charitable fund (e.g. IPad for patients awake during surgery)	Paul Athey	EPMA business case approved by EMT in May Bid submitted to Technology Fund for EPMA support. Working groups set up to identify opportunities for nursing technology fund bids.	• Clear strategy for what investment would have greatest benefit • Develop scope of digital dictation project • Quick wins around web site improvement	Paul Athey	See above re: strategy & digital dictation Some initial adjustments made to web-site. Further review due in Q3/Q4 2014.
	• IT Informatics reps to be more actively involved in TBALD and direct	Paul Athey	IMT Strategy includes plan to streamline day to day reporting to	• Collect information across the trust about IT information systems that	Paul Athey	Consideration still being given to best way of communicating IMT

	meetings • Review of staff access educational internet sites		allow Informatics team to focus more on the needs of the business.	have been developed then do a sharing event at TBALD • Liaise with UHB to gain access to their TIE feed to provide live patient movements – enable nursing and H&S agenda		Strategy once agreed See above re: TIE business case
Improving engagement and development of staff **Tables 2, 6 and 8**	• Staff focus group – information • Feedback from today	Anne Cholmondeley	All feedback was collated and uploaded onto the CEO Discussion Board a week after the stakeholder event in April. The artist's visual representation of the day has been displayed on the main hospital corridor. Feedback on stakeholder day also included in staff briefings in May and June.	• Mentor/coaching relationships • Use staff forum to get views on developments • Embedding and engaging staff with strategy and communications up and down • Local robust induction – shadowing (what you job entails, emergency planning skills) • Patient journey – understanding your contribution to patient experience	Anne Cholmondeley	Coaching arrangements are available for all staff in management roles via coaching collaborative Staff engagement approaches to be included in People Strategy to be agreed by Board in late summer
	• Seeing results from these 2 days in practice and learning • Experience exchange with other trusts e.g. Stanmore	Anne Cholmondeley	See above Exchange options to be pursued but not yet actioned	• Full use of TBLDs (June 14) communication up and down and across and training • Empowerment to all staff at all levels within the trust • More workshops and PowerPoint presentations • Structured idea learning	Anne Cholmondeley	TBALD and stand-alone briefings being used for team and corporate communications. New Team Brief provides new feedback approach Empowerment approaches to be actioned in Q3 as per agreed business case
	• More positive feedback	Anne	Internal	• Feedback from today	Anne	Investment in learning

	– less emphasis on the negatives (use TV screens) • Task & Finish groups to promote a bottom up approach	Cholmondeley	communications now include positive items and "thank you's" Bottom up approach will be addressed via empowerment in Q3(see above)	• Invest in training and planned developments for domestic and catering staff • Analysis of capacity and acuity • Customer service training (possibly charter) bring in from outside. • Support services passion • More carrots and less stick	Cholmondeley	for staff that have roles in Facilities is underway and has been supported by Trade Unions using Charitable Funds. Patient acuity is measured on a daily basis via "Safe Staffing" Approach to customer service development to be determined now values and strategy have been agreed
Delivering high clinical standards Tables 1, 3 and 7	• Share what we collect – how we deliver standards • Recognize good practice and share • Ask the patient for 1 thing they would change	Andy Pearson and Helen Shoker Helen Shoker	A piece of work is currently underway to determine position and gaps in patient outcome data. The Trust is exploring the purchase of an integrated outcomes collection system. The Friends and Family test conducted on both inpatients and outpatients shows that our patients biggest concerns relate to communication and patients feeling that they are not always being kept informed. Examples of this include waiting in OPD, progress of their	• Customer service awareness for all staff • Learning from the data we collect – e.g. imaging waiting times & improving patient flows standard	Ann Cholmondeley Amanda Markall	See above The Out Patient Experience group was established in May and reports to Clinical Program Board. The Intensive Support Team Demand and Capacity tool has been sourced and is being used to conduct specialty specific, OP and Imaging Demand and Capacity studies. Large joint Demand and Capacity exercise will be completed by the end of July and it is anticipated all other specialty D/C will be finalized by end of August. D/C of

			referral (both of which form part of work streams in the Patient Access Review Program) and delays to answering call bells and progress on discharge plans.			remaining imaging modalities and OP will commence in late August. Mobile MRI scanner will be on site in September, work started to prepare the pad on which it will sit in July. Agreement was gained from EMT in April to bring reporting of scans in house and this will commence from October in conjunction with appointment of new Radiologist. Business case for permanent MRI will be submitted to EMT in Q3.
				• Staff groups to develop clinical standards	Andy Pearson and Helen Shoker	Clinical Standards have been developed in draft form by the Medical Director and discussed at Clinical Directors forum, EMT and Operational Management Team. Feedback has been positive and they will continue to be discussed with consultant and other clinical colleagues and

				• Maintain consistent staff base in all areas	Anne Cholmondeley	refined throughout Q2. Vacancy factor is currently <6% with highest vacancies in Nursing. Directorates are preparing plans to address this and to formulate specific succession plans for those specialties who expect to have a high number of retirees in the next 5 years. This will be discussed with Directorate Teams via quarterly Performance Reviews.
	• Define standards to benchmark against • Set audit outcomes	Andy Pearson and Helen Shoker	A paper outlining standards was presented at July CD meeting. These will need crystallizing to match with agreed Trust values As above. In the interim, work with the Governance Team has commenced and will continue, to ensure that data currently collected is managed in accordance with Data Quality Standards.	• Joined up approach to collecting audit data • Finance to agree funding for IT infrastructure • ROH outcome app • Decision re commercial or In house outcomes solution– implementation	Andy Pearson and Helen Shoker Paul Athey Andy Pearson	Stakeholder meetings with Outcomes Database suppliers have commenced with a positive response from clinicians involved. Related technical implementation issues are being explored by the Head of IT. It is expected that a tender exercise will commence in Q4. See above See above

				do it!!		
	• Value staff and the work they do • Challenge to do better all the time	Anne Cholmondeley	Visible attention is being given by executive team to valuing staff via simple "thank you's", and increase in corporate communications, back to the floor days etc. A drive to do better is a key theme in the transformational initiatives formed as part of the trust strategy	• Agree standards – prioritize • Accurate measurement of outcomes and events and reporting of these • Standardized pathways • Transparency – keep good communications with patients • Develop staff • Openness to report errors and likely errors across the trust • Clinicians do clinical work – support services to do the rest	Andy Pearson Amanda Markall Anne Cholmondeley	As above. Outcomes and standardization are now part of the transformational initiatives Seamless whole patient pathways to maximize patient experience are being developed and implemented via clinical program board and will continue under transformational objectives. Administrative support must be optimal to maximize efficient clinical activity and this will be supported further by advanced in IT including a new referral management system and digital dictation. To promote transparency, the trust has subscribed to "speak out safely campaign" along with a new whistleblowing policy in consultation with Trade Unions. Embedding values into Personal Development

				• Patients and relatives made to feel welcome		Reviews and the recruitment process to be actioned by end of October. Standards to be matched to values and agreed.
Improving and increasing services and diagnostic capacity Tables 4, 10 and 12	• New services in development speak to commissioners to pilot an approach • Arrange a commissioner ROH BO to BO meeting to take place within 90 days	Paul Athey Paul Athey	Discussions taking place with CCG lead GPs at JCCG meeting. Plan to pilot Direct Access Ultrasound from Autumn 2014. Awaiting feedback from CCG.	• Benchmarking imaging within elective context for best practice • Find a way to assess whether internal use of imaging is clinically necessary – standardize	Amanda Markall	The Trust joined a national imaging benchmarking group in May with the first data pack being completed and submitted in June. The Imaging Superintendent is liaising directly with other organizations to scope out practice in other centers. When benchmarking is complete it will be easier to focus on use of modalities if we are a specific outlier.
	• Site map to ensure patients have information prior to appointment	Amanda Markall	To Come In (TCI) and appointment letters have maps currently on the back however they do not include the new Admissions and Day Case Unit (ADCU) building. A meeting has taken place with Head of Patient Access and Head of Estates and a new map (preferred	• Admin process registering/managing referrals	Amanda Markall	Directorate Manager for Patient Access commenced in post in May and is leading on transformational change at start of and throughout the patient pathway. This work program is expected to last 6-9 months and will be delivered via the Patient Access Review Program which

			to be printed in colour) is being devised. Director of Operations and Head of Estates have undertaken a walkabout and additional signage was put up in June. In addition, Head of Estates, with input from volunteers undertook "sign post" walkabout in June and further signs were requested which have been ordered and will be put up before mid-August.	• Evening/routine OPD xray availability		commenced in June with objective to improve patient admin processes. The referral process has been mapped out with input from appointments staff and IT and has been identified as a project in the IT strategy. Clinical Commissioning Groups (CCG) circulated a letter in April at ROH request to GPs requesting that referrals into ROH are sent to the appointments office as opposed to directly to consultants. Joint working between ROH and CCG to increase referrals made electronically via Choose and Book (currently only 22%) commenced in May via Joint Clinical Commissioning Group (JCCG) X-Ray opening hours were extended in June from 0800-1800 (from 08:30-17:00 previously) A paper

				• C.Arm training planning		going to EMT in August to increase imaging capacity in week to 20:00hrs. Further extended and weekend working in OPD/ therapy's and Imaging is being explored via 7 day working group in line with Keogh recommendations. Initial assessment against 10 recommendations taken to EMT in June with further actions and recommendations required to be presented to EMT in September. ODPs and 1 consultant have expressed a wish to have C Arm training. This is being explored with theatre directorate and imaging team to identify a training provider and may be run as a pilot if radiation safety can be assured. Theatre team is currently collecting data to illustrate the regularity and need.
	Parity/accountability of OPD	Amanda	Clinic rules by	• Service to meet patients'	Amanda	7 day working group

	activity – difference in clinic numbers seen by clinicians within same specialty • Engage with CCGs re health promotion and prevention • Clarify true mismatch of capacity vs demand by consultant and sub-specialty	Markall	consultant by specialty were sent to all Clinical Directors and Directorate Managers on 13/6/14 to explore differences with individual consultants and make proposals for changes by 1/8/14 Discussion regarding further development of MSK services takes place at the Joint Clinical Commissioning Group. Joint working with Bournville Village Trust to provide support in the new Extra Care Village from 2015 is now well developed. A capacity and demand exercise commenced in June and is expected to be completed for specialties by the end of August. OP and further Imaging modalities will also commence demand and capacity review at the end of August.	needs not 9-5 service • Collaboration with community MSK services surgical/non surgical	Markall	has been established to scope out Sir Keogh's recommendations with a paper going to EMT in June. A Short Life Working Group has been established to propose recommendations and undertake an associated risk assessment, which will be taken back to EMT in September in line with commissioner timescales. Due to possible changes to job plans and terms and conditions this is likely to be a contentious issue for some disciplines. Further collaboration to expand Muscular Skeletal (MSK) services is planned for 14/15 in line with Trust Strategy and can be seen in attached appendix which shows current services and proposed developments.

Additional Quick Wins Identified by Execs at Away Day

Map the preventative services (all MSK)	Amanda Markall	Services have been mapped out to show current services and future developments
Baseline of existing activity and resource	Amanda Markall	Demand and Capacity exercises to be completed on all specialties before end of August with commencement on Out Patients and Imaging from September.
Seek feedback from staff through (individual) performance reviews on things that staff think can be done better	Anne Cholmondeley	Directorate teams asked to collate this information and feedback via performance reviews
Communicate with reference groups	Anne Cholmondeley	All reference groups have met at least once since the strategy away day
Values- how we treat each other- (internal customers) and behaviour statements to be complete this year	Anne Cholmondeley	Behaviours statements will be finalised by the end of August which will cover all aspects of roles including how staff behave with one another
Leading managing and engaging with staff- communicating effectively	Anne Cholmondeley	Leadership strategy will review current needs and leadership expected in the future.
To inspire the workforce with a common vision to which everyone contributes	Anne Cholmondeley	Sharing of trust strategy and ongoing communications through core brief, ROH life, blogs and back to the floor time will assist in creating trust and improving staff engagement.
Be in the conversations with commissioners about demographics, needs etc	Paul Athey	Regular conversations taking place at JCCG. Discussions ongoing with NHS England public health team to look at specific demographic trends for joint replacements.
Public v private spaces to be defined	Amanda Markall	Stuart Lovack has locked down the passage between kitchens and Trust Head Quarters with swipe access only.
Visibility of smokers- clean air site in the longer term	Amanda Markall	Additional no smoking signs have been put up. A longer term plan to achieve a clean air site will be managed via the Smoking Group. Plan to be presented to EMT in Q3
Wifi access for patients (subject to any significant implications for the trust)	Paul Athey	This has been reviewed and is possible to deliver at a reasonable price, however it requires the new IT infrastructure to be in place. To be reviewed at the end of 2014.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: **30 July 2014** **ENCLOSURE NUMBER: 15**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Acting Company Secretary**
SUBJECT:	**Constitution**

To seek the approval of the Board of the amended Constitution attached at Appendix 1 which gives effect to the changes referred to below in the paper for the meeting of the Council of Governors held on 27 November 2013.

This paper summarises the background for seeking the approval of the Board.

IMPLICATIONS

The Trust Board has previously supported the principle of amendments changes to the Constitution.

Under the Health and Social Care Act 2012, Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act.

Mills and Reeve, solicitors to the Trust have advised that the amendments to the constitution to give effect to the changes referred to in (a) – (d) below must be approved by both the Council of Governors and the Board of Directors but do not also require the approval of members at an Annual General Meeting as they do not mean a change to the powers or duties of the Council of Governors or approval by Monitor.

Lawyers have drafted the final amended constitution attached as Appendix 1 and assume responsibility for assuring the Trust of such compliance.

RECOMMENDATIONS

The Board is asked to approve the amended constitution attached at Appendix 1 and to adopt it from 30 July 2014.

This paper represents the final step in a process designed to amend the Constitution of the Trust which is described below.

Meeting of the Council of Governors: 27 November 2013

In November 2013 a paper was circulated to the Council of Governors proposing changes to the constitution. The nature of the changes were:

a) Adopting Monitor's new model constitution
b) Making changes to the public constituencies which nonetheless cover the same geographical area as in the original constitution
c) A change in the number of representatives from each constituency
d) Including a requirement that the Trust provide a description of the requirement of the role to prospective governors

The rationale for these changes included:

- Developing the governor role to ensure that the Trust will be better able to gain the assurance challenge from governors that it requires and to encourage people who recognise their responsibilities to commit to the role
- To avoid the problem in some of the smaller existing public constituencies of the Trust finding itself suddenly without governors pending the election of new ones while ensuring that the geographical areas of the Trust's public constituencies reflect the population it serves.
- To create a flexible framework within which further amendments to the Constitution may be made more simply than at present (provided the process referred to in the implications section is followed) as and when such a need arises

The final amended constitution attached as Appendix 1 also builds in transitional arrangements to give effect to the changes referred to in (b) and (c) above.

The paper was approved by the Council of Governors and was used as the basis for briefing Mills and Reeve to draft the amended Constitution.

Meeting of the Council of Governors: 3rd July 2014

This meeting received the amended Constitution and unanimously approved in principle subject to:

- Further amendments which were agreed at that meeting of the Council of Governors being incorporated into a final draft by Mills and Reeve
- Delegating to the Lead Governor and the Chair of the Trust the authority to approve this final draft

The Final Draft of the Amended Constitution (Appendix 1)

This was prepared by Mills and Reeve and reviewed by Yve Buckland, Chair and Alan Last, Lead Governor. The Chair and the Lead Governor confirm that the amended constitution attached at Appendix 1 incorporates all the changes agreed by the governors at the Council of Governors meeting of 3rd July 2014 to the draft constitution that was considered at that meeting and recommend that the Trust Board approve the amended constitution attached at Appendix 1 and adopt it from July 30 2014.

Appendix 1

CONSTITUTION OF THE ROYAL ORTHPAEDIC HOSPITAL NHS FOUNDATION TRUST

(updated as per the Health and Social Care Act 2012)

www.roh.nhs.uk

July 2014

Constitution of The Royal Orthopaedic Hospital NHS Foundation Trust

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TABLE OF CONTENTS

Paragraph

1. Interpretation and definitions

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph11 of the constitution

constitution means this constitution and all annexes to it.

Monitor is the body corporate known as Monitor, as provided by Section 61of the 2012 Act.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. Name

The name of the foundation trust is The Royal Orthopaedic Hospital NHS Foundation Trust (the trust).

3. Principal purpose

3.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The trust may provide goods and services for any purposes related to—

3.3.1 the provision of services provided to individuals for

or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the trust are set out in the 2006 Act.

4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

The trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency

5.2 the staff constituency

6. Application for membership

An individual who is eligible to become a member of the trust may do so on application to the trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

8.1.1 he is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the trust that he does not wish to do so.

10. Restriction on membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 9 – Further Provisions.]

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

12. Council of Governors – composition

12.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13. Council of Governors – election of governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the trust's Authorisation are attached at Annex 5.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 45 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

13.5 In order to assist prospective governors in deciding whether to nominate themselves for election the Trust shall publish a description of the requirements of the role, which shall be reviewed by the Council of Governors from time to time.

14. Council of Governors - tenure

14.1 An elected governor may hold office for a period of up to 3 years.

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.3 An elected governor shall be eligible for re-election at the end of his term.

14.4 An appointed governor may hold office for a period of up to 3 years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.6 An appointed governor shall be eligible for re-appointment at the end of his term.

15. Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

15.4 Annex 6 makes provision for the removal of Governors.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

17.1 The Chairman of the trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26) or, in his absence, the Vice Chairman (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors unless they have a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.3 For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons

appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

19.1.1 to act in accordance with its constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust.

22. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

23. Board of Directors – composition

23.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 up to 7 other non-executive directors; and

23.2.3 up to 7 executive directors.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer

23.5 One of the executive directors shall be the finance director

23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the executive directors is to be a registered nurse or a registered midwife.

24. Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

25. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a non-executive director only if –

25.1 he is a member of a Public Constituency, or

25.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university , and

25.3 he is not disqualified by virtue of paragraph 29 below.

26. Board of Directors – appointment and removal of chairman and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the trust and the other non-executive directors.

26.2 Removal of the chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

27. Board of Directors – appointment of vice chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a vice chairman.

28. Board of Directors - appointment and removal of the Chief Executive and other executive directors

28.1 The non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

29. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

29.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

29.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been

discharged in respect of it.

29.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

30. Board of Directors – meetings

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

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8.

32. Board of Directors - conflicts of interest of directors

32.1 The duties that a director of the trust has by virtue of being a director include in particular –

32.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust.

32.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2 The matter has been authorised in accordance with the constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than –

32.4.1 The trust, or

32.4.2 A person acting on its behalf.

32.5 If a director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the director must declare the nature and extent of that interest to the other directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered –

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the directors

appointed for the purpose under the constitution.

32.10 A matter shall have been authorised for the purposes of paragraph 32.2.2 above if:

32.10.1 The Board of Directors, in accordance with the requirements set out in this paragraph 32.10, authorise any matter or situation proposed to them by any director which would, if not authorised, involve a director (an "Interested Director") breaching his duty under paragraph 32.1.1 above to avoid Conflicts;

32.10.2 The matter in question shall have been proposed by any director for consideration in the same way that any other matter may be proposed to the Board of Directors under the provisions of this Constitution;

32.10.3 Any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interested Director; and

32.10.4 The matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

33. Board of Directors – remuneration and terms of office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

33.2 The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34. Registers

The trust shall have:

34.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of governors;

34.4 a register of directors; and

34.5 a register of interests of the directors.

35. Admission to and removal from the registers

Not Used

36. Registers – inspection and copies

36.1 The trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the trust, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

37. Transition

37.1 With effect from the end of the 30th July 2014 (Effective Date)

the following provisions of this paragraph 37.1 shall take effect:

37.1.1 Public members who on the Effective Date live in an electoral area comprised in a Birmingham public constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of Annex 1 shall become members of the Birmingham and Solihull public constituency as described in Part B of Annex 1;

37.1.2 Public members who on the Effective Date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become members of the Rest of England public constituency as described in Part B of Annex 1;

37.1.3 Public governors who on the Effective Date live in an electoral area comprised in a Birmingham public constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of Annex 1 shall become governors in the Birmingham and Solihull public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.4 Public governors who on the effective date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become governors in the Rest of England public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.5 If the number of governors for any public constituency following implementation of the preceding provisions of this paragraph would exceed the number of governors allowed for that constituency, then the governors in that constituency shall draw lots to determine which of

their number shall retire

38. Documents available for public inspection

38.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current constitution,

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of

State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40. Audit committee

The trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 Monitor may with the approval of the Secretary of State give

directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the trust's auditor.

41.4 The trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. Annual report, forward plans and non-NHS work

42.1 The trust shall prepare an Annual Report and send it to Monitor.

42.2 The trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

42.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about –

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must –

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the directors of the trust of its determination.

42.7 A trust which proposes to increase by 5% or more the proportion

of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the governors and members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the annual accounts

43.1.2 any report of the auditor on them

43.1.3 the annual report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1with the Annual Members' Meeting.

44. Instruments

44.1 The trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The trust may make amendments of its constitution only if –

45.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

45.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

45.2 Amendments made under paragraph 45.1 take effect as soon as

the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust) –

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

45.4 Amendments by the trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and significant transactions

46.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the council of governors.

46.2 The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

PART A (until the Effective Date – see paragraph 37.1)

There are five public constituencies reflecting the populations the Trust serves:

- South Birmingham
- Heart of Birmingham
- Eastern and Northern Birmingham
- Other West Midlands
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

South Birmingham Public Constituency:

Bartley Green
Billesley
Bournville
Brandwood
Edgbaston
Hall Green
Harborne
King's Norton
Longbridge
Moseley
Northfield
Quinton
Selly Oak
Weoley

Heart of Birmingham

Aston
Bordesley Green
Handsworth Wood
East Handsworth
Ladywood

Lozells
Nechells
Small Heath
Soho
Sparkbrook
Sparkhill
Springfield

Eastern and Northern Birmingham

Northern Birmingham:

- Kingstanding
- Perry Barr
- Oscott
- Sutton Four Oaks
- Sutton New Hall
- Sutton Vesey

Eastern Birmingham:

- Acock's Green
- Erdington
- Hodge Hill
- Kingsbury
- Shard End
- Sheldon
- Stockland Green
- Washwood Heath
- Yardley.

Other West Midlands - comprising the metropolitan boroughs of:

- Coventry
- Dudley
- Sandwell
- Solihull
- Walsall
- Wolverhampton

Rest of England and Wales

Initially the Trust will utilise the details of patients from the Patient Administration System as information to support membership recruitment within the Public Constituency in addition to other recruitment efforts.

The Trust intends to develop membership numbers in the Public Constituency over time, however the minimum number of members in the public constituency described above is to be 100 persons split across the 5 constituencies as follows:

Public Constituency	Minimum Number
South Birmingham	41
Heart of Birmingham	9
Eastern and Northern Birmingham	13
Other West Midlands	31
Rest of England and Wales	6
Total	100

PART B (with effect from the Effective Date– see paragraph 37.1)

Two public constituencies reflecting the populations the Trust serves:

- Birmingham and Solihull
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

Birmingham and Solihull

The electoral areas listed in Part A of this Annex for the three former Birmingham constituencies plus Solihull.

Rest of England and Wales

The electoral areas in England and Wales not comprised in the Birmingham and Solihull constituency. The minimum number of members for each Public Constituency is as follows:

Public Constituency	Minimum Number
Birmingham and Solihull	67
Rest of England and Wales	33
Total	100

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

All Staff eligible for membership as described in paragraph8 of the constitution will automatically become members of the Staff Membership Constituency upon Authorisation. Staff will have the right to opt out of automatic membership if they so wish.

There will be two classes of Staff Membership which will be determined based on Whitley Staff Groups:

- Clinical–comprising Medical, Nursing, Allied Health Professionals and Scientists

- Non-Clinical – comprising all staff not included in the clinical class.

There will be a minimum of 25% of total staff within each class, as specified below:

Staff Membership Class	**Number of Staff in Post**	**Minimum Number in Constituency**
Clinical	**468**	**117**
Non-Clinical	**339**	**85**

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust will not have a Patient Constituency, patients of the Trust may become members within the Public Constituency providing they fulfil the membership criteria.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 12.2 and 12.3)

PART A (until the Effective Date)

The Council of Governors is to comprise:

Elected Members

13 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
South Birmingham	5
Heart of Birmingham	1
Eastern and Northern Birmingham	2
Other West Midlands	4
Rest of England and Wales	1
Total	**13**

3 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	1
Total	**3**

In order to take into account the changing nature of the local health economy at the commissioning level, the Trust intends to retain the flexibility to increase the staff Members of Council and the Nominated Members of Council. Any increases in Staff Members of Council will require an increase in Public Members of Council in order to ensure that the relative proportion of Staff members to
other Constituencies remain constant.

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
South Birmingham PCT	1
Heart of Birmingham (Teaching) PCT	1
Birmingham City Council	1
University of Birmingham	1
University of Central England	1
Patient Support Group Representative	1
Birmingham Council of Faiths Representative	1
Local Member of Parliament Representative	1
Bournville Village Trust	1
Total	**9**

PART B (with effect from the Effective Date – see paragraph 37.1

Elected Members

9 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
Birmingham and Solihull	5
Rest of England and Wales	4
Total	**9**

4 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	2
Total	**4**

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
Birmingham City Council	1
Birmingham City University	1
Local Member of Parliament Representative	1
University of Birmingham	1
Bournville Village Trust	1
Total	**5**

ANNEX 5 –THE MODEL ELECTION RULES

(Paragraph 13.2)

Part 1-Interpretation

1.Interpretation

Part 2–Timetable for election

2.Timetable
3.Computation of time

Part 3–Returning officer

4.Returning officer
5.Staff
6.Expenditure
7.Duty of co-operation

Part 4-StagesCommontoContestedandUncontestedElections

8.Notice of election
9.Nomination of candidates
10.Candidate's consent and particulars
11.Declaration of interests
12.Declaration of eligibility
13.Signature of candidate
14.Decisions as to validity of nomination papers
15.Publication of statement of nominated candidates
16.Inspection of statement of nominated candidates and nomination papers
17.Withdrawal of candidates
18.Method of election

Part 5–Contested elections

19.Poll to be taken by ballot
20.The ballot paper
21.The declaration of identity

Action to be taken before the poll

22.List of eligible voters
23.Notice of poll
24.Issue of voting documents
25.Ballot paper envelope and covering envelope

Part 10 – Election expenses and publicity

Expenses

55. Expenses incurred by candidates
56. Expenses incurred by other persons
57. Personal, travelling, and administrative expenses

Publicity

58. Publicity about election by the Trust
59. Information about candidates for inclusion with voting documents
60. Meaning of “for the purposes of an election”

Part 11 – Questioning elections and irregularities

61. Application to question an election

Part 12 – Miscellaneous

62. Secrecy
63. Prohibition of disclosure of vote
64. Disqualification
65. Delay in postal service through industrial action or unforeseen event
66. Effect of administrative or clerical errors on election

Part 1 - Interpretation

1.Interpretation

(1)In these rules, unless the context otherwise requires:

"the Trust"	Means the Royal Orthopaedic Hospital NHS Foundation Trust;
"election"	Means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;
"Monitor"	Means the Independent Regulator for NHS foundation trusts; and
"the2006Act"	Means the National Health Service Act 2006.

(2)Other expressions used in these rules and inSchedule7 of the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2.Timetable

(1)The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

(1) In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday; or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2)In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

(1)Subject to rule 64, the returning officer for an election is to be appointed by the Trust.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

(1) Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

(1) The Trust is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules; and
(b) such remuneration and other expenses as the Trust may determine.

7. Duty of co-operation

(1) The Trust is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

(1) The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;
(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;
(c) the details of any nomination committee that has been established by the Trust;
(d) the address and times at which nomination papers may be obtained;
(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer;
(f) the date and time by which any notice of withdrawal must be received by the returning officer;
(g) the contact details of the returning officer; and
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

(1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer:

(a) is to supply any member of the Trust with a nomination paper; and
(b) is to prepare a nomination paper for signature at the request of any member of the Trust,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

(1) The nomination paper must state the candidate's:

(a) full name;
(b) contact address in full; and
(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

(1) The nomination paper must state:

(a) any financial interest that the candidate has in the Trust; and
(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

(1) The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

(1) The nomination paper must be signed and dated by the candidate, indicating that:

(a) they wish to stand as a candidate;
(b) their declaration of interests as required under rule 11, is true and correct; and
(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

(1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand;
(b) decides that the nomination paper is invalid;
(c) receives satisfactory proof that the candidate has died; or
(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election;
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;
(d) that the paper does not include a declaration of eligibility as required by rule 12; or
(e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

(1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing; and
(b) the declared interests of each candidate standing, as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the Trust as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

(1) The Trust is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the Trust is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

(1) A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

(1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.
(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the Trust.

Part 5 – Contested elections

19. Poll to be taken by ballot

(1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper

(1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify:

(a) the name of the Trust;
(b) the constituency, or class within a constituency, for which the election is being held;
(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;
(e) instructions on how to vote;
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and
(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter is the person to whom the ballot paper was addressed;
(b) that the voter has not marked or returned any other voting paper in the election; and
(c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter;
(b) the address of the voter;
(c) the voter's signature; and
(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(1) The Trust is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll

(1) The returning officer is to publish a notice of the poll stating:

(a) the name of the Trust;
(b) the constituency, or class within a constituency, for which the election is being held;
(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency;
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post;
(f) the address for return of the ballot papers, and the date and time of the close of the poll;
(g) the address and final dates for applications for replacement ballot papers; and
(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer

(1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the Trust named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope;
(b) a declaration of identity (if required);
(c) information about each candidate standing for election, pursuant to rule 59 of these rules; and
(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

(3)The returning officer shall have the right to edit or not publish any election statement if it exceeds the permitted number of words or because it contains statements which he reasonably believes are factually inaccurate, offensive or libellous.

25. Ballot paper envelope and covering envelope

(1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and
(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed declaration of identity if required; and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote

(1) An individual who becomes a member of the Trust on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

(1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers

(1) If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter’s identity; and
(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”):

(a) the name of the voter; and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and
(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers

(1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she:

(a) is satisfied as to the voter's identity;
(b) has no reason to doubt that the voter did not receive the original ballot paper; and
(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers"):

(a) the name of the voter; and
(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper

(1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers"):

(a) the name of the voter; and
(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration; and
(b) of the particulars of that member's qualification to vote as a member of the public or patient constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for:

(a) the name of the voter;
(b) the address of the voter;
(c) the voter's signature; and
(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents

(1) Where the returning officer receives a:

(a) covering envelope; or
(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or
(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper

(1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) put the declaration of identity if required in a separate packet; and
(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”;
(b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it the ballot paper;
(c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and
(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (public and patient constituency)

(1) Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to:

(a) mark the declaration of identity “disqualified”;
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and
(c) place the declaration of identity in a separate packet.

35. Sealing of packets

(1) As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;
(b) the declarations of identity if required;
(c) the list of spoilt ballot papers;
(d) the list of lost ballot papers;
(e) the list of eligible voters; and
(f) the list of tendered ballot papers.

Part 6 - Counting the votes

36. Interpretation of Part 6

(1) In Part 6 of these rules:

“continuing candidate”	Means any candidate not deemed to be elected, and not excluded;
“count”	Means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;

“deemed to be elected”	Means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;
“mark”	Means a figure, an identifiable written word, or a mark such as “X”;
“non- transferable vote”	Means a ballot paper– (a) on which no second or subsequent preference is recorded for a continuing candidate, or (b) which is excluded by the returning officer underrule44(4)below;
“preference”	As used in the following contexts has the meaning assigned below– (a) “first preference” means the figure “1” or any mark or word which clearly indicates a first (or only) preference, (b) “next available preference” means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and (c) in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on;
“quota”	Means the number calculated in accordance with rule 41 below;
“surplus”	Means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both)exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value)of all transferable papers from the candidate who has the surplus;

“stage of the count”	means– (a) the determination of the first preference vote of each candidate, (b) the transfer of a surplus of a candidate deemed to be elected, or (c) the exclusion of one or more candidates at any given time;
“transferable paper”	Means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;
“transferred vote”	means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred; and
“transfer value”	Means the value of a transferred vote calculated in accordance with paragraph(4) or (7) of rule 42 below.

37. Arrangements for counting of the votes

(1) The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count

(1)The returning officer is to:

(a) count and record the number of ballot papers that have been returned; and
(b) count the votes according to the provisions in this Part of the rules.

(2)The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3)The returning officer is to proceed continuously with counting the votes as far as is practicable.

39. Rejected ballot papers

(1)Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate;
(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or
(d) which is unmarked or rejected because of uncertainty,

Shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and soon, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2)The returning officer is to end orsethe word “rejected” on any ballot paper which under this rule is not to be counted.

(3)The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

40. First stage

(1)The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2)The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3)The returning officer is to also ascertain and record the number of valid ballot papers.

41. The quota

(1)There turning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2)The result, increased by one, of the division under paragraph(1)above(any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate(in these rules referred to as “the quota”).

(3)At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 44 has been complied with.

42. Transfer of votes

(1)Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those papers for any continuing candidate; or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2)The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3)The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1) (a) to the candidate for whom the next available preference is given on those papers.

(4)The vote on each ballot paper transferred under paragraph(3)above shall beat a value("the transfer value")which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5)Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those papers for any continuing candidate; or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6)The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5) (a)to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at:

(a) a transfer value calculated as set out in paragraph (4)(b) above; or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

(8)Each transfer of a surplus constitutes a stage in the count.

(9)Subject to paragraph(10),the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10)Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11)This rule does not apply at an election where there is only one vacancy.

43. Supplementary provisions on transfer

(1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2)The returning officer shall, on each transfer of transferable papers under rule42 above:

(a) record the total value of the votes transferred to each candidate;
(b) add that value to the previous total of votes recorded for each candidate and record the new total;
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and
(d) compare
    (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with
    (ii) the recorded total of valid first preference votes.

(3)All ballot papers transferred under rule 42 or 44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time toeachvoteonthatpaperor,asthecasemaybe,allthepapersinthatsub-parcel.

(4)Where a ballot paper is so marked that it is unclear to the returning officer

at any stage of the count under rule 42 or 44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non- transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

44. Exclusion of candidates

(1)If:

(a) all transferable papers which under the provisions of rule 42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred; and
(b) subject to rule 45 below, one or more vacancies remain to be filled,

The returning officer shall exclude from the election at that stage the candidate with the lowest vote (or, where paragraph (12) below applies, the candidates with the lowest votes).

(2)The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph(1)above into two sub-parcels so that they are grouped as:

(a) ballot papers on which a next available preference is given; and
(b) ballot papers on which no such preference is given (thereby including ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3)The returning officer shall, in accordance with this rule and rule 43 above, transfer each sub-parcel of ballot papers referred to in paragraph(2)(a) above to the candidate for whom the next available preference is given on those papers.

(4)The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5)If, subject to rule 45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6)The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7)The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8)Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9)After there turning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and soon until he has dealt with each sub-parcel of a candidate excluded under paragraph(1) above.

(10) The returning officer shall after each stage of the count completed under this rule:

(a) record:
    (i) the total value of votes; or
    (ii) the total transfer value of votes transferred to each candidate;
(b) add that total to the previous total of votes recorded for each candidate and record the new total;
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total; and
(d) compare:
    (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes; with
    (ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs(5) to (10) of rule 42 and rule 43.

(12)Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, there turning officer shall in one operation exclude such two or more candidates.

(13)If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

45. Filling of last vacancies

(1)Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall there upon be deemed to be elected.

(2)Where only one vacancy remains unfilled and the votes of anyone continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall there upon be deemed to be elected.

(3)Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

46. Order of election of candidates

(1)The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which the irrespective surpluses were transferred, or would have been transferred but for rule 42 (10) above.

(2)A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3)Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4)Where the number of votes credited to two or more candidates were equal at all stages of the count, there turning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

47. Declaration of result for contested elections

(1)In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;
(b) give notice of the name of each candidate who he or she has declared elected:
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the North Staffordshire Combined Healthcare NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust; or
    (ii) in any other case, to the chairman of the Trust; and

(c) give public notice of the name of each candidate who he or she has declared elected.

(2)There turning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not;
(b) any transfer of votes;
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place;
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule 39(1), available on request.

48. Declaration of result for uncontested elections

(1)In an uncontested election, there turning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;
(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the Trust; and
(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

49.Sealing up of documents relating to the poll

(1)On completion of the counting at a contested election, there turning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers;
(b) the ballot papers endorsed with “rejected in part”;
(c) the rejected ballot papers; and
(d) the statement of rejected ballot papers.

(2)There turning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;
(b) the declarations of identity;
(c) the list of spoilt ballot papers;
(d) the list of lost ballot papers;
(e) the list of eligible voters; and

(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

(a) its contents;
(b) the date of the publication of notice of the election;
(c) the name of the Trust to which the election relates; and
(d) the constituency, or class within a constituency, to which the election relates.

50.Delivery of documents

(1)Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, there turning officer is to forward them to the chair of the Trust.

51.Forwarding of documents received after close of the poll

(1)Where:

(a) any voting documents are received by the returning officer after the close of the poll; or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or
(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

There turning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the Trust.

52.Retention and public inspection of documents

(1)The Trust is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2)With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the Trust shall be available for inspection by members of the public at all reasonable times.

(3)A person may request a copy or extract from the documents relating to an election that are held by the Trust, and the Trust is to provide it, and may impose a reasonable charge for doing so.

53.Application for inspection of certain documents relating to an election

(1)The Trust may not allow the inspection of, or the opening of any sealed

packet containing:

(a) any rejected ballot papers, including ballot papers rejected in part;
(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers;
(d) any declarations of identity; or
(e) the list of eligible voters,

By any person without the consent of the regulator.

(2)A person may apply to the regulator to inspect any of the documents listed in(1),and there regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;
(b) time;
(c) place and mode of inspection;
(d) production or opening,

and the Trust must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1):

(a) in giving its consent, the regulator; and
(b) and making the documents available for inspection, the Trust,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given; and
(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

54.Counter m and or abandonment of poll on death of candidate

(1)If, at a contested election, proof is given to there turning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then there turning officer is to:

(a) publish a notice stating that the candidate has died; and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:
    (i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and
    (ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2)The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49(1)(a).

Part 10 – Election expenses and publicity

Election expenses

55.Election expenses

(1)Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

56.Expenses and payments by candidates

(1)A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election.

(2)Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

57.Election expenses incurred by other persons

(1)No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise; or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2)Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58.Publicity about election by the Trust

(1)The Trust may:

(a) compile and distribute such information about the candidates; and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2)Any information provided by the Trust about the candidates, including information compiled by the Trust under rule 59, must be:

(a) objective, balanced and fair;
(b) (as far as the information provided by the candidates so allows)equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election; and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3)Where the Trust proposes to hold a meeting to enable the candidates to speak, the Trust must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the Trust must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59.Information about candidates for inclusion with voting documents

(1)The Trust must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2)The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words (if supplied by the candidate); and
(b) a photograph of the candidate (if supplied by the candidate).

60.Meaningof “for the purposes of an election”

(1)In this Part, the phrase “for the purposes of an election” means with a view to, or otherwise in connection with, promoting or procuring a candidate’s election, including the prejudicing of another candidate’s electoral prospects;

and the phrase “for the purposes of a candidate’s election” is to be construed accordingly.

(2)The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

61.Application to question an election

(1)An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2)An application may only be made once the outcome of the election has been declared by the returning officer.

(3)An application may only be made to the regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote; or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4)The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and
(b) be in such a form as the regulator may require.

(5)The application must be presented in writing within 21 days of the declaration of the result of the election.

(6)If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(7) The regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.

(8)The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the Trust, the applicant and the members of the constituency (or class with in a constituency) including all the candidates for the election to which the application relates.

(9) The regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

62.Secrecy

(1)The following persons:

(a) the returning officer; and
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the Trust who has or has not been given a ballot paper or who has or has not voted;
(ii) the unique identifier on any ballot paper; and
(iii) the candidate(s)for who many member has voted.

(2)No person may obtain or attempt to obtain information as to the candidate(s)for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3)The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63.Prohibition of disclosure of vote

(1) No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification

(1) A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the Trust;
(b) an employee of the Trust;
(c) a director of the Trust; or
(d) employed by or on behalf of a person who has been nominated for election.

65.Delay in postal service through industrial action or unforeseen event

(1)If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24; or
(b) the return of the ballot papers and declarations of identity,

The returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the regulator.

66.Effect of administrative or clerical errors on election

(1)Elections shall not be invalidated by any administrative or clerical error on the part of the Trust or any acts or omissions of the returning officer acting in good faith on the basis of such error.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 15.3)

1. The Council of Governors will meet quarterly.

2. Any Member of Council judged by the Council of Governors to have acted in a manner which brings the Trust into disrepute will not be permitted to continue as a Member of Council.

3. NOT USED

4. The number of full terms of office for Elected Members of Council will be 3.

5. Where a vacancy arises due to an unforeseen event, the elected Member may only serve for the remaining term of office of the vacant position.

6. Under Clause 26.1, 75% of all the Members of Council have to be in support in order to remove the Chairman or Non-Executive Directors

7. The following may not become or continue as a member of the Council of Governors:

   7.1. They area Director of the Trust, or a Governor, Member of Council or Director of another NHS Body, or of an independent/private sector health care provider whose activities compete with those of the Trust. These restrictions do not apply to Appointed Partnership Members of Council;

   7.2. they are under sixteen years of age;

   7.3. being a member of a public constituency, they were or were entitled to be a member of one of the classes of the staff constituency at any point during the preceding two years;

   7.4. being a member of one of the public constituencies, they refuse to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

   7.5. they are currently on the sex offenders register.

   7.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, expiry of a fixed term

contract, disability, ill health or age from any paid employment with a health service body. In other cases of dismissal, such as capability, an individual may be permitted to become a Member of Council, at the discretion of the trust, and subject to full disclosure of the relevant circumstances and facts concerning that dismissal;

7.7. they are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non- attendance at meetings, or for non-disclosure of a pecuniary interest;

7.8. they have had their name removed, by a direction under section 46 of the 1977 NHS Act from any list prepared under Part II of that Act or have otherwise been disqualified or suspended from any healthcare profession, and have not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable);

7.9. they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

7.10. they are an elected Member of Council and they cease to be a member of the constituency or class by which they were elected. This may include, but is not restricted to, the reasons for ceasing to be a member identified in Annex 9;

7.11. they are a Member of Council appointed by a partnership organisation and they cease to be sponsored by their partnership organisation;

7.12. they are a member of the Patient and Public Involvement Forum relating to this Foundation Trust or anybody succeeding it in this role;

7.13. they fail to or indicate that they are unwilling to act in the best interests of the Trust and in accordance with The Seven Principles of Public Life laid out by the Committee on Standards in Public Life in its First Report as amended from time to time;

7.14. they fail to agree (or, having agreed, fail) to abide by the values of the Trust Principles set out in Annex 10.

8. A member of the Council of Governors shall immediately cease to be so if:

8.1. they resign in writing to the secretary;

8.2. they fail to attend at least half of the meetings of the Council of

Governors in any financial year, unless the majority of the Council of Governors are satisfied that;

8.2.1. their absences were due to reasonable causes, and

8.2.2. they will be able to start attending meetings of the Council of Governors again within such a period as the majority of Members of the Council of Governors consider reasonable.

8.3. if any of the provisions in paragraph 7 above apply.

8.4. without good reason they fail to undertake any training which the Council of Governors requires all members of the Council of Governors to undertake.

9. Members of the Council of Governors from elected staff who are subject to on-going formal disciplinary action in respect of their employment or engagement with the Trust, will be suspended from their membership of the Council of Governors pending the outcome of disciplinary action.

10. A Member of the Council of Governors may be removed from the Council of Governors by a resolution approved by not less than two-thirds of the remaining members of the Council of Governors present and voting at a general meeting of the Council of Governors on the grounds that:

10.1.1. they have committed a serious breach of the Trust Principles set out in Annex 10, or

10.1.2. they have acted in a manner detrimental to the interests of the trust, and

10.1.3. the Council of Governors consider that it is not in the best interests of the trust for them to continue as a member of the Council of Governors.

11. Where a vacancy arises from any reason (other than expiry of term of office) amongst the appointed member of the Council of Governors the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

12. Vacancies amongst the elected members of the Council of Governors will be dealt with under paragraph 9 of Annex 9.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 18)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Standing Orders
Council of Governors

21 July 2006

CONTENTS

1. INTRODUCTION

Statutory Framework

The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act").

The principal places of business of the Trust is:

- The Royal Orthopaedic Hospital, Bristol Road South, Northfield, Birmingham B31 2AP.

NHS Foundation Trusts are governed by Act of Parliament, mainly the 2006 Act and by their constitutions (Regulatory Framework).

The functions of the Trust are conferred by the Regulatory Framework. As a body corporate it has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The Regulatory Framework requires the Council of Governors to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders(on which he/she should be advised by the Company Secretary).

2.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in the interpretation and in addition:

"TRUST" means the Royal Orthopaedic Hospital NHS Foundation Trust.

"COUNCIL OF GOVERNORS" means the Council of Governors of the Trust as defined in the Constitution.

"BOARD OF DIRECTORS" means the Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.

"CHAIRMAN OF THE BOARD" or "Chairman of the Trust" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the

Trust as a whole. The expressions “the Chairman of the Board” and “the Chairman of the Trust” shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is so otherwise unavailable.

“CHIEF EXECUTIVE” means the chief executive officer of the Trust.

“COMMITTEE” means a committee of the Council of Governors

“CONSTITUTION” means the constitution of the Foundation Trust.

“COMMITTEE MEMBERS” means the Chairman and the Members of Council or Directors formally appointed by the Council of Governors or Board of Directors to sit on or to chair specific committees.

“COMPANY SECRETARY TO THE TRUST” means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust’s compliance with the Regulatory Framework and these standing orders.

“EXECUTIVE DIRECTOR” means a Member of the Board of Directors who holds an executive office of the Trust.

“LEAD GOVERNOR” means a Member of the Council elected by the Council of Governors to hold that office for a term determined by the Council of Governors who may also be removed from office by a resolution of the Council of Governors.

“MEMBEROFTHECOUNCIL” means a Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the Chairman).

“NON-EXECUTIVE DIRECTOR” means a member of the Board of Directors who does not hold an executive office with the Trust.

“OFFICER” means employee of the Trust or any other person holding a paid appointment or office with the Trust.

“SOs” means these Standing Orders.

“VICE CHAIRMAN” means the Non-Executive Director appointed from amongst the Non-Executive Directors as Vice Chairman by the Council of Governors to take on the Chairman’s duties in his capacity as chairman of the Council of Governors if the Chairman is absent for any reason.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council of Governors

3.1.1 In accordance with the Constitution of the Foundation Trust, the composition of the Council of Governors after the Effective Date shall be:

- 9 Public representatives
- 4 Staff representatives
- 5 nominated representatives comprising
  - 1 University of Birmingham representative
  - 1 Birmingham City University representative
  - 1 Birmingham City Council representative
  - 1 Member of Parliament representative
  - 1 representative of Bournville Village Trust

3.2 Role of the Chairman

3.2.1 The Chairman is not a member of the Council of Governors. However under the Regulatory Framework, he/she presides at meetings of the Council of Governors and has a casting vote.

3.2.2 Where the Chairman of the Trust has died or has ceased to hold office, or where he/she has been unable to perform his/her duties as Chairman owing to illness or any other cause, the Vice Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his/her duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include references to the Vice Chairman.

3.3 Role and Responsibilities of the Council of Governors

3.3.1 The role and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust Constitution, are:

- To appoint or remove the Chairman and other Non-Executive Directors of the Foundation Trust at a members' general meeting (except for the initial Chairman and Non-Executive Directors)
- To approve (by a majority of members of the Council of Governors) the appointment by the Non-Executive Directors of the Chief Executive (except for the initial Chief Executive)
- To appoint or remove the auditor at a general meeting of the Council of Governors.
- To be consulted by the Trust's Board of Directors on forward planning and to have the Council of Governors' views taken into account
- To be presented with, at a general meeting of the Council of Governors, the Annual Report and Accounts and the report of the auditor

3.3.2 The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its Directors. The Council of Governors does not have the right to veto decisions made by the Board of Directors.

3.3.3 The Members' Council, and individual Members of Council, are not empowered to speak on behalf of the Trust, and must seek the advice and views of the Chairman concerning any contact from the media or any invitation to speak publicly about the Trust or their role within it.

4. MEETINGS OF THE COUNCIL

4.1 Admission of the Public

4.1.1 The public shall be afforded facilities to attend all formal meetings of the Council of Governors except where the Council resolves:

(a) That members of the public be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public; and/or

(b) That in the interests of the public order the meeting adjourn for a period to be specified in such resolution to enable the Council to complete business without the presence of the public.

4.1.2 Nothing in these Standing Orders shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

4.2 Calling Meetings

4.2.1 Ordinary meetings of the Council shall be held at such times and places as the Council may determine and there shall be not less than 3 or more than 4 formal meetings in any year except in exceptional circumstances.

4.2.2 The Chairman of the Foundation Trust may call a meeting of the Council at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of Members of the Council, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at Trust's Headquarters, such one third or more Members of the Council may forthwith call a meeting.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his/her behalf shall be delivered to every Member of the Council, or sent by post to the usual

place of residence of such Member of the Council, so as to be available to him at least three clear days before the meeting.

4.3.2 Want of service of the notice on any Member of the Council shall not affect the validity of a meeting.

4.3.3 In the case of a meeting called by Members of the Council in default of the Chairman, the notice shall be signed by those Members of the Council and no business shall be transacted at the meeting other than specified in the notice.

4.3.4 Agendas will be sent to Members of the Council before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

4.3.5 Before each meeting of the Council a public notice of the time and place of the meeting shall be displayed at the Trust's offices at least three clear days before the meeting.

4.4 Setting the agenda

4.4.1 The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2 A Member of the Council desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5 Petitions

4.5.1 Where a petition has been received by the Trust, the Chairman of the Council shall include the petition as an item for the agenda of the next Council meeting.

4.6 Chairman of Meeting

4.6.1 At any meeting of the Council, the Chairman of the Trust, if present, shall preside, unless he/she has a conflict of interest. If the Chairman is absent from the meeting or has a conflict of interest the Vice Chairman, if he/she is present, shall preside, unless he/she also has a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive

Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

4.7 Notices of Motion

4.7.1 A Member of the Council desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

4.8 Withdrawal of Motion or Amendments

4.8.1 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.9 Motion to Rescind a Resolution

4.9.1 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Member of the Council who gives it and also the signature of four other Council Members. When any such motion has been disposed of by the Council, it shall not be competent for any member other that the Chairman to propose a motion to the same effect within six months, however the Chairman may do so if he/she considers it appropriate.

4.10 Motions

4.10.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.10.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Council to move:

- An amendment to the motion
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business(*)
- The appointment of an adhoc committee to deal with a specific item of business
- That the motion be now put.(*)
- A motion resolving to exclude the public under SO4.1.1.

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Member of the Council who has not previously taken part in debate and who is eligible to vote.

No amendment to the motion shall be admitted, if in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.11 Chairman's Ruling

Statements of Members of the Council made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.12 Voting

4.12.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Members of the Council present and voting on the question and, in the case of number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

4.12.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Council present so request.

4.12.3 If at least one-third of the Members of the Council present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Council present voted or abstained.

4.12.4 If a Member of the Council so requests, his/her vote shall be recorded by name upon any vote (other than paper ballot).

4.12.5 In no circumstances may an absent Member of the Council vote by proxy. Absence is defined as being absent at the time of the vote.

4.13 Minutes

4.13.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

4.13.3 Minutes shall be circulated in accordance with the members' wishes.

4.14 Suspension of Standing Orders

4.14.1 Except where this would contravene any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one public Member of Council and one patient Member of Council, and that a majority of those present vote in favour of suspension.

4.14.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.14.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Members of the Council.

4.14.4 No formal business may be transacted while Standing Orders are suspended.

4.15 Variation and Amendment of Standing Orders

4.15.1 These Standing Orders shall be amended only if:

- a notice of a motion under Standing Order 4.7 has been given; and
- no fewer than half the total of the members of the Council of Governors vote in favour of amendment; and
- at least two-thirds of the members of the Council of Governors are present; and
- the variation proposed does not contravene a statutory provision and is approved in accordance with paragraph 45 of the Trust's Constitution .

4.16 Record of Attendance

4.16.1 The names of the Chairman and Members of the Council present at the meeting shall be recorded in the minutes.

4.17 Quorum

4.17.1 No business shall be transacted at a meeting unless at least six Members of Council are present of which at least two are public Members of Council.

4.17.2 If a Member of the Council has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6, 7 or 8) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. COMMITTEES

5.1 Subject to the Regulatory Framework, the Council may appoint committees of the Council to assist the Council in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly of the Chairman and Members of the Council of Governors.

5.2 A committee appointed under this regulation may, subject to any restriction imposed by the Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chairman" is to be read as a reference to the Chairman of the Committee as the context permits, and the term "Member of the Council" is to be read as a reference to a member of the committee also as the context permits.

5.4 Subject to Standing Order 5.5, each sub-committee shall have such terms of reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance for Governors issued by Monitor. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Council may not delegate any decision-making or executive powers to any committee or sub-committee.

5.6 The Council shall approve the appointments to each of the committees which it has formally constituted.

5.7 The committees and sub-committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 The Regulatory Framework requires Council Members to declare interests which are relevant and material to the Council of which they are a Member. All existing Council Members should declare such interests. Any Council Members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as "relevant and material" are defined in the Trust's Constitution as follows:

any pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors

6.1.3 At the time Council members' interests are declared, they should be recorded in the Council minutes. Any changes in interests should be declared at the next Council meeting following the change occurring.

6.1.4 Council members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.1.5 During the course of a Council Meeting, if a conflict of interest is established, the Member of the Council concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.1.6 There is no requirement for the interests of Council members' spouses or partners to be declared. However Standing Order 7, which is based on the regulations, requires that the interests of Members of the Council's spouses, if living together, in contracts should be declared. Therefore the interests of Council Members' spouses and cohabiting partners should also be regarded as relevant.

6.1.7 If Council members have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.2 Register of Interests

6.2.1 The Company Secretary to the Trust will ensure that a Register of Interests is established to record formally declarations of interests of Council Members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by Council Members, as defined in Standing Order 6.1.2.

6.2.2 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared will be incorporated.

6.2.3 The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.2.4 In establishing, maintaining, updating and publicising the Register, the Trust shall comply with the Regulatory Framework.

7. DISABILITY OF CHAIR AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chairman or another Member of the Council has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council may exclude the Chairman (or Member of the Council) from a meeting of the Council while any contract, proposed contract or other matter in which he/she has pecuniary interest, is under consideration.

7.3 For the purpose of this Standing Order the Chairman or Member of the Council shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she, is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.4 The Chairman or a member of the Council shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in a company, body or person with which he/she is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Member of the Council in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Member of Council:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

7.6 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Council and applies to a Member of the Council of any such committee or sub-committee as it applies to a Member of the Council.

8. STANDARDS OF BUSINESS CONDUCT POLICY

8.1 Members of Council should comply with the Trust Constitution, the NHS principles of conduct, the NHS Foundation Trust Code of Governance, published by Monitor, the requirements of the Regulatory Framework, and any guidance for Governors issued by Monitor.

8.2 Interest of Members of Council in Contracts

8.2.1 If it comes to the knowledge of a Member of Council that a contract in which he/she has any pecuniary interest not being a contract to which he/she is a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Company Secretary of the Trust of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A Member of Council should also declare to the Company Secretary of the Trust any other employment or business or other relationship of his/hers, or of cohabitating spouse, which might reasonably be predicted could conflict with the interests of the Corporation.

8.3 Canvassing of and recommendations by Members of the Council in Relation to Appointments

8.3.1 Canvassing of Members of Council of the Trust or of any Committee of the Council of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment.

8.3.2 A Member of the Council shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Member of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.4 Relatives of Members of the Council or Officers

8.4.1 Candidates for any staff appointment under the Trust, shall when making application, disclose in writing to the Trust whether they are related to any Member of the Board of Directors or Council of Governors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.4.2 The Chairman and every Member of the Council and officer of the Trust shall disclose to the Chief Executive any relationship between him/herself and a candidate of whose candidature that Member of the Council or Officer is aware.

8.4.3 On appointment, Members of the Council (and prior to acceptance of an appointment in the case of officer members) should disclose to the Council whether they are related to any other Member of the Council or holder of any office in the Trust.

8.4.4 Where the relationship to a Member of the Council of the Trust is disclosed, the Standing Order headed Disability of Chairman and Members of the Board in proceedings on account of pecuniary interest (SO 7) shall apply.

9. MISCELLANEOUS

9.1 Standing Orders to be given to Members of the Council

9.1.1 It is the duty of the Company Secretary to the Trust to ensure that existing Members of the Council and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

9.2 Review of Standing Orders

9.2.1 Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 31)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Board of Directors

STANDINGORDERS

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, and subject to the Constitution at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing orders (on which they should be advised by the Company Secretary to the Board of Directors in their absence the Chief Executive or Director of Finance

1.2 Any expression to which a meaning is given in the National Health Service Acts or the Health and Social Care(Community Health and Standards)Act 2003 or in the Regulations and Orders made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions, unless the context otherwise requires and in addition:

1.2.1 **"Accounting Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means the Royal Orthopaedic Hospital NHS Foundation Trust.

1.2.3 **"Board of Directors"** means the Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **“Budget holder”** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chairman of the Board of Directors"** is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions “the Chairman of the Board” and "the Chairman of the Trust" shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable. The Chairman is also the Chairman of the Council of Governors.

1.2.7 **"Chief Executive"** means the Chief Executive Officer of the Trust.

1.2.8 "**Executive Director**” means a member of the Board of Directors who

holds an executive office of the Trust.

1.2.9 **“Integrated Governance Committee"** means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Royal Orthopaedic Hospital NHS Foundation Trust has responsibility.

1.2.10 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.11 **"Committee"** means a formal committee or sub-committee created and appointed by the Board of Directors.

1.2.12 "**Committee members**" means members formally appointed by the Board of Directors to sit on or to chair specific committees.

1.2.13 "**Constitution**" means the constitution of the Foundation Trust.

1.2.14 "**Company Secretary**" means a person appointed to act independently of the Board of Directors to provide advice on corporate governance issues to the Board of Directors and the Chairman and monitor the Trust's compliance with the Regulatory Framework and the Standing Orders.

1.2.15 "**Director of Finance**" means the Chief Financial Officer of the Trust.

1.2.16 “**Funds held on trust**” shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under the Regulatory Framework. Such funds may or may not be charitable.

1.2.17 "**Member**" means Executive Director or Non-Executive Director of the Board of Directors as the context permits.

1.2.18 “**Associate Member**” means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Board of Directors for them to perform and these duties have been recorded in an appropriate Board minute or other suitable record.

1.2.19 "**Members’ Council**" means the Members’ Council of the Trust defined in the Constitution.

1.2.20 "**Officer**" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.21 “**Nominated officer**" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.22 "**Non-Executive Director**" means a member of the Board of Directors who does not hold an executive office with the Trust and is appointed by the Council of Governors (accept the initial Non-Executive Directors).

1.2.23 "**Officer**" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.24 "**SFIs**" means Standing Financial Instructions.

1.2.25**"SOs"** means Standing Orders.

1.2.26 **“Vice Chairman"** means the Non-Executive Director appointed by the Council of Governors in general meeting from the Non- Executive Directors as Vice Chairman to take on the Chairman's duties in his capacity as Chairman if the Chairman is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act").

(1) The principal place of business of the Trust is Royal Orthopaedic Hospital NHS Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

(2) NHS Foundation Trusts are governed by Act of Parliament, mainly the 2006 Act and by their constitutions(the Regulatory Framework)

(3) The functions of the Corporation are conferred by the Regulatory Framework.

(4) As a body corporate, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients property held by the Trust on behalf of patients.

(5) The Regulatory Framework requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust has also adopted Standing Financial Instructions(SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

(6) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 Monitor and the NHS Framework

(1) In addition to the statutory requirements, Monitor's provider licence requires the Trust to comply with best practice in the NHS.

(2) The Regulatory Framework requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board of Directors, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The framework also requires the establishment of audit and remuneration and appointment committees with formally agreed terms of reference. The Code of Conduct, which the Trust has adopted

as the Code of Conduct for its directors, makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee or sub-committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as required by any guidance issued by Monitor". Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). (See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual.) This document has effect as if in corporated into the Standing Orders. Delegated Powers are covered in a separate document entitled–'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.4 Integrated Governance

Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision- making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance will better enable the Board of Directors to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Board of Directors

In accordance with the Trust's constitution, the composition of the Board of Directors shall be:

(1) The Chairman of the Trust who is also the Chairman of the Council of Governors will be appointed by the Council of Governors;

(2) Up to 7Non-Executive Directors appointed by the Council of Governors;

(3) Up to 7 Executive Directors including:

- the Chief Executive (whose appointment is to be approved by the Council of Governors except the initial Chief Executive);
- the Director of Finance;
- a Medical Practitioner
- a Registered Nurse

2.2 Terms of Office of the Chairman and Members

(1) The period of tenure of office of the Chairman and members of the Board of Directors and the termination or suspension of office of the Chairman and Directors are matters to be decided by their appointer under the Constitution

2.3 Appointment and Powers of Vice Chairman

(1) Subject to Standing Order 2.3(2) below, the Chairman and members of the Trust may appoint one of their number who is not also an Executive Director, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Deputy-Chairman by giving notice in writing to the Chairman. The Chairman and members may there upon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.3 (1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where he/she have been unable to perform his her duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case maybe; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

(4) The Chairman should appoint one of the Non-Executive Directors to be the senior Director in consultation with the Council of Governors and the Non-Executive Directors.

2.4 NOT USED

2.5 Role of Members

The Board of Directors will function as a corporate decision-making body, Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Directors**

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. They should be the **Accounting Officer** for the Trust and shall be responsible to Monitor under the NHS Foundation Trust Accounting Officer Memorandum.

(3) **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They should be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chairman**

The Chairman shall be responsible for the operation of the Board of Directors and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the

Board of Directors to inform the debate and ultimate resolutions.

The Chairman will also be the Chairman of the Council of Governors.

2.6 Corporate Role of the Board of Directors

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall beheld in the name of the Trust as corporate trustee.

2.7 Schedule of Matters Reserved to the Board of Directors and Scheme of Delegation

(1) The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.8 Lead Roles for Board Members

The Chairman will ensure that the designation of Lead roles or appointments of Board members as set out in any statutory or other guidance binding on the Trust will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may determine.

(2) The Chairman of the Trust may call a meeting of the Board of Directors at any time.

(3) One third or more members of the Board of Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forth with call a meeting.

(4) The Board of Directors will meet at least once per annum in public.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

(5) Before each public meeting of the Board of Directors a notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting.

3.3 Agenda and Supporting Papers

The Agenda will be sent to members 6 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 ‘Motions: Procedure at and during a meeting’ and 3.8 ‘Motions to rescind a resolution’, a member of the Board of Directors wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

(2) The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 ‘Motions: Procedure at and during a meeting’, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

(i) Who may propose

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

(ii) Contents of motions

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board of Directors;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

(iii) Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(iv) **Rights of reply to motions**

(a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

(v) **With drawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

(vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business (*);
- that the question should be now put (*);
- the appointment of an 'adhoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion resolving to exclude the public, including the press.

(*) In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

1. Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who give sit and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

2. When any such motion has been dealt with by the Board of Directors it shall not be competent for any director other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive

3.9 Chairman of meeting

(1) At any meeting of the Board of Directors the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (if the Board of Directors has appointed one), if present, shall preside.

(2) If the Chairman and Vice-Chairman are absent, such member(who is not also an Executive Director of the Trust) as the members present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity(including procedure on handling motions)and their interpretation of the Standing Orders and Standing Financial Instructions ,at the meeting, shall be final.

3.11 Quorum

(i) No business shall be transacted at a meeting unless at least

one-third of the whole number of the Chairman and members(including at least one member who is also an Executive Director of the Trust and one Non-Executive Director)is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

(i) Save as provided in Standing Orders 3.l3 - Suspension of Standing Orders and 3.l4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote.

(ii) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(iv) If a member so requests, their vote shall be recorded by name.

(v) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

(vi) A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

(vii) A manager attending the Board of Directors meeting to

represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or rules relating to the quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board of Directors are present (including at least one member who is an Executive Director of the Trust and one Non-Executive who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the decision to suspend Standing Orders shall be recorded in the Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

(iii) Formal business can only be transacted while standing orders have been suspended with the written agreement of the Audit Committee.

(iv) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.16 has been given; and
- no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
- at least two-thirds of the Board members are present; and
- the variation proposed does not contravene the requirements of Monitor.

3.15 Record of Attendance

The names of the Chairman and Directors present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted

for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

3.17 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all public meetings of the Trust, but shall be required to withdraw upon the Board of Directors as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'-*Guidance should be sought from the NHS Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.*

(ii) **General disturbances**

The Chairman (or Deputy-Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

- `That in the interests of public order the meeting adjourn for(the period to be specified)to enable the Board of Directors to complete its business without the presence of the public'.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed' Items Taken in Private 'outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.18 Observers at Board of Directors meetings

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board of Directors' meetings and may change, alter or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

Subject to the Regulatory Framework, the Board of Directors may appoint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term "Chairman" is to be read as a reference to the Chairman of other committees as the context permits, and the term "member" is to be read as a reference to a member of other committees also as the context permits. (There is no requirement to hold meetings of committees established by the Board of Directors in public.)

4.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.4 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

4.5 Approval of Appointments to Committees

The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.6 Appointments for Statutory functions

Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Regulatory Framework, and where such appointments are to

operate independently of the Board of Directors such appointment shall be made in accordance with the relevant legislation.

4.7 Committees established by the Board of Directors

The committees and sub-committees established by the Board of Directors are:

4.7.1 Audit Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs Report, an Audit Committee will be established and constituted to provide the Board of Directors with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Board of Directors and reviewed on a periodic basis.

The Higgs Report recommends a minimum of three non-executive directors be appointed, unless the Board of Directors decides otherwise, of which one must have significant, recent and relevant financial experience.

4.7.2 Remuneration and Appointments Committee

In line with the recommendations in Monitor's Foundation Trust Code of Governance and the Higgs Report, a Remuneration and Appointments Committee will be established and constituted.

The Higgs Report recommends the committee be comprised exclusively of Non- Executive Directors, a minimum of three, who are independent of management.

The purpose of the Committee will be to advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms.

4.7.3 Charitable Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Board of Directors will

establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charity Commission.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions 29.

4.7.4 **Integrated Governance Committee**

In line with the recommendations in the 'Integrated Governance Handbook' an Integrated Governance Committee will be established and constituted to provide the Board of Directors with assurance that robust systems and processes are in place for the delivery of excellent governance across all areas of the Trust's activities. It will carry out this role through the monitoring of a set of high level key performance indictors in both the clinical and non-clinical areas.

The committee will advise the Board of Directors on achievement of the eight elements of Integrated Governance:-

- resources
- efficiency and economy
- compliance with authorisations
- compliance with Standards for Better Health
- duty of quality
- duty of partnership
- duty of patient and public involvement
- ongoing Board development.

The committee will be chaired by a Non-Executive Director of the Trust.

4.7.5 **Other Committees**

The Board of Directors may also establish such other committees as required to discharge the Trust's responsibilities

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 The Board of Directors may make arrangements for the exercise, on behalf of the Board of Directors, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 4,or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board of Directors has reserved to itself within these Standing Orders (see Standing Order2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board of Directors for noting.

5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by other committees or sub-committees, which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees, or sub-committees and their specific executive powers shall be approved by the Board of Directors.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board of Directors. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance to provide information and advise the Board of Directors in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board of Directors as set out in the "Schedule of Matters Reserved to the Board" and “Scheme of Delegation” of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and

Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non- compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the Royal Orthopaedic Hospital NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for the Royal Orthopaedic Hospital NHS Foundation Trust staff

- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the

Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to the Board of Directors

(i) The Regulatory Framework requires members of the Board of Directors to declare interests which are relevant and material to the Board of Directors of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do soon appointment.

7.1.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
(b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
(c) Majority or controlling shareholding in organisations likely or possibly seeking to do business with the NHS;
(d) A position of Authority in a charity or voluntary organisation or local authority in the field of health and social care;
(e) Any connection with a voluntary or the organisation contracting for NHS services;
(f) Research funding/ grants that may be received by an individual or their department;
(g) Interests in pooled funds that are under separate management.

(ii) Any member of the Board of Directors who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare their

interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 **Advice on Interests**

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Board of Directors or with the Trust's Company Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 **Recording of Interests in Board minutes**

At the time Board members' interests are declared, they should be recorded in the Board minutes.

Any changes in interests should be declared at the next Board of Directors meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

7.2.1 The Company Secretary will ensure that a Register of Interest is established to record formally declarations of interests of Board or Committee members. In particular, the Register (as defined in SO7.1.2) which have been declared by both executive and non-executive board directors.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Members in proceedings on account of Pecuniary Interest

7.3.1 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"
Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

(a) they, or a nominee of theirs, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(b) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) Exception to Pecuniary interests
A person shall not be regarded as having a pecuniary interest in any contract if:-

(a) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or

(b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract, or

(c) those securities of any company in which they (or any person connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one percent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph(c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 **Exclusion in proceedings of the Board of Directors**

(i) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contractor other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Board of Directors may exclude the Chairman or a member of the Board from a meeting of the Board of Directors while any contract, proposed contractor other matter in which they have a pecuniary interest is under consideration.

(iii) Any remuneration, compensation or allowance payable to the Chairman or a Member in their capacity as Chairman or member of the Board of Directors as agreed by the Remuneration and Appointments Committee shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(iv) This Standing Order applies to a committee or sub-committee as it applies to the Board.

7.3.3 **Waiver**

The disability in Standing Orders which prevents a Chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he/she has a pecuniary interest) is removed (waiver) as stated in sub- sections (2) to (4) below.

(2) Definition of ‘Chairman’ for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3)(below), the “relevant Chairman” is –

(a) at a meeting of the Board of Directors, the Chairman of the Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;
(ii) in the case of any other member, the Chairman of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of the Royal Orthopaedic Hospital NHS Foundation Trust ("the Trust"), who is a health care professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance of services in accordance with the Trust's Constitution for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he/she is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant Chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose their interest as soon as

practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant Chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3(2)(b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it; but

(iii) the resolutions which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Board of Directors.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff and Directors must comply with the Trust's Constitution, the requirements of the Regulatory Framework and any guidance that has been adopted by the Trust.

7.4.2 Interest of Officers in Contracts

(i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Company Secretary or Chief Executive as soon as practicable.

(ii) An Officer should also declare to the Company Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

(iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

(i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust

7.4.4 Relates of Directors or Officers

(i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(ii) The Chairman and every Executive and Non-Executive Director of the Trust shall disclose to the Board of Directors any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

(iii) On appointment, Non-Executive Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed "Disability of Chairman and members in proceedings on account of pecuniary interest" (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Company Secretary or a nominated manager by them in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Company Secretary shall keep a register in which they, or another manager of the Authority authorised by them, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS (see overlap with SFINo.21.3)

9.1 **Standing Orders to be given to Board of Directors**

9.1.1 It is the duty of the Company Secretary to the Trust to ensure that existing Board of Directors and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

9.2 **Review of Standing Orders**

9.2.1 Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph 10.4)

1. A person may not become a member of the Foundation Trust if within the last five years they have been involved as a perpetrator in an incident of violence or abuse at any NHS hospitals or facilities; against any NHS employees or other persons who exercise functions for the purposes of the NHS; against registered volunteers; against patients or the public on NHS premises.

2. A member shall cease to be a member if:

   - they resign by notice to the Company Secretary;
   - they die;
   - they are expelled from membership under this constitution;
   - they cease to been titled under this constitution to be a member of any of the public constituencies or of any of the classes of the staff constituency;
   - if after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a member of the Trust.

3. A member may be expelled by a resolution approved by not less than two- thirds of the members of the Council of Governors present and voting at a General Meeting. The following procedure is to be adopted:

   - Any member may complain to the Company Secretary that another member has acted in away detrimental to the interests of the Trust.
   - The Chair of the Council of Governors, assisted by the Company Secretary, will judge the manner in which the complaint should be managed.
   - If appropriate, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that the point of view of the members involved is heard and may either:
     - dismiss the complaint and taken no further action; or
     - arrange for the complaint to be considered at the next General Meeting of the Council of Governors.
   - Details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the next General Meeting of the Council of Governors.
   - At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.
   - If the member complained of fails to attend the meeting without reasonable cause the meeting may proceed in their absence.
   - The Council of Governors will take a view on the complaint and

may decide to expel the member from membership of the Foundation Trust. To effect expulsion from membership, the Council of Governors will adopt a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a General Meeting.

- A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel the miscarried.

4. A member who is expelled may apply for re-admission to membership. This application is to be made in writing to the Chair, who will arrange for the application to be considered by the next General meeting of the Council of Governors. No person who has been expelled from membership is to be re- admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a General Meeting.

5. The Trust may have a Company Secretary, who may be appointed and removed by resolution of the Board of Directors.

6. The Company Secretary and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly and the Trust may also take out and maintain for their benefit insurance against such risks. Any costs arising in this way will be met by the Trust.

7. The validity of any act of the Trust is not affected by any vacancy among the directors or the Members of Council or by any defect in the appointment of any director or Member of Council.

8.

8.1. If:

(a) an executive director is temporarily unable to perform their duties due to illness or some other reason(the "Absent Director");and

(b) the Board of Directors agree that it is in appropriate to terminate the Absent Director’s term of office and appoint a replacement director; and

(c) the Board of Directors agree that the duties of the Absent Director need to be carried out;

Then the Chair (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting director as an additional director to carry out the Absent Director’s duties temporarily.

8.2. For the purposes of paragraph 8.1 of this Annex, the maximum number

of directors that may be appointed under paragraph 23.2.3 of the Constitution shall be relaxed accordingly.

8.3. The Acting director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint them under this paragraph notifies them that they are no longer to act as an Acting director.

8.4. An Acting director shall be an Executive Director for the purposes of the 2006 Act. They shall be responsible for their own acts and defaults and they shall not be deemed to be the agent of the Absent Director.

8.5. If:

(a) an executive director post is vacant ("Vacant Position");and
(b) the board of directors agree that the Vacant Position needs to be filled by an inter impost holder pending appointment of a permanent post holder,

Then the Chair (if the Vacant Position is the Chief Executive) or the Chief Executive (in any other case) may appoint a director as an interim director ("Interim Director") to fill the Vacant Position pending appointment of a permanent post holder.

8.6. The Interim Director will vacate office on the appointment of a permanent post holder or, if earlier, the date on which the persons entitled to appoint them under this paragraph notifies them that they no longer wish them to act as an Interim Director.

8.7. An Interim Director shall be an Executive Director for the purposes of the 2006 Act.

9. When a vacancy arises for one or more elected Members of Council, the Council of Governors shall have the option:

(a) to take from the list of members who stood for election at the most recent election of Members of Council for the class or constituency in question whichever member who was not elected as a Member of Council at the recent election but had secured the next most votes at that time. This procedure, which shall be an uncontested election for the purposes of the Model Rules for Elections as they apply to the trust, shall be available to the Members of Council on 2 occasions within 12 months of the previous election. Members of Council appointed in this way shall hold office for a minimum of 6 months from their appointment but, subject thereto, shall hold office until the earlier of the conclusion of the next election of Members of Council and (except where the vacancy arose through expiry of a term of office) the date on which would have expired the term of office of that Member of Council whose cessation of office gave rise to the vacancy;

(b) to hold the post vacant until the next scheduled annual election of Members of Council; or
(c) proceed to call an election for the vacant post.

ANNEX 10 – TRUST PRINCIPLES

Trust

The Trust's values aim to create a culture of excellent patient care by ensuring all at the Trust:

- Respect and listen to everyone
- Have compassion for all
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Be open, honest and challenge ourselves to deliver the best
- Learn, innovate and improve to continually develop orthopaedic care

Members of Council

As to qualities of Members and Members of Council:

- Honesty and integrity
- Promotion of racial and religious tolerance
- Representation of broad public constituency
- Awareness of community diversity and a willingness to be trained in that context

The Council of Governors may from time to time amend or vary such statement of principles as it thinks fit.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: **30 July 2014** **ENCLOSURE NUMBER: 16**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Rod Anthony Chair of Audit Committee**
SUBJECT:	**Chair of Audit Committee's Update**

SUMMARY

To provide an update to the Board from the Chair of the Audit Committee

IMPLICATIONS

Provides assurance to the Board regarding the work of the Audit Committee

RECOMMENDATIONS

That the Board note this report

The Audit Committee met on the 8 July, matters to brief the Board are:

1. **Internal and External Audit and Counter Fraud**

   The committee received reports from Internal Audit (Baker Tilly), Counter Fraud (Baker Tilly) and Deloitte (external audit).

   a. Due to the timing of the meeting (early July), there was little to update. Both Deloitte and Baker Tilly, therefore briefed the committee on developments within the wider NHS.
   b. We considered developments in:
      i. The Monitor "well led" framework (and noted that this had been discussed at the Board)
      ii. The NAO review of Whistleblowing procedures (the committee noted the current review ongoing within ROH)
      iii. The current Consultation on "False or Misleading Information"
      iv. NHS Procurement Development Programme- aiming to save £1.5bn across the NHS (the committee discussed the possible impact of this on ROH)
      v. 2015/16 National Tariff
      vi. PAS/EPR lifecycle and challenges
   c. The committee also received from Baker Tilly an update on benchmarking of the Levels of Fraud in the NHS; source of fraud referrals, type of referrals, and emerging fraud risks. The committee considered briefly the fraud risks facing the ROH.
   d. The committee also considered the risk of a cyber-attack, as identified in recent studies across the NHS.
   e. Deloitte had also undertaken a risk assessment of ROH (as part of normal audit planning for 2014/15). This covered EBITDA Margin, Liquidity, Governance, CIPs, Workforce. Key areas of risk were – achieving challenging CIPs targets and the high cost of Agency staff within the Trust. The DoF would take these to EMT/SMT for further consideration.
   f. The committee felt that all of the above were relevant matters, and should be tabled/communicated to the SMT/EMT- the DoF agreed to come back to next audit committee with a management view/steer on each the areas.

2. **Whistle blowing procedure**

   In the context of the discussion about the Whistle blowing procedure, the committee discussed the current broadening of the Whistle blowing procedure definition, but recognised the distinction between formal whistle blowing (which has a legal status) and the ability for staff to raise concerns, especially within meeting standards of care. This needed an open and learning based culture where all staff felt at ease.

3. Self-assessment and reference costing return

The committee had sight of the draft internal audit report from Baker Tilly which provided for *Substantial Assurance* over the controls operating within the reference costing process. Following a discussion, the committee approved the submission of the self-assessment and reference costing return to the DoH as compliant with the relevant guidance. The return is due on 31 July 2014.

4. Waiting Lists

The committee received an update on the review of the Management of the Waiting Lists from Amanda Markell (Director of Operations). This update focused on the progress implementing the Internal Audit actions and recommendations. The following were noted:

a. Amanda and her team had worked closely with Internal Audit in completing the implementation plan
b. Significant progress had been made, and this would be reviewed with IA next week.
c. The management of this areas was now close to “business as usual”, however the audit committee would like to receive final update at the next meeting in November- is was noted that the current Director of Operations may have moved on by that date, in which case this would be presented by her deputy and/or successor.
d. The committee was keen to receive assurances that the progress made would not be lost in the succession.
e. Amanda and her team were to be commended for the progress made- and with the consequential improvement in the overall control of waiting list management

5. Audit recommendations

The committee received an update on the tracking of implementation of all internal and external audit recommendations. It was noted that there were no “high” risk items that were overdue. However it was also noted that there were some outstanding recommendations that has been delayed some time. The committee asked for a consolidated table that showed the number of recommendations, those that had missed their due date and the rating of the recommendations- this would allow the committee to track implementation performance over time to ensure that recommendations were being managed accordingly.

6. Declarations of Interest Register

In reviewing the Declarations of Interest Register, the committee felt that the register could be enhanced with the inclusion of details of the

business of the organisations declared. The committee were encouraged by the proposal that all declarations across the Trust should be “re-declared” at least annually.

7. Board Assurance Framework

The committee received an update on the BAF from Helen Shoker. It was noted that significant progress made with the recent reviews of, and enhancements to, the BAF. As an approach, it is now becoming an effective management tool within the Trust. It was also noted that this was just the start of the journey and that further progress would be made- and the audit committee offered its full support. Helen Shoker mentioned the ongoing review of governance and sub-committee structures within the Trust.

8. Role of the Committee in relation to the BAF

The committee clarified its role in supporting the BAF- to provide a level of guidance, oversight and to receive assurances from the sub committees over the satisfactory operation of risk management and mitigation processes. The committee could then provide assurances to the Board. Unless otherwise directed or specifically identified in the BAF, it was not the committee’s role to re-challenge or manage the risks themselves. This was the responsibility of the relevant sub committees. The Trust Board would need assurance on this point, and the current governance review was relevant to the outcome. Agreed to organise a meeting with NEDs from AC and CGC, together with Helen Stoker, to think this through and provide support.

9. Other matters discussed/noted by the committee

a. IT/Information management systems strategy came up on a number of occasions as key to improving systems of control and assurance over the coming years.
b. Information Governance came up a few times- especially in the context of ensuring a level of compliance at level 2 (at least). Paul Athey recently appointed as SIRO, however the IG Manager was a key role.

Enclosure 1

Minutes of the Trust Board Meeting
held in public on Wednesday 30th July 2014 in the Boardroom

Present:
Trust Board
Mr Tim Pile (Acting Chairman)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Ms Elizabeth Chignell, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director

In attendance:
Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Julian Denney, (Acting Company Secretary)
Mr Roger Tilman Deputy Medical Director (Part of Meeting)

Apologies:
Ms Joy Street Company Secretary
Dame Yve Buckland, Chairman
Mr Rod Anthony Non-Executive Director

Agenda No.	Agenda Item	ACTION
07/14/91	**Apologies and welcomes** Apologies were received from Dame Yve Buckland, Rod Anthony, and Joy Street.	
07/14/92	**Declarations of Interest** No Declarations of Interest other than those registered previously.	
07/14/93	**Patient Case – an illustration of the work we do** This was presented by Sharon Medhurst a Senior Sister. The case referred to an 'expert patient' with a spinal injury admitted for reasons unconnected with that injury. Despite his high level of competence in understanding and managing his own condition and health, insufficient account was taken of this by Trust staff with implications for patient experience. Despite the above overall the patient appreciated the care given and the attitude of staff towards him so left feeling positive about the ROH.	

	The main wider learning points included: •Staff should value patients' expertise about their own condition •There were some specific learning points relating to the handling of spinal injury. •Pre-operative assessments will need to be looked at in a more holistic way considering the full spectrum of patient needs and the likely impact of the treatment on the patient. •The implications for the consent process need to be considered. •The Board requested that a further discussion be held about the pre-operative pathway.	**AM**
07/14/94	**Minutes of the Trust Board meeting held on 23rd May 2014** **Resolved:** That the minutes be approved as a true record.	
07/14/95	**Trust Board Action Points** The action notes were updated (see separate sheet):	

Action	Comment
03/14/44	Completed but leave on as a reminder
04/14/58	Completed
05/14/75	Now mainstream business Helen S to feedback in September
05/14/76	Re study leave action assurance was requested re the value of study leave; the revalidation exercise shows that in general study leave was linked to learning outcomes. It was considered that this should be taken off the action list but revisited in three months' time
05/14/78 (A)	Completed
05/14/78 (B)– external governance review	External governance review To come back to the Board in September
05/14/79	Completed
05/14/80	Completed
05/14/83	Noted that longer term this can be embedded within the transformation process
05/14/87	Completed
05/14/85	Now mainstream business Helen S to feedback in September
05/14/88	Leave on

07/14/96	**Chairman and NEDs' update** . Tim Pile drew the Board's attention to the update paper provided by Dame Yve Buckland, Chairman. The following points were made in discussion : •The Board supported the Chairman's suggestions relating to NEDS involvement in the Quality Summit, the role for the Governors in holding NEDS to account and establishing from September a rota for NEDS to undertake ward visits. •The Board agreed that objectives should be set in September based on the five year strategy, although in the longer term in might be preferable to set them earlier. •Regarding the timing of the improvements to administration the Director of Operations described the progress that was being made within the improvement project. **Resolved:** That the Chairman and NEDS update be noted.	
07/14/97	**Chief Executive's Report** Jo Chambers introduced her report and made a number of supplementary points as follows: **ROH Charity** – the Trustees meeting was cancelled but will be rearranged. In building the relationship with the charity the CEO is focussing on understanding their interests and objectives and how to align them with ROH priorities. This is most likely to be development of the research and teaching centre. Board members strongly supported this approach. **HTA Visits -** There has been significant work to prepare for the HTA recent visits and to ensure that the Trust is compliant. **EMT July23rd**- The Director Finance reported on the following highlights: ***Risks*** •EMT lead risks were reviewed and updated. ***Staff Survey re Safety*** •A baseline report has been received on the CQINN based patient safety scheme. There was only a 10% response rate from staff but the sample appeared representative. • It was considered that some analysis of the different modalities for responses should be looked at to optimise response rates in future (Tim P to support off line).	

	•The results were positive in that staff appeared happy to speak up regarding patient safety concerns and felt supported by managers. •There continue to be low levels of incident reporting – managers are considering how to address this •There were some concerns about inter Department cooperation. ***MSK Business Case*** •EMT approved a business case for MSK developments which will allow the Trust to address some of the capacity issues including putting more ESPs in spinal areas to improve efficiency. •New pathways for sciatica patients will be supported. •The spine injection service will be made more profitable potentially shifting some work from doctors to ESPs. •Additional general support will be added to the Physiotherapy services to help cope with additional growth. **Resolved:** That the CEO's report be noted.	
07/14/98	**<u>Medical Director's Update</u>** Andrew Pearson gave an update and invited a discussion as follows : ***Outcomes*** • The DoF noted that by the end of the year the relevant information systems will have been improved which should impact on the outcomes work. ***Infection rates*** •An analysis has been carried out of a wide range of potentially relevant factors to help inform the improvement of SSIs- these have now dropped. •Patient monitoring has been lengthened e.g. arthroplasty patients are monitored for one year using Board increased funding. •Clinical audit work has been done on infections. •Work will also be undertaken regarding variations in SSI rates by clinician. •There should be a flow of information from this area to CGC. •These issues should be considered as part of the wider review of Quality Governance. ***Clinical Standards*** •The intention is to share these, via a cascaded process, throughout the Trust. The Chair of the MSC, the Clinical	

	Directors and the Senior Nurses have already seen the standards. •The Board needs to have oversight of this work e.g. via the strategy and values work. This could be part of one of the Transformation work streams; one way to monitor this might be the level of sign up to the standards or the level of complaints. •There is a role for CGC in supporting the embedding of these standards. •The standards could be attached to individual clinicians' appraisal documents. ***Caldicott Guardian - Personal Databases*** •The ROH is not legally responsible if individuals during their private activities breach Data protection standards provided the Trust has met its obligations e.g. in writing to individuals. However it would be reasonable to ask clinicians with a private practice for documentary evidence of compliance with the relevant legislation. •There is a moral and reputational dimension to this as well as a legal one and the personal databases issue should be added to the risk register. •The Medical Director agreed to resend his letter with a return copy to be returned signed by the individual clinician. **Resolved:** That the Medical Director's report be noted.	**AP** **AP**
07/14/99	**<u>Corporate Performance report</u>** Amanda Markall gave a presentation on activity (re dated in the CPR) highlighting the following points: ***Large Joints*** •Large joint performance is significantly under plan and lower than the corresponding period last year. Factors include annual leave and potentially an over ambitious plan. Large joint referrals are relatively flat. • A sonographer has been agreed to support large joints which should help re capture some shoulder work currently going elsewhere. There may some opportunities to accept referrals from other centres helping them to meet 18 week targets. •Some sessions have been released by the team which can be recycled – e.g. to paediatrics and spinal where there is high growth potential. •Further studies including benchmarking are being carried out to help optimise the large joint workload. •There may be risks associated with staff concerns regarding the changes to sessions and the benchmarking exercise.	

Oncology
•Activity is slightly behind plan; work is begin done to create additional sessions and to create capacity by bringing in additional surgeons from overseas.
• Expected to be on plan by the year end.
•Clinical fellows give additional flexibility.

Paediatrics
•Over plan to date; some further growth potential. Achieved 18 weeks target.

Spinal
•Expect to meet their plan.
•New Consultant creates further opportunities for growth in capacity which will help to reduce long waiting times.

Small Joints
•Strong performance; expect to meet or exceed their plan.

CSS
•Strong performance; expect to meet or exceed their plan.

Summary
•Rebasing exercise is being undertaken for all activities. Further discussions will be held at EMT.
•The activity plan overall should be achieved by year end but the financial impact needs to be analysed and mitigations put in place.

The Chair invited a discussion as follows :

•There should be capacity to absorb additional work from other centres, which will help to address the national drive to reduce waiting times for patients.
•The additional physiotherapy post should help address some of the PROMS concerns.

Other Corporate Performance Report Issues
Paul Athey presented the CPR highlighting the following points:

•Experience and Treatment and Workforce are all rated green; all treatments targets have been achieved and there has been low levels of sickness.
•Finance is tight – continuity of service rating is 4 but within this capital servicing capacity rating is 3 associated with the Q1 deficit. There is continuing and growing pressure on junior doctor costs and vacancy levels. Opportunities for greater cost

	control are being explored in HDU. •CIP performance is ahead of plan; 85% of QIAs signed off; the remainder to be received by July 31. •Some capital schemes are slightly behind plan mainly due to phasing/timing issues. No material impacts on performance are expected. •The activity issues described earlier are being reflected in commissioner plans. **Resolved:** That the Corporate Performance report be noted.	
07/14/100	**<u>The Patient Quality Report</u>** Helen Shoker introduced her report and highlighted the following : ***Vulnerable Patients*** •Work is in progress to improve care for the most vulnerable patients. ***Deaths*** •There have been three patient deaths; one was an end stage oncology patient – there has been a review of this case with some learning around involvement of senior staff early. •There is a new Chair of the VTE Committee who will report to the CGC on the second death in August. •The third death has been reported on by the coroner and there is no causal link with the ROH work. ***Friends and Family*** • Feedback from children has been positive but with a request for more tailored information for them. ***Avoidable Pressure Ulcers*** •There were three Grade 2s in the period- all on one ward – action has been taken to investigate and respond. The Chair invited a discussion as follows : • There is a review of the outreach team to consider how it could be used to support ward staff and best align its work with that of the ward teams especially for complex / seriously ill patients. •One of the deaths is currently included in hospital statistics; this might increase to 2 depending on the VTE report. •Additional metrics relevant to patient concerns (e.g. waiting times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.	**HS**

	•This work should develop into an end to end view of the patient pathway. •The wider goal will to create a set of metrics relevant to the ROH's strategic objectives. **Resolved:** That the Patient Quality report be noted.	
07/14/101	**<u>Safe Staffing</u>** Helen Shoker introduced her report highlighting a number of issues including : •The work is a requirement from the National Quality Board •There was one safe-staffing incident – this related to HDU. Following additional funding this is not expected to re occur •Data has been uploaded to Unify in a timely manner. •Hand held devices are being trialled to meet national standards and improve efficiency. •Overall the ROH is considered to be in a good position in comparison with many other Trusts. •A safe-staffing benchmarking exercising exercise is planned with the two other specialist hospitals. The Chair invited a discussion as follows : • Some staff might give a different view regarding what they feel represents safe staffing. This can reflect a misunderstanding of national guidance. Education will continue to be important. Staff surveys and CQC interviews with staff help triangulate self-staffing data. **Resolved:** That the Safe Staffing report be noted.	
07/14/102	**<u>Board Assurance framework (BAF)</u>** Helen Shoker presented the BAF and the Chair invited a discussion as follows: **General Risk Matters** • A fuller report will be given in September. • There will be some workshops in September and October to demystify the BAF. Board members are welcome. •Some risks may need escalation to the BAF. •Risks are being reviewed by the lead committee. •There are some timing/updating issues which mean that a few updates need to be made to the BAF. •The Director Operations noted that risk number 269, relating to activity, which had been reported as an 8 should have been a 12.	

	Staff Engagement •The risk level has been left unchanged because while there are early signs of improvement it is too early to say that a fundamental change has taken place. **Strategic Risks** •These have been considered during the strategic planning exercise; the new Transformation Board should become the lead Committee for the implementation risks associated with the programme to implement the five year strategy. These risks can then be integrated into the BAF. •The strategic risks themselves should be brought to the Board for it to consider and should not be delegated. **EMT Managed Risks** The formal accountability for these need to be considered in the context of the review of the Scheme of Delegation, SFIs, Standing Orders and in the light of external reviews of Governance. The terms of reference of EMT and its relationship with the Board need to be considered. **Resolved:** That the Board Assurance Framework be noted.	**HS/JC**
07/14/103	**<u>Quarterly Workforce Report</u>** Anne Cholmondeley introduced her report following which the Chair invited a discussion: •The level of stress related absence is improving with the benefits of management education and supporting staff coming through. •The Friends and Family test showed a low return rate (although higher than some neighbouring trusts). The negative score may reflect a bias in the scoring e.g. 'likely to recommend 'is not counted. The Director of HR agreed to recalculate the score using more conventional approaches. • Free text comments are expected to have an over representation of negative views; this is common to most staff surveys. • Matters such as communications and leadership continue to be an issue for some staff. •The direction of travel is right but it is still very early on the journey. •The Board agreed that improvement in staff attitudes and perceptions underpins improvement in all areas. **Resolved:** That the Quarterly Workforce report be noted.	**AC**
07/14/104	**<u>Quarter 1 Declaration – April to June 2014</u>**	

	The CEO introduced the Quarter 1 declaration and invited a discussion as follows : • This is a regular responsibility of the Board and forms part of a report to Monitor •The Board is overseeing a number of activities relevant to Quality Governance. These include a rapid external "mini–review" of governance, feedback from CQC, self-assessment activity as well as assurance received via an external review for the annual governance statement and from the annual report from the Audit Committee. With recent changes to Board members including a new Chair and CEO and with new expectations post Francis it intends to set ambitious improvement standards and associated delivery plans. Further details will be included in subsequent quarterly reports as this work develops, and will inform the board's development programme going forward. •.CGC have been actively involved in overseeing improvements in this area. •The Board encouraged early communication with Monitor to keep them informed of existing and planned developments in this area. **Resolved:** That the Board approve the Quarter 1 Declaration and delegate to the Chair and CEO the authority to finalise it based on the above points and submit it to Monitor	
07/14/105	**<u>Revalidation Annual Report</u>** Andrew Pearson presented the report and invited a discussion: • The new electronic appraisal process supports a more standardised approach. • Appraiser refresher training has been introduced. • Key questions for each person being appraised are being identified which ensures a tighter focus to the appraisals. •The appraisal process should address deviations from standard practice (e.g. if there are higher than average infection rates) but it is not possible to monitor every aspect of clinical practice. •In relation to the remediation process it was noted that previously there had been three doctors involved one of whom had subsequently resigned. There was a general discussion as to whether the acceptance of the doctor's resignation was appropriate in the circumstances and whether the public's interests had been protected. Anne Cholmondeley confirmed that should the doctor not reach an acceptable level of performance prior to the end of his employment with the Trust,	

	then the GMC would be notified accordingly. It was noted that these matters are sensitive and confidential and that in future discussions consideration would be given to the discussion being carried out in the private session of the Board. **Resolved:** That the Board approve the Revalidation Annual Report.	
07/14/106	**<u>Audit Committee Annual Report</u>** Paul Athey presented the report and highlighted the following: •.Assurance has been gained around referral to treatment targets – these have been fed into the BAF. •The reference to the IGC should be replaced by CGC. •A regular update to the Board of audits being carried out should be made going forward. **Resolved:** That the Board approve the Audit Committee Annual Report.	**PA**
07/14/107	**<u>Update on Five Year Strategic Plan</u>** ***Tariff reductions going forward*** Paul Athey explained current proposals by Monitor: •.There is due to be a teleconference with Monitor covering proposed changes to tariffs which will be introduced over several years. •Reference costs are being updated. •Monitor are building in a 3-5% efficiency element into tariffs; ROH are modelling 4%. •£5.8M of admitted patient income (c12%) appears to be at risk based on early modelling. £3.1M relates to scoliosis work. Revision joint and primary knee tariffs are also being substantially reduced. These reductions are also being seen to have major impacts at other specialist orthopaedic hospitals. •It is believed that Monitor may be using an over simplistic use of 2012 reference costs without the adjustments appropriate to specialist hospitals ; it is critical, but may be difficult to try to influence Monitor to modify these proposals. **Key points raised in discussion:** • The Board strongly supported the DoF in taking a robust approach to the negotiations with Monitor. • The DoF was requested to provide an interim update on the proposed tariff reductions before the September meeting, given the criticality of these issues. ***Other Matters :*** Jo Chambers drew the Board's attention to the following	**PA**

	supplementary points to her report: ***Local Health Economy: Chief Officers Group*** •.There is an ongoing work across the local health economy covering such matters as shifting work to the community, and making efficiency improvements ; there is a c£720M gap to be bridged if no action is taken. •The Chief Officer group felt that it was not a decision making body but would seek to influence members' own governing bodies. •ROH is engaged in the clinical design groups. **Research Stocktake** •Regarding the baseline stocktake of research the CEO's view is that while there is a range of good work being carried out it is very fragmented. •One of the Transformation programme work streams covers developing an integrated research capability. Initially it is intended to gather together what is currently being done and to assess the resources involved. This activity should include clinical audit, outcomes and some of the quality work. • It was agreed that Tauny S should meet up with the key individuals carrying out the Research Stocktake. **Governors' request** The Governors had previously requested an update on the 30 day and 90 day actions agreed at the stakeholder event in April, which are attached to this report. It was agreed to check that board papers are routinely sent to Governors, including this update. **Resolved:** That the Board note the Strategy Update.	**TS** **JC**
07/14/108	**<u>Constitution</u>** Julian Denney presented his report which explained the background to the amended Constitution attached as Appendix 1 to that report which had been prepared by the Trust's solicitors and incorporates all the changes approved by the Council of Governors on 3rd July 2014. •It was noted that a number of suggestions had been made for further amendments to the Constitution and that the standing orders of both the Council of Governors and the Board of Directors were also being reviewed and that these potential additional changes would need to be considered as part of a further revision to the Constitution after the amended	**JD**

	Constitution had been approved and adopted by the Board. Such further amendments to the Constitution would need to be approved by the Council of Governors and Board before the further amended Constitution could be adopted. •The Board wished this subsequent activity to be carried out as rapidly as practicable. •Some of the feedback provided could be handled through the recruitment process for Governors. **Resolved:** That the Board approve the amended Constitution attached at Appendix 1 and agree to adopt it from July 30 2014.	
07/14/109	**Audit Committee** Paul Athey drew Board members attention to the report written by Rod Anthony, Chair of the Audit Committee which was considered by Board members to be a helpful report on its work. **Resolved:** That the Board : •Note the report of the Audit Committee	
07/14/110	**Clinical Governance Committee** Tauny Southwood presented the CGC report and a number of issues were discussed: •Understanding better violence and aggression events •Patient safety- as reported earlier the results appear positive in that staff feel free to speak out about their concerns. •Improving incident forms completion – this needed to be seen in the context of wider culture change to build trust with staff to continue to shift to a learning and supportive culture. **Resolved:** That the Board : •Note the assurances provided by the CGC meeting.	
07/14/111	**Remuneration Committee** Elizabeth Chignell gave a verbal update regarding the work of the Remuneration Committee including its work to agree the Job Descriptions and person specifications for the posts of Director of Operations and Director of Strategy and Transformation. **Resolved:** That the Board :	

	•Note the update of the Remuneration Committee.	
07/14/112	**<u>Charitable Funds committee</u>** Frances Kirkham noted that there had been no meeting of the Committee since the last Board meeting and made the following comments : • Some expenditure on the playroom had been approved •The ROHBTS Charity would be invited to the next meeting of the CFC. **Resolved:** That the Board : •Note the update from the Chair of the Charitable Funds Committee.	
07/14/113	**<u>Council of Governors</u>** The CEO gave a verbal update regarding the work of the Council of Governors which at its last meeting focused on the review of the Constitution. **Resolved:** That the Board : •Note the CEO's update regarding the work of the Council of Governors.	
07/14/114	**<u>Any Other Business</u>** Tauny Southwood reported on a forthcoming conference concerning "delivering the future hospital" – he would forward details to Board members. Attendance should be coordinated for reasons of efficiency and economy. Regarding the forthcoming appointment of the Director of Operations it was agreed that the Board delegate to the interview panel the authority to confirm the appointment. There has been a visit from the ROH's main CCG regarding the safeguarding of adults and children. A formal report has not yet been received but informal feedback has been very positive.	
<u>Date and Time of Next Trust Board Meeting</u> 24 September 2014 time to be confirmed subject to AGM planning. The location is to be agreed.		
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 MEETING
TO BE HELD
ON
WEDNESDAY 30 JULY 2014,
8.30AM IN THE BOARD ROOM

AGENDA

ITEM	TITLE		BOARD ACTION	PAPER
07/14/91	**Apologies & Welcomes**	Dame Yve Buckland Rod Anthony	To Note	
07/14/92	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
07/14/93	**Patient Case – an illustration of the work we do** Director of Nursing and Governance			
07/14/94	**Minutes of Public Board Meeting held on the 23rd May 2014** Chairman		For Approval	Enc. 1
07/14/95	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
07/14/96	**Chairman & NED update** Chairman & NEDs		For Information	Enc. 3
07/14/97	**Chief Executive's Report** **-Including update on CQC visit** Chief Executive Officer		For Information and Assurance	Enc. 4
07/14/98	**Medical Director's Update** Medical Director		For Information and Assurance	Enc. 5
	Performance Management / Assurance Reports			
07/14/99	**Corporate Performance Report** Director of Finance		For Assurance	Enc. 6
07/14/100	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 7
07/14/101	**Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 8
07/14/102	**Board Assurance Framework** Director of Nursing & Governance		For Assurance	Enc. 9

07/14/103	**Quarterly Workforce Report** Director of Workforce and OD		For Assurance	Enc.10
07/14/104	**Quarter 1 Declaration – April to June 2014** Chief Executive		For Approval	Enc.11
07/14/105	**Revalidation Annual Report** Medical Director		For Approval	Enc.12
07/14/106	**Audit Committee Annual Report** Director of Finance		For Approval	Enc.13
	Strategy			
07/14/107	**Update on Five Year Strategic Plan** Chief Executive		For Information	Enc.14
07/14/108	**Constitution** Company Secretary		For Approval	Enc.15
	Board Committees			
07/14/109	**Audit Committee**		For Assurance	Enc.16
07/14/110	**Clinical Governance Committee** - to provide assurance on Adult safeguarding Annual Report		For Assurance	Enc.17 – **to follow**
07/14/111	**Remuneration Committee**		For information	Verbal
07/14/112	**Charitable Funds Committee**		For Assurance	Verbal
07/14/113	**Council of Governors**		For Information	Verbal
07/14/114	**Any Other Business**			
	Date of Next Meeting: Wednesday 24 September 2014 at 8.30am			

Confidential Matters

To resolve:

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

Enclosure 1

Minutes of the Trust Board Meeting held in public on September 24th 2014 in the Boardroom

Present:
Trust Board
Dame Yve Buckland, Chairman
Mrs Jo Chambers, Chief Executive
Mr Jonathan Lofthouse, Director of Operations
Mr Paul Athey, Director of Finance
Mr Rod Anthony Non-Executive Director
Mr Tim Pile Non-Executive Director
Ms Elizabeth Chignell, Non-Executive Director
HH Frances Kirkham, Non-Executive Director

In attendance:
Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Julian Denney, (Interim Company Secretary)
Mr Roger Tillman Deputy Medical Director
Professor Phil Begg Director of Strategy and Transformation (Designate)
Mr Ed Davis Director of Research
Ms Lisa Pim Deputy Director of Nursing & Governance

Apologies:
Mrs Helen Shoker, Director of Nursing & Governance
Mr Andrew Pearson, Medical Director
Professor Tauny Southwood, Non-Executive Director

Agenda No.	Agenda Item	ACTION
09/14/115	**Apologies and welcomes** Apologies were received from Helen Shoker, Andrew Pearson and Tauny Southwood The Chairman welcomed Jonathan Lofthouse to the Board and congratulated him on his appointment as Director of Operations. She also thanked Amanda Markall who had been the previous Director of Operations and passed on the Board's best wishes for the future She also welcomed Phil Begg Director of Strategy and Transformation who will be taking up appointment at the Trust in November , Ed Davis Director of Research and Ms Lisa Pim Deputy Director of Nursing & Governance The Chairman noted that it was intended to recruit another NED with a clinical background.	

09/14/116	**Declarations of Interest** Jonathan Lofthouse declared an interest stating that he was the sole owner and director of the consultancy company Healthy Delivery Limited. Through this limited company he currently has his partner as one of his company's employees working within the KMPG UK Health Audit division as a clinical advisor to both KPMG and Monitor.	
09/14/117	**Patient Case – an illustration of the work we do** •It was agreed to defer the patient case to the next full public meeting.	
09/14/118	**Minutes of the Trust Board meeting held on 30th July 2014** It was noted that the spelling of Elizabeth Chignell's surname would be corrected. **Resolved:** That with the above correction the minutes of the above meeting be and are hereby approved as a true record.	
09/14/119	**Trust Board Action Points** The action notes were updated (see separate sheet):	

Action	Comment
03/14/44 Corporate Performance Report (26.03.14)	
05/14/78	Being handled at Oct 1 Board workshop – take off
05/14/83	
05/14/88	
07/14/93	Will be brought back to the next full public Board meeting
07/14/98	
07/14/100	
07/14/102	Being handled at Oct 1 Board workshop – take off
07/14/103	Completed : AC confirmed that when calculating the FFT results using the approach used in the commercial sectors,

		90% of staff recommend the Trust as a place to receive care and treatment and 64% of staff would recommend the Trust as a place to work	
	07/14/106	Completed – feedback given later in the meeting today	
	07/14/107A	Completed	
	07/14/107B		
	07/14/107C	Completed. Paper prepared for the Governors meeting taking place today. Agendas and minutes are being sent to the Governors.	
	07/14/108	In progress – completion expected end October	
09/14/120	**Procedural Matters** Mr Rod Anthony left the room for this item. ***Ratification of Appointment of Rod Anthony as Non-Executive Director and Chair of the Audit Committee*** The Chairman reported that, due to a misunderstanding on the Trust's part, the meeting of the Council of Governors of 23rd May 2014 at which the appointment of Rod Anthony as a non-executive director was approved was not quorate and that the Council was taking steps to rectify this position at its meeting a few hours after this Board meeting. She also noted that the meeting of the Audit Committee of July 8th 2014 at which Rod Anthony and Elizabeth Chignell were present was as a consequence also not quorate. The Trust considers that all business conducted at the Audit Committee of July 8th 2014 was conducted properly and in good faith. However in order that there can be no doubt about the validity of business transacted and the legal effect of decisions taken at the above committee meeting , the Board on behalf of the Audit Committee hereby: (a) ratifies retakes and approves the decisions taken at, and the business of, the above committee meeting. (b) re-adopts and approves the minutes of the above committee meeting as subsequently adopted and approved, and	

	(c) agrees that, to the maximum extent possible in law, the decisions taken at and business of the above meeting shall be treated as having taken effect at the date of the said meeting (d) ratifies the appointment of Mr Rod Anthony as Chair of the Audit Committee subject to the Council of Governors retaking and approving the decisions taken at its meeting of 23rd May 2014 at which the appointment of Rod Anthony as a non-executive director was approved ***Public Notice of Meetings*** The Interim Company Secretary reported that, notwithstanding advance publication on the Trust's website and elsewhere of the public meetings of the Board of Directors of the Trust, the Trust had been in breach of paragraph 3.2 (5) of Annex 8 in that notice of such meetings have not been displayed in advance at the Trust headquarters since the Trust became an NHS foundation trust. Given the advance publicity which was provided for all such meetings, the Interim Company Secretary reported that the Trust is not aware that the interests of any person have been adversely affected by the failure of the Trust to provide notice of the said meetings at the Trust Offices. He further reported that the Trust believes that business at the said meetings was conducted in good faith and properly. However in order that there can be no doubt about the legal effect of decisions taken at the said meetings, the Board of Directors hereby: (a) retakes and approves the decisions taken at each of the said meetings (b) re-adopts and approves the minutes of the said meetings as subsequently adopted and approved (c) and agrees that, to the maximum extent possible in law, the decisions shall be treated as having taken effect at the date of the said meetings	
09/14/121	**<u>Chairman and NEDs' update</u>** Dame Yve Buckland, Chairman updated the Board as follows: ***Paediatrics ward*** • She had been delighted to participate in the opening of the new Children's Ward. This had been an excellent day for the Trust's younger patients and the staff and had helped raise the profile of the organisation as a whole ***Walkabouts to the wards and theatres*** •The Chairman had spent a lot of time on Wards 2, 3 and 1.	

	Patient feedback was overwhelmingly very good. •There had been one complainant, a carer of a patient who wanted to go home more quickly. • She was now capturing helpful suggestions more formally to be passed to the Directors of Nursing and Operations for consideration and implementation. ***Chairman and NED objectives appraisals*** •The Chairman is working through these with the NEDS and has agreed her own objectives with Alan Last ***FTN Conference*** •The CEO and Chairman are already attending together with some other executive directors. Elizabeth Chignell offered to attend and this was agreed and the CEO said that she would add her to the list. ***Clinical audit meetings*** •NEDs wished to know the dates of clinical audit meetings - . Roger Tillman agreed to ask Jane Jones to let all NEDs know the dates of the meetings. **Resolved:** That the Chairman and NEDS update be noted.	**JC** **RT**
09/14/122	**<u>Chief Executive's Report</u>** Jo Chambers introduced her report and made a number of supplementary points as follows: **CQC Visit**– the CEO noted that the CQC had produced a final version of their inspection report which would be presented to the Quality Summit on Monday 29 September. This would be attended by representatives from the Trust and other organisations such as Commissioners and NHS England. NEDs were welcome to attend. The Trust had written to the CQC regarding some matters of factual accuracy. **Top 100 places to work** – the CEO was delighted that the Trust had been included in this list produced by the HSJ **Genomics Clinical Centre Application** - The CEO reported that the Trust had been invited to collaborate in a West Midlands proposal to participate in the UK's 100,000 Genomics Programme and this was an exciting opportunity for the Trust. The Trust's lead for the project will be Mr Ed Davis, Director of Research and Development. This is a good opportunity for the	

Trust to actively engage in a wider set of research activities and be part of a nationally important project. Bids were currently being assessed and it was thought there would be 3 – 5 centres in the UK.

ROH Charity – the CEO has had a further meeting with the Chairman of Trustees of the ROH Orthopaedic Charity, Mr John Wheatley who is keen to explore opportunities to work in partnership with the Trust to support the objects of the charity. She has been invited to the next meeting of the trustees in mid-November to talk about the Trust's new strategic plan and in particular its ambitions in relation to developing an integrated research, evaluation, education and innovation capability, and the ROH as a knowledge leader workstream.

EMT – In addition to the items noted in the CEO report, the Director of Finance reported on the following highlights from the meeting last week in which the EMT:

- Reviewed and supported a paper on next steps in embedding values driven behaviours
- Reviewed EMT held risks and escalated the tariff risk from amber to red and closed a risk around management of complex patients.
- Approved the budget setting and business planning timetable
- Approved a Stage 1 business case for a new referral management system: this is an early win for the IT strategy
- The CD for Spinal Services presented the spinal strategy; it was agreed to set up a working group to look at short term pressures (Long term issues needed to be addressed as part of the tariff question).
- Prepared a high level model for medical workforce which recommends the introduction of an on call registrar rota and a number of non-medical posts to cover some work currently covered by locums

Policy Documents-The CEO drew the Board's attention to two policy documents exploring:

- Sustainability in the NHS in the long term
- The Better Care Fund

There are substantial concerns re deficits across the FT sector and there are widespread concerns re RTT.

The Board considered that the Trust should consider scenario planning drawing on the FTN work to model the impact of different polices having regard to any restrictions that may be in place at this stage in the electoral cycle .

Resolved:

	That the CEO's report be noted.	
09/14/123	**<u>Director of Research Report</u>** Ed Davis thanked the Board for the invitation to present and for the important role research had been given in the Trust strategy. He gave a presentation. ***The Chairman invited comments as follows:*** ***The Trust's attractiveness as a research centre*** • The CEO commented on the opportunity to collaborate with the wider system e.g. via the Genomics project. Some of our studies have very small volumes but may be the only or leading site in the country. Ed Davis considered the Trust well placed to attract high research interest given the high volume of mainstream patients plus the Trust's position as the national leader for a number of specialist conditions. ***Measuring Success*** •Regarding how success is measured Ed Davis commented that measuring clinical impact is difficult for everyone: NIHR use the number of patients accrued to studies as a surrogate for clinical impact. •NIHR were changing their approach to measurement to place a greater emphasis on research quality and patient impact – with more emphasis on patient stories. •The patient story approach, while less formal was important in raising the perception of the Trust as a world leader in terms of the difference it makes for patients - for example the ROH can offer a number of treatment opportunities that other centres cannot e.g. drug treatment for osteoarthritis. The Trust needed to celebrate research successes more ***Broadening the research talent base*** •The Board considered it important to involve a broader based number of clinicians in research – a small number of key people at the moment are doing a lot of this work in their own time and this may not be sustainable. Research needs to be considered core business. It is essential for the executive team to support research becoming mainstream e.g. in the discussion of job plans; the strategy supports this approach •Work is being done to nurture young doctors who wish to do research and see the ROH as the centre of choice for orthopaedic research •The Trust should continue to encourage nurses and AHP to lead research	

	Other matters •The employment of full time grant writer has been very helpful is supporting grant applications •We will seek accreditation of the tissue bank at ROH to ensure we get full NIHR credit The Board passed on its thanks on to Ed Davis and the rest of the team: they had made a very great contribution to developing the profile of research at the Trust **Resolved:** That the Director of Research's report be noted	
09/14/124	**<u>Corporate Performance report</u> <u>including report on action to improve referral to treatment times</u>** ***RTT – report on actions to reduce the number of long waiters*** Johnathan Lofthouse presented his report and highlighted the following points: •Commissioners have rejected an earlier application by the ROH for financial and other support to clear the backlog ; this position has been confirmed following two further applications to them •The ROH is in a vulnerable position regarding the number of patients in backlog pathways both from the perspective of patients and the Trust's reputation. •A letter has been received from the CEOs of NHS England, Monitor and the TDA reaffirming national standards and appearing to permit 18 week failure in order to reduce back log, provided this failure is temporary •Paediatric spinal deformity is the most critical area and we only have facilities to treat one patient a week typically at the BCH •We are working with our clinicians to understand the status of all of our patients and how to respond appropriately if capacity becomes free including looking outside of the immediate area for PICU beds ***Points made in discussion:*** The Board considers that, regarding the RTT backlog: •For adult patients the Trust should reallocate some theatre sessions to those clinicians with serious backlogs. This may also free up some clinicians to support the Transformation agenda •For paediatric patients the Trust should seek PICU beds from any realistic source; managing the consultant timetable will still	**JL**

	be difficult even if these are found •The Board supports the Director for Operations in pressing the Commissioners to have a Clinical Senate debate where there are clear clinical risks for particular patients Paul Athey presented the remainder of the CPR highlighting the following points: •There is one red rated area around the 62 day wait for cancer patients. This is a single patient breach – a secondary referral from the Royal Liverpool for specialist care. This has been reviewed in detail – it is considered that the care given by the ROH was very appropriate •Financial performance for August was good but there are some strong financial pressures around locum and similar costs and theatre staffing (which we are working to alleviate via recruitment locally and internationally and for which there is a national shortage) •Average LOS is a key issue: we are focussing on understanding this better •Cancelled operations – the Trust is assessing if our benchmarks set at the right level – there have been considerable inroads to date. Avoidable cancellations have fallen considerably. •Falls – the persistent red rating may be associated with increased reporting of falls and some of the activity may also be linked to enhanced recovery and earlier mobilisation. Work is being done on patient education to reduce the risk of falls. The Chairman has received feedback regarding the design of the bathrooms being sub optimal – is possible that charitable funds. Could be used to reduce the risk of falls. Only one fall this year was associated with major harm. **Resolved:** That the Corporate Performance report be noted.	
09/14/125	**<u>The Patient Quality Report</u>** Lisa Pim introduced her report and highlighted the following : •SSI infections rates – very positive progress has been made to reduce these •One patient attempted suicide – he was transferred to the QE Hospital and has been discharged with no ill effects. A review indicated that the patient's care was appropriate and that his mental health issues had been considered adequately. •Work is being to explore the possibility of automating the WHO checklist and tighten up the procedures for its completion	

	Resolved: That the Patient Quality report be noted.	
09/14/126	**<u>Safe Staffing</u>** Lisa Pim introduced her report noting that the Trust responded to ensure patient safety regarding the incidents described in the report The Chair invited a discussion as follows : • An assessment will be made regarding how the level of incidents compares with other providers **Resolved:** That the Safe Staffing report be noted.	**HS/LP**
09/14/127	**<u>Board Assurance framework (BAF)</u>** Lisa Pim presented the BAF and the Chair invited a discussion as follows: • The tariff risk has been escalated and will be discussed later on this agenda •The strategic risks will be considered at the forthcoming Board workshop **Resolved:** That the Board Assurance Framework be noted.	
09/14/128	**<u>Update on Five Year Strategic Plan including update on the tariff</u>** ***Tariff reductions going forward*** The Director of Finance updated the Board on the current position: •There have been concerns raised with Monitor regarding the impact of the tariff ; we have reinforced these concerns via the Orthopaedic Alliance •There has been a more positive recent meeting with Monitor supported by colleagues from Robert Jones and Agnes Hunt NHS Foundation Trust and the Orthopaedic Alliance. Monitor have agreed to work towards a solution and accept that that their initial proposals had scope for further adjustment and welcomed the ROH and colleagues' contribution to this activity. •Monitor have suggested a number of approaches to transition between the current tariff and their recent proposals. •There is still considerable uncertainty regarding the likely end point of these discussions. •The formal consultation output is due to be released on the	

	23rd of October **Key points raised in discussion:** • The Board supported the Director of Finance in seeking to find a satisfactory outcome to these negotiations. ***Transformation Agenda :*** Jo Chambers drew the Board's attention to the following supplementary points to her report which were endorsed by Tim Pile: •We continue to make progress on the Transformation programme including confirming Phil Begg as a substantive appointee and engaging Karen Yates as interim programme director in the meantime •Tim Pile has had constructive meetings with Karen Yates in scoping the programme including ensuring the inclusion of cross cutting themes; this will be used to update the model in the Board papers. •Phil Begg has been liaising with Karen Yates to steer the development of the programme even before he starts his contract with the ROH in November •The Trust must proceed at pace seeking quick wins as well as refining the structures and processes. **Resolved:** That the Board note the Strategy Update.	
09/14/129	**<u>Constitution/ Review of Standing Orders</u>** The Chairman introduced this item and noted that following the revision of the main body of the constitution in July, it was necessary to update the Standing Orders. In parallel the terms of reference of Board committees were being updated (and in the case of the new Transformation Committee drafted) and the membership of each committee was being reviewed. An update of this work would be given in October. The Interim Company Secretary presented his report which explained the reasons for a further update to the Constitution particularly around the need to update the Council of Governors' and Board of Directors' Standing Orders, which formed Annexes 7 and 8 respectively and highlighted the more important changes that were proposed. He noted that the Chairman, CEO, DoF and Chair of Audit had reviewed the latest proposed revisions in detail already. Frances Kirkham had also reviewed the proposed changes and her suggestions will be considered in the final draft.	

He further noted that Mills and Reeve, solicitors to the Trust have advised that the amendments to the constitution to giving effect to the changes referred to in his the report paper must be approved by both the Council of Governors and the Board of Directors but do not also require the approval of members at an Annual General Meeting as they do not mean are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust

Under the National Health Service Act 2006, ("the 2006 Act") Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act.

Mills and Reeve have reviewed the draft revised constitution attached at Appendix 2 to the Interim Company Secretary's report and in their view the revised constitution complies with the 2006 Act and the requirements of Monitor.

It was noted that the process for approving the revised constitution would be as follows:

1.Any further changes agreed at today's meeting would be incorporated in the final draft of the revised constitution which would be amended and re-circulated.

2.Council members would also be considering the proposed changes and any further changes proposed by them would be included in a final draft of the revised constitution.
3.The Council of Governors would be asked to approve the amended constitution at the meeting of the Council on October 29th 2014
4. The Board of Directors would be asked to approve the amended constitution at the meeting of the Board on October 29th 2014.

Resolved:

That the amendments to the revised Constitution be and are hereby approved in principle with the expectation that a final amended constitution would finally be approved by both the Council of Governors and the Board of Directors on 29th October 2014 and adopted on that date.

09/14/130	**<u>Audit Committee</u>** Rod Anthony, Chair of the Audit Committee gave a verbal update as follows: • There has not been a Committee meeting since the last meeting •Deloitte have been appointed as external auditors •The Director of Operations will provide a further update around assurances from reporting systems and will be reporting to the Committee in November ; this has been subject to audit by Baker Tilly •The Director of Finance reported that in addition there have been audits undertaken regarding reference costs and the quality impact of CIPs; there are also a number of general financial audits planned for the next month **Resolved:** That the Board : •Note the update of the Audit Committee	
09/14/131	**<u>Clinical Governance Committee</u>** No report this Board meeting	
09/14/132	**<u>Charitable Funds committee</u>** Frances Kirkham gave a verbal update noting progress in raising the profile of the Charity and the availability of funds to support bids. **Resolved:** That the Board : •Note the update from the Chair of the Charitable Funds Committee.	
09/14/133	**<u>Council of Governors</u>** The Chairman gave a verbal update regarding the work of the Council of Governors. •Work is ongoing to strengthen governance , improve governor training and to look at different approaches to governor involvement **Resolved:** That the Board : •Note the Chairman's update regarding the work of the Council of Governors.	

09/14/134	**<u>Any Other Business</u>** • Whistle blowing – the Trust continues to ensure that staff are encouraged to come forward where appropriate • Patient Access - the Trust is considering the whether anything can be do to improve patient access to the building • Publicity- The Board agreed to ensure that photographs updated for new members of the Board and that Tim Pile would be noted as the whistle blowing contact on the public photographs • Smoking on site - concerns to be referred to the Director of Operations and the Estates Committee	
<u>Date and Time of Next Trust Board Meeting</u> 29 October 2014 11.00-12.00 - short public Board meeting in the Board room. Note that it is important that at least two thirds of the Members of the Board are present at the next meeting for formal approval of changes to the Standing Orders. This will be followed by lunch, a private NEDs meeting and a Board workshop in the afternoon.		
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 MEETING
TO BE HELD
ON
WEDNESDAY 24 SEPTEMBER,
10.30AM IN THE BOARD ROOM

AGENDA

ITEM	TITLE	NOTES	BOARD ACTION	PAPER
09/14/115	**Apologies & Welcomes**	Helen Shoker and Andrew Pearson	To Note	
09/14/116	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
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09/14/120	**Procedural Matters** Chairman		For Approval	
09/14/121	**Chairman & NED update** Chairman & NEDs		For Information	
09/14/122	**Chief Executive's Report** **-Including update on CQC visit** Chief Executive		For Information and Assurance	Enc. 3
	Performance Management / Assurance Reports			
09/14/123	**Director of Research Report** Director of Research and Development	Ed Davis	For Assurance	Enc. 4

09/14/124	**Corporate Performance Report including report on action to improve referral to treatment times** Director of Finance and Director of Operations		For Assurance	Enc. 5 and 5a
09/14/125	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 6
09/14/126	**Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 7
09/14/127	**Board Assurance Framework** Director of Nursing & Governance		For Assurance	Enc. 8
	Strategy			
09/14/128	**Update on Five Year Strategic Plan including update on the tariff** Chief Executive and Director of Finance		For Information	Enc. 9 and 9a
09/14/129	**Constitution/ Review of Standing Orders** Chairman and Company Secretary		For Approval in principle with the final approval in October.	Enc. 10
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09/14/130	**Audit Committee**		For Assurance	Verbal
09/14/131	**Clinical Governance Committee**		For Assurance	Verbal
09/14/132	**Charitable Funds Committee**		For Assurance	Enc. 11
09/14/133	**Council of Governors** Chairman		For Information	Verbal
09/14/134	**Any Other Business**			

	Date of Next Meeting: Wednesday 29 October 2014 at 11.00 a.m (short public Board meeting) followed by a private Board development event in the afternoon. The Governors will be invited to join the short public Board meeting which follows their own meeting **There is also a private Board development event planned for Wednesday 1st October 2014 at 3.30pm.**

Confidential Matters

To resolve:

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

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD
ON
WEDNESDAY 24 SEPTEMBER,
10.30AM IN THE BOARD ROOM

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(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

Enclosure 1

Minutes of the Trust Board Meeting
held in public on Wednesday 30th July 2014 in the Boardroom

Present:
Trust Board
Mr Tim Pile (Acting Chairman)
Mrs Jo Chambers, Chief Executive
Mrs Amanda Markall, Director of Operations
Mrs Helen Shoker, Director of Nursing & Governance
Mr Paul Athey, Director of Finance
Mr Andrew Pearson, Medical Director
Ms Elizabeth Mountford, Non-Executive Director
Professor Tauny Southwood, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director

In attendance:
Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Julian Denney, (Acting Company Secretary)
Mr Roger Tilman Deputy Medical Director (Part of Meeting)

Apologies:
Ms Joy Street Company Secretary
Dame Yve Buckland, Chairman
Mr Rod Anthony Non-Executive Director

Agenda No.	Agenda Item	ACTION
07/14/91	**Apologies and welcomes** Apologies were received from Dame Yve Buckland, Rod Anthony, and Joy Street.	
07/14/92	**Declarations of Interest** No Declarations of Interest other than those registered previously.	
07/14/93	**Patient Case – an illustration of the work we do** This was presented by Sharon Medhurst a Senior Sister. The case referred to an 'expert patient' with a spinal injury admitted for reasons unconnected with that injury. Despite his high level of competence in understanding and managing his own condition and health, insufficient account was taken of this by Trust staff with implications for patient experience. Despite the above overall the patient appreciated the care given and the attitude of staff towards him so left feeling positive about the ROH.	

	The main wider learning points included: •Staff should value patients' expertise about their own condition •There were some specific learning points relating to the handling of spinal injury. •Pre-operative assessments will need to be looked at in a more holistic way considering the full spectrum of patient needs and the likely impact of the treatment on the patient. •The implications for the consent process need to be considered. •The Board requested that a further discussion be held about the pre-operative pathway.	**AM**
07/14/94	**Minutes of the Trust Board meeting held on 23rd May 2014** **Resolved:** That the minutes be approved as a true record.	
07/14/95	**Trust Board Action Points** The action notes were updated (see separate sheet):	

Action	Comment
03/14/44	Completed but leave on as a reminder
04/14/58	Completed
05/14/75	Now mainstream business Helen S to feedback in September
05/14/76	Re study leave action assurance was requested re the value of study leave; the revalidation exercise shows that in general study leave was linked to learning outcomes. It was considered that this should be taken off the action list but revisited in three months' time
05/14/78 (A)	Completed
05/14/78 (B)– external governance review	External governance review To come back to the Board in September
05/14/79	Completed
05/14/80	Completed
05/14/83	Noted that longer term this can be embedded within the transformation process
05/14/87	Completed
05/14/85	Now mainstream business Helen S to feedback in September
05/14/88	Leave on

07/14/96	**Chairman and NEDs' update** . Tim Pile drew the Board's attention to the update paper provided by Dame Yve Buckland, Chairman. The following points were made in discussion : •The Board supported the Chairman's suggestions relating to NEDS involvement in the Quality Summit, the role for the Governors in holding NEDS to account and establishing from September a rota for NEDS to undertake ward visits. •The Board agreed that objectives should be set in September based on the five year strategy, although in the longer term in might be preferable to set them earlier. •Regarding the timing of the improvements to administration the Director of Operations described the progress that was being made within the improvement project. **Resolved:** That the Chairman and NEDS update be noted.	
07/14/97	**Chief Executive's Report** Jo Chambers introduced her report and made a number of supplementary points as follows: **ROH Charity** – the Trustees meeting was cancelled but will be rearranged. In building the relationship with the charity the CEO is focussing on understanding their interests and objectives and how to align them with ROH priorities. This is most likely to be development of the research and teaching centre. Board members strongly supported this approach. **HTA Visits -** There has been significant work to prepare for the HTA recent visits and to ensure that the Trust is compliant. **EMT July23rd**- The Director Finance reported on the following highlights: ***Risks*** •EMT lead risks were reviewed and updated. ***Staff Survey re Safety*** •A baseline report has been received on the CQINN based patient safety scheme. There was only a 10% response rate from staff but the sample appeared representative. • It was considered that some analysis of the different modalities for responses should be looked at to optimise response rates in future (Tim P to support off line).	

	•The results were positive in that staff appeared happy to speak up regarding patient safety concerns and felt supported by managers. •There continue to be low levels of incident reporting – managers are considering how to address this •There were some concerns about inter Department cooperation. ***MSK Business Case*** •EMT approved a business case for MSK developments which will allow the Trust to address some of the capacity issues including putting more ESPs in spinal areas to improve efficiency. •New pathways for sciatica patients will be supported. •The spine injection service will be made more profitable potentially shifting some work from doctors to ESPs. •Additional general support will be added to the Physiotherapy services to help cope with additional growth. **Resolved:** That the CEO's report be noted.	
07/14/98	**<u>Medical Director's Update</u>** Andrew Pearson gave an update and invited a discussion as follows : ***Outcomes*** • The DoF noted that by the end of the year the relevant information systems will have been improved which should impact on the outcomes work. ***Infection rates*** •An analysis has been carried out of a wide range of potentially relevant factors to help inform the improvement of SSIs- these have now dropped. •Patient monitoring has been lengthened e.g. arthroplasty patients are monitored for one year using Board increased funding. •Clinical audit work has been done on infections. •Work will also be undertaken regarding variations in SSI rates by clinician. •There should be a flow of information from this area to CGC. •These issues should be considered as part of the wider review of Quality Governance. ***Clinical Standards*** •The intention is to share these, via a cascaded process, throughout the Trust. The Chair of the MSC, the Clinical	

	Directors and the Senior Nurses have already seen the standards. •The Board needs to have oversight of this work e.g. via the strategy and values work. This could be part of one of the Transformation work streams; one way to monitor this might be the level of sign up to the standards or the level of complaints. •There is a role for CGC in supporting the embedding of these standards. •The standards could be attached to individual clinicians' appraisal documents. ***Caldicott Guardian - Personal Databases*** •The ROH is not legally responsible if individuals during their private activities breach Data protection standards provided the Trust has met its obligations e.g. in writing to individuals. However it would be reasonable to ask clinicians with a private practice for documentary evidence of compliance with the relevant legislation. •There is a moral and reputational dimension to this as well as a legal one and the personal databases issue should be added to the risk register. •The Medical Director agreed to resend his letter with a return copy to be returned signed by the individual clinician. **Resolved:** That the Medical Director's report be noted.	**AP** **AP**
07/14/99	**<u>Corporate Performance report</u>** Amanda Markall gave a presentation on activity (re dated in the CPR) highlighting the following points: ***Large Joints*** •Large joint performance is significantly under plan and lower than the corresponding period last year. Factors include annual leave and potentially an over ambitious plan. Large joint referrals are relatively flat. • A sonographer has been agreed to support large joints which should help re capture some shoulder work currently going elsewhere. There may some opportunities to accept referrals from other centres helping them to meet 18 week targets. •Some sessions have been released by the team which can be recycled – e.g. to paediatrics and spinal where there is high growth potential. •Further studies including benchmarking are being carried out to help optimise the large joint workload. •There may be risks associated with staff concerns regarding the changes to sessions and the benchmarking exercise.	

Oncology
•Activity is slightly behind plan; work is begin done to create additional sessions and to create capacity by bringing in additional surgeons from overseas.
• Expected to be on plan by the year end.
•Clinical fellows give additional flexibility.

Paediatrics
•Over plan to date; some further growth potential. Achieved 18 weeks target.

Spinal
•Expect to meet their plan.
•New Consultant creates further opportunities for growth in capacity which will help to reduce long waiting times.

Small Joints
•Strong performance; expect to meet or exceed their plan.

CSS
•Strong performance; expect to meet or exceed their plan.

Summary
•Rebasing exercise is being undertaken for all activities. Further discussions will be held at EMT.
•The activity plan overall should be achieved by year end but the financial impact needs to be analysed and mitigations put in place.

The Chair invited a discussion as follows :

•There should be capacity to absorb additional work from other centres, which will help to address the national drive to reduce waiting times for patients.
•The additional physiotherapy post should help address some of the PROMS concerns.

Other Corporate Performance Report Issues
Paul Athey presented the CPR highlighting the following points:

•Experience and Treatment and Workforce are all rated green; all treatments targets have been achieved and there has been low levels of sickness.
•Finance is tight – continuity of service rating is 4 but within this capital servicing capacity rating is 3 associated with the Q1 deficit. There is continuing and growing pressure on junior doctor costs and vacancy levels. Opportunities for greater cost

	control are being explored in HDU. •CIP performance is ahead of plan; 85% of QIAs signed off; the remainder to be received by July 31. •Some capital schemes are slightly behind plan mainly due to phasing/timing issues. No material impacts on performance are expected. •The activity issues described earlier are being reflected in commissioner plans. **Resolved:** That the Corporate Performance report be noted.	
07/14/100	**<u>The Patient Quality Report</u>** Helen Shoker introduced her report and highlighted the following : ***Vulnerable Patients*** •Work is in progress to improve care for the most vulnerable patients. ***Deaths*** •There have been three patient deaths; one was an end stage oncology patient – there has been a review of this case with some learning around involvement of senior staff early. •There is a new Chair of the VTE Committee who will report to the CGC on the second death in August. •The third death has been reported on by the coroner and there is no causal link with the ROH work. ***Friends and Family*** • Feedback from children has been positive but with a request for more tailored information for them. ***Avoidable Pressure Ulcers*** •There were three Grade 2s in the period- all on one ward – action has been taken to investigate and respond. The Chair invited a discussion as follows : • There is a review of the outreach team to consider how it could be used to support ward staff and best align its work with that of the ward teams especially for complex / seriously ill patients. •One of the deaths is currently included in hospital statistics; this might increase to 2 depending on the VTE report. •Additional metrics relevant to patient concerns (e.g. waiting times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.	**HS**

	•This work should develop into an end to end view of the patient pathway. •The wider goal will to create a set of metrics relevant to the ROH's strategic objectives. **Resolved:** That the Patient Quality report be noted.	
07/14/101	**<u>Safe Staffing</u>** Helen Shoker introduced her report highlighting a number of issues including : •The work is a requirement from the National Quality Board •There was one safe-staffing incident – this related to HDU. Following additional funding this is not expected to re occur •Data has been uploaded to Unify in a timely manner. •Hand held devices are being trialled to meet national standards and improve efficiency. •Overall the ROH is considered to be in a good position in comparison with many other Trusts. •A safe-staffing benchmarking exercising exercise is planned with the two other specialist hospitals. The Chair invited a discussion as follows : • Some staff might give a different view regarding what they feel represents safe staffing. This can reflect a misunderstanding of national guidance. Education will continue to be important. Staff surveys and CQC interviews with staff help triangulate self-staffing data. **Resolved:** That the Safe Staffing report be noted.	
07/14/102	**<u>Board Assurance framework (BAF)</u>** Helen Shoker presented the BAF and the Chair invited a discussion as follows: **General Risk Matters** • A fuller report will be given in September. • There will be some workshops in September and October to demystify the BAF. Board members are welcome. •Some risks may need escalation to the BAF. •Risks are being reviewed by the lead committee. •There are some timing/updating issues which mean that a few updates need to be made to the BAF. •The Director Operations noted that risk number 269, relating to activity, which had been reported as an 8 should have been a 12.	

	Staff Engagement •The risk level has been left unchanged because while there are early signs of improvement it is too early to say that a fundamental change has taken place. **Strategic Risks** •These have been considered during the strategic planning exercise; the new Transformation Board should become the lead Committee for the implementation risks associated with the programme to implement the five year strategy. These risks can then be integrated into the BAF. •The strategic risks themselves should be brought to the Board for it to consider and should not be delegated. **EMT Managed Risks** The formal accountability for these need to be considered in the context of the review of the Scheme of Delegation, SFIs, Standing Orders and in the light of external reviews of Governance. The terms of reference of EMT and its relationship with the Board need to be considered. **Resolved:** That the Board Assurance Framework be noted.	**HS/JC**
07/14/103	**<u>Quarterly Workforce Report</u>** Anne Cholmondeley introduced her report following which the Chair invited a discussion: •The level of stress related absence is improving with the benefits of management education and supporting staff coming through. •The Friends and Family test showed a low return rate (although higher than some neighbouring trusts). The negative score may reflect a bias in the scoring e.g. 'likely to recommend 'is not counted. The Director of HR agreed to recalculate the score using more conventional approaches. • Free text comments are expected to have an over representation of negative views; this is common to most staff surveys. • Matters such as communications and leadership continue to be an issue for some staff. •The direction of travel is right but it is still very early on the journey. •The Board agreed that improvement in staff attitudes and perceptions underpins improvement in all areas. **Resolved:** That the Quarterly Workforce report be noted.	**AC**

07/14/104	**<u>Quarter 1 Declaration – April to June 2014</u>** The CEO introduced the Quarter 1 declaration and invited a discussion as follows : • This is a regular responsibility of the Board and forms part of a report to Monitor •The Board is overseeing a number of activities relevant to Quality Governance. These include a rapid external "mini–review" of governance, feedback from CQC, self-assessment activity as well as assurance received via an external review for the annual governance statement and from the annual report from the Audit Committee. With recent changes to Board members including a new Chair and CEO and with new expectations post Francis it intends to set ambitious improvement standards and associated delivery plans. Further details will be included in subsequent quarterly reports as this work develops, and will inform the board's development programme going forward. •.CGC have been actively involved in overseeing improvements in this area. •The Board encouraged early communication with Monitor to keep them informed of existing and planned developments in this area. **Resolved:** That the Board approve the Quarter 1 Declaration and delegate to the Chair and CEO the authority to finalise it based on the above points and submit it to Monitor	
07/14/105	**<u>Revalidation Annual Report</u>** Andrew Pearson presented the report and invited a discussion: • The new electronic appraisal process supports a more standardised approach. • Appraiser refresher training has been introduced. • Key questions for each person being appraised are being identified which ensures a tighter focus to the appraisals. •The appraisal process should address deviations from standard practice (e.g. if there are higher than average infection rates) but it is not possible to monitor every aspect of clinical practice. •In relation to the remediation process it was noted that previously there had been three doctors involved one of whom had subsequently resigned. There was a general discussion as to whether the acceptance of the doctor's resignation was appropriate in the circumstances and whether the public's interests had been protected. Anne Cholmondeley confirmed that should the doctor not reach an acceptable level of performance prior to the end of his employment with the Trust,	

	then the GMC would be notified accordingly. It was noted that these matters are sensitive and confidential and that in future discussions consideration would be given to the discussion being carried out in the private session of the Board. **Resolved:** That the Board approve the Revalidation Annual Report.	
07/14/106	**<u>Audit Committee Annual Report</u>** Paul Athey presented the report and highlighted the following: •.Assurance has been gained around referral to treatment targets – these have been fed into the BAF. •The reference to the IGC should be replaced by CGC. •A regular update to the Board of audits being carried out should be made going forward. **Resolved:** That the Board approve the Audit Committee Annual Report.	**PA**
07/14/107	**<u>Update on Five Year Strategic Plan</u>** ***Tariff reductions going forward*** Paul Athey explained current proposals by Monitor: •.There is due to be a teleconference with Monitor covering proposed changes to tariffs which will be introduced over several years. •Reference costs are being updated. •Monitor are building in a 3-5% efficiency element into tariffs; ROH are modelling 4%. •£5.8M of admitted patient income (c12%) appears to be at risk based on early modelling. £3.1M relates to scoliosis work. Revision joint and primary knee tariffs are also being substantially reduced. These reductions are also being seen to have major impacts at other specialist orthopaedic hospitals. •It is believed that Monitor may be using an over simplistic use of 2012 reference costs without the adjustments appropriate to specialist hospitals ; it is critical, but may be difficult to try to influence Monitor to modify these proposals. **Key points raised in discussion:** • The Board strongly supported the DoF in taking a robust approach to the negotiations with Monitor. • The DoF was requested to provide an interim update on the proposed tariff reductions before the September meeting, given the criticality of these issues. ***Other Matters :*** Jo Chambers drew the Board's attention to the following supplementary points to her report:	**PA**

	Local Health Economy: Chief Officers Group •.There is an ongoing work across the local health economy covering such matters as shifting work to the community, and making efficiency improvements ; there is a c£720M gap to be bridged if no action is taken. •The Chief Officer group felt that it was not a decision making body but would seek to influence members' own governing bodies. •ROH is engaged in the clinical design groups. **Research Stocktake** •Regarding the baseline stocktake of research the CEO's view is that while there is a range of good work being carried out it is very fragmented. •One of the Transformation programme work streams covers developing an integrated research capability. Initially it is intended to gather together what is currently being done and to assess the resources involved. This activity should include clinical audit, outcomes and some of the quality work. • It was agreed that Tauny S should meet up with the key individuals carrying out the Research Stocktake. **Governors' request** The Governors had previously requested an update on the 30 day and 90 day actions agreed at the stakeholder event in April, which are attached to this report. It was agreed to check that board papers are routinely sent to Governors, including this update. **Resolved:** That the Board note the Strategy Update.	**TS** **JC**
07/14/108	**<u>Constitution</u>** Julian Denney presented his report which explained the background to the amended Constitution attached as Appendix 1 to that report which had been prepared by the Trust's solicitors and incorporates all the changes approved by the Council of Governors on 3rd July 2014. •It was noted that a number of suggestions had been made for further amendments to the Constitution and that the standing orders of both the Council of Governors and the Board of Directors were also being reviewed and that these potential additional changes would need to be considered as part of a further revision to the Constitution after the amended Constitution had been approved and adopted by the Board. Such further amendments to the Constitution would	**JD**

	need to be approved by the Council of Governors and Board before the further amended Constitution could be adopted. •The Board wished this subsequent activity to be carried out as rapidly as practicable. •Some of the feedback provided could be handled through the recruitment process for Governors. **Resolved:** That the Board approve the amended Constitution attached at Appendix 1 and agree to adopt it from July 30 2014.	
07/14/109	**Audit Committee** Paul Athey drew Board members attention to the report written by Rod Anthony, Chair of the Audit Committee which was considered by Board members to be a helpful report on its work. **Resolved:** That the Board : •Note the report of the Audit Committee	
07/14/110	**Clinical Governance Committee** Tauny Southwood presented the CGC report and a number of issues were discussed: •Understanding better violence and aggression events •Patient safety- as reported earlier the results appear positive in that staff feel free to speak out about their concerns. •Improving incident forms completion – this needed to be seen in the context of wider culture change to build trust with staff to continue to shift to a learning and supportive culture. **Resolved:** That the Board : •Note the assurances provided by the CGC meeting.	
07/14/111	**Remuneration Committee** Elizabeth Mountford gave a verbal update regarding the work of the Remuneration Committee including its work to agree the Job Descriptions and person specifications for the posts of Director of Operations and Director of Strategy and Transformation. **Resolved:** That the Board : •Note the update of the Remuneration Committee.	

07/14/112	**<u>Charitable Funds committee</u>** Frances Kirkham noted that there had been no meeting of the Committee since the last Board meeting and made the following comments : • Some expenditure on the playroom had been approved •The ROHBTS Charity would be invited to the next meeting of the CFC. **Resolved:** That the Board : •Note the update from the Chair of the Charitable Funds Committee.	
07/14/113	**<u>Council of Governors</u>** The CEO gave a verbal update regarding the work of the Council of Governors which at its last meeting focused on the review of the Constitution. **Resolved:** That the Board : •Note the CEO's update regarding the work of the Council of Governors.	
07/14/114	**<u>Any Other Business</u>** Tauny Southwood reported on a forthcoming conference concerning "delivering the future hospital" – he would forward details to Board members. Attendance should be coordinated for reasons of efficiency and economy. Regarding the forthcoming appointment of the Director of Operations it was agreed that the Board delegate to the interview panel the authority to confirm the appointment. There has been a visit from the ROH's main CCG regarding the safeguarding of adults and children. A formal report has not yet been received but informal feedback has been very positive.	
<u>Date and Time of Next Trust Board Meeting</u> 24 September 2014 time to be confirmed subject to AGM planning. The location is to be agreed.		
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

Enclosure 2

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 30th July 2014

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
03/14/44 Corporate Performance Report (26.03.14)	FK asked that a report on paediatrics be given to a future meeting.	AM	Done	√	Completed but kept on register as a reminder re Strategy Development
05/14/78	Commission an external governance review to establish a baseline and also support the organisational and board development plans. Circulate guidance, to Board members for information. Bring the output from the review back to the Board in September	JC/YB JC JC	End of June 2014 End of May 2014 End of Sep 2014	√ √	Governance review commissioned. Circulated guidance discussed at Board Workshop in June 2014.
05/14/83	Consider approach to deal with cultural and housekeeping issues covering theatre equipment linen etc.	Executive Team	Noted that longer term this can be embedded within the transformation process in September / October		
05/14/88	Create Action Plan to address issues identified by the CGC	TS/AP/HS	September 24 2014		
07/14/93	The Board requested that a	AM	September 24 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	further discussion be held about the pre-operative pathway.				
07/14/98	The personal databases issue should be added to the risk register. The Medical Director agreed to resend his letter with a return copy to be returned signed by the individual clinician	AP	August 15 2014		
07/14/100	Additional metrics relevant to patient concerns (e.g. waiting times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.	HS	September 24 2014		
07/14/102	**EMT Managed Risks** The formal accountability for these need to be considered in the context of the review of the Scheme of Delegation, SFIs, Standing Orders and in the light of external reviews of Governance. The terms of reference of EMT and its relationship with the Board need to be considered.	HS/JC	September 24 2014		
07/14/103	The Friends and Family test	AC	September 24 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	showed a low return rate (although higher than some neighbouring trusts). The negative score may reflect a bias in the scoring e.g. 'likely to recommend' is not counted. The Director of HR agreed to recalculate the score using more conventional approaches.				
07/14/106	A regular update to the Board of audits being carried out should be made going forward.	PA	September 24 2014		
07/14/107	The DoF was requested to provide an interim update on the proposed tariff reductions before the September meeting, given the criticality of these issues.	PA	End August 2014		
07/14/107	It was agreed that Tauny S should meet up with the key individuals carrying out the Research Stocktake.	TS	End August 2014		
07/14/107	The Governors had previously requested an update on the 30 day and 90 day actions agreed at the stakeholder event in April, which are attached to this	JC	August 8 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	report. It was agreed to check that board papers are routinely sent to Governors, including this update.				
07/14/108	It was noted that a number of suggestions had been made for further amendments to the Constitution and that the standing orders of both the Council of Governors and the Board of Directors were also being reviewed and that these potential additional changes would need to be considered as part of a further revision to the Constitution after the amended Constitution had been approved and adopted by the Board. Such further amendments to the Constitution would need to be approved by the Council of Governors and Board before the further amended Constitution could be adopted.	JC/JD	End October 2014		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24 September 2014 **ENCLOSURE NUMBER: 3**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Chief Executive's Report**

SUMMARY

This report provides an update to Board members of key issues and activities since the last meeting.

IMPLICATIONS

To ensure Board members are aware of the context and policy framework in which the Trust is operating, and to highlight matters of interest.

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update the Board on national and local issues.
Recommendation	The Board is asked to note the contents of the report and discuss items as appropriate.

This report provides Board members with an overview of key issues in relation to the Trust.

1 Care Quality Commission Inspection – Pilot for new regime

At the time of writing this report we are still awaiting feedback from the Care Quality Commission (CQC) on the points of factual accuracy in the first draft of the inspection report. All trusts have the opportunity to undertake a factual accuracy check and a number of points have been brought to the CQC's attention. It is anticipated that the draft report will be corrected and be taken into account in the final assessment of ratings.

The Trust is due to receive the final report no later than one week before the Quality Summit scheduled for 29 September 2014. All information is confidential until the CQC publish the report.

We are one of two specialist trust pilot sites for the new inspection regime and consequently we are working closely with the Royal National Orthopaedic Hospital NHS Trust to support the development of the CQC's approach to specialist organisations.

2 ROH in the HSJ Top 100 NHS Places to Work

The Health Service Journal, in conjunction with NHS Employers, has undertaken an analysis of all NHS organisations using a variety of data sources and has published a list of the top 100 NHS places to work.

I am delighted to report that we have been recognised in the top 100 places to work. It is particularly pleasing that we compare so favourably with other organisations and we continue to prioritise these important areas within our new 5 year strategic plan.

Seven core areas were assessed from the NHS staff survey and other performance metrics:

- Leadership and planning
- Corporate culture and communications
- Role satisfaction
- Work environment
- Relationship with supervisor
- Training and development
- Employee engagement and satisfaction

3 Genomics Clinical Centre Application

We have been invited to collaborate in a West Midlands proposal to participate in the UK's 100,000 Genomics Programme. The Government's stated aims are to achieve by 2017:

- being the first country in the world to sequence 100,000 whole human genomes of patients with cancer or a rare disease;
- having high consent rates from patients and public support for genomics;
- having in place a world leading genomics service ready for adoption by the NHS;
- having trained and developed specialist health professionals applying genomic medicine within the NHS and supported by non-specialist staff with an awareness and understanding of genomics;
- being the home of world leading genomics companies and research institutions;
- producing new medicines, devices, diagnostics, treatments and understanding of how genomics influence disease.

The initial timescale for the bid was very tight and the response was developed by University Hospital Birmingham NHSFT, Birmingham Children's Hospital NHSFT, Birmingham Women's Hospital NHSFT, the University of Birmingham and the West Midlands AHSN.

It is hoped that one of the 3 – 5 Genomics Clinical Centres will be in the West Midlands and to this end all Trusts have been invited to collaborate as partners in the scheme. We indicated our support and interest by the submission deadline of 29 August.

The organisational arrangements for the collaboration are still to be determined and I have indicated our interest in the partnership as well being a collaborating trust. Our lead for the project will be Mr Ed Davis, Director of Research and Development.

This is a good opportunity for the Trust to actively engage in a wider set of research activities and be part of a nationally important project.

4 ROH Orthopaedic Charity

I have had a further meeting with the Chairman of Trustees of the ROH Orthopaedic Charity. Mr John Wheatley has recently taken over the Chair and is keen to explore opportunities to work in partnership with the Trust to support the objects of the charity. There are funds available from a previous fundraising campaign which supported the original development of the Research and Teaching Centre. Mr Wheatley is intending to test the appetite of the trustees to embark upon a new fundraising campaign. Several members of staff are trustees of this charity.

I have been invited to the next meeting of the trustees in mid-November to talk about our new strategic plan and in particular our ambitions in relation to developing an integrated research, evaluation, education and innovation capability, and the ROH as a knowledge leader workstream. This is a great opportunity to work in partnership with the charity on mutually beneficial interests and secure a longer term development plan for research and educational activities.

Some time ago plans were drawn up with a view to developing the building but these were not progressed at the time. I have asked Andrew Pearson to form a small group to review the plans against our new strategic plan and to update as necessary so that we can progress our thinking in support of discussions with the charity.

5 Other External and Partnership Engagement

- I continue to meet regularly with the CEO of Birmingham Children's Hospital Sarah-Jane Marsh. The Children's Hospital is a key operational and strategic partner of the ROH. I have also met with the Director of Strategy at the Children's Hospital to better understand the medium and longer-term plans of the Trust, covering the plans to merge with Birmingham Women's Hospital, relocate substantial elements of their service to the Queen Elizabeth Hospital campus and the arrangements for the residual estate at Steelhouse Lane.
- I have met with the CEO of the Robert Jones and Agnes Hunt NHS Foundation Trust, which is a specialist orthopaedic hospital in Oswestry. We are continuing to build alliances with partner organisations involved in the specialist orthopaedic alliance which is helpful to for sharing best practice and working together on common challenges such as proposed changes to the tariff for our services.
- I am due to visit the Elective Orthopaedic Centre in South West London on 22 September, which is held up as an organisation with good patient flow processes.
- We have had two meetings with the regulator Monitor during this period, firstly for informal review of our 5 year strategic plan and secondly in partnership with the Specialist Orthopaedic Alliance regarding the proposed tariff changes; both of these issues are covered in more detail in other board papers.
- The first meeting of the West Midlands Academic Health Science Network central spoke, took place on 11 September, which I will chair at the ROH. This initial meeting will provide all other partners (NHS and Non-NHS) within the Birmingham and Black Country area with an opportunity to understand more

about the work of the AHSN and opportunities to improve the adoption and spread of new innovations in health care delivery and industry collaboration.

- I am due to attend the Foundation Trust Network Chair and CEOs meeting on 18 September which provides a good opportunity to network with others and also receive briefings on the national picture, policy issues and common challenges across the NHS.

6 Executive Management Team – August 2014

6.1 Key points to note:

- There were discussions regarding the proposed new tariff, the recent Care Quality Commission inspection and the development of the strategic initiatives. The excellent joint work between clinicians and the finance team in relation to the proposed tariff changes was noted.
- EMT risks on the BAF and corporate risk register were discussed. It was noted that a full review of the BAF and corporate and strategic risks were planned by the Board and new risks would be incorporated from that event.
- Routine reports were received in relation to corporate performance, quality, safe staffing and the Clinical Programme Board, noting that the CPB activities are to be reviewed and mapped across to the new strategic transformational initiatives.
- The Carbon Reduction strategy update was received and will be monitored by the Estates Programme Board.
- The Patient Access Review Programme update was received and further work is ongoing; this will be reviewed again by EMT in October.
- The Getting it Right First Time update report was received and reviewed. This is a national project supported by the British Orthopaedic Association and enables peer review of clinical outcomes. The report will be considered further by the Clinical Governance Committee.
- Policies approved by EMT – Whistle Blowing and Retirement.

6.2 September 2014

This meeting is due to take place on 17 September and a verbal report of any key points will be made to the Board.

7 National Policy and Context

7.1 The independent Commission on the Future of Health and Social Care in England, established by the King's Fund and led by Dame Kate Barker, has published its report. The commission recommends moving to a single, ring-fenced budget for the NHS and social care and proposes funding changes, including changes to national insurance contributions to meet the costs that would be required to improve social care entitlements.

Read the full report at http://www.kingsfund.org.uk.

7.2 21 organisations from the NHS, local governance, charities and the professions have developed a document aimed at all political parties for consideration in advance of the general election in 2015, *'The 2015 Challenge Manifesto: a time for action'.* Building on the '2015 Challenge' document produced earlier this year, this documents sets out a view of the essential components of a new health and social care system. It provides some 'asks' of politicians and policy makers. It is a further indication of the concerns that the NHS and social care system is unsustainable in their current forms and requires substantial development to meet the growing needs of the population going forward. It recognises the pressures in the system at present and emphasises a future system that prioritises helping people to remain well and self-manage conditions.
Read the full report at http://www.nhsconfed.org.

7.3 These two documents identify real and enduring challenges in the current health system. It is likely that the structure and funding of the NHS and social care will remain a central theme before and after the next general election in May 2015. This, coupled with the on-going work of our local Unit of Planning, provides for a complex and evolving strategic context in which we are planning the future of our services. The proposed tariff changes are also a cause for concern and we continue to make representation on that point.

It is essential that we continue to review the national and policy context in order to plan for high-quality and sustainable services into the future.

8 Recommendation

The Board is asked to note the contents of this report and discuss as appropriate.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24/09/2014 **ENCLOSURE NUMBER: 4**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Mr Edward Davis Director of R&D**
SUBJECT:	**Research & Development Update**

TITLE: Research & Development (R&D) Update

SUMMARY

For information purposes.

IMPLICATIONS

Strategic implications for delivering the Trust's 5 year plan.

RECOMMENDATIONS

Consider the paper and discuss/propose solutions and improvements to allow the Trust to position itself at the forefront of Research and Innovation.

Background

The Trust continues to expand its research opportunities through the support of the dedicated research and development team. The department was set up in 2009 and has been successful in increasing the amount of research undertaken by engaging and supporting clinicians and other allied healthcare professionals (AHP's) to conduct clinical research projects, for the benefit of the Trust and the patients it serves.

The R&D department is located in the nurses home and the team have expanded considerably from a head count of only 2 staff members in 2009, to 20 members of staff currently employed within the department, comprising of management, nursing, governance, data management and other AHP's (physiotherapy and pharmacy) staff.

The current research portfolio consists of a broad mix of different types of research projects, including drug and device studies, human tissue basic science studies and questionnaire/qualitative studies. The projects are coordinated both in-house and with external partners such as academic institutions, commercial companies and other NHS providers.

Performance

Year on year recruitment has increased considerably from approximately 20 patients per year (<2009) to over one thousand participants recruited last year (Figure 1).

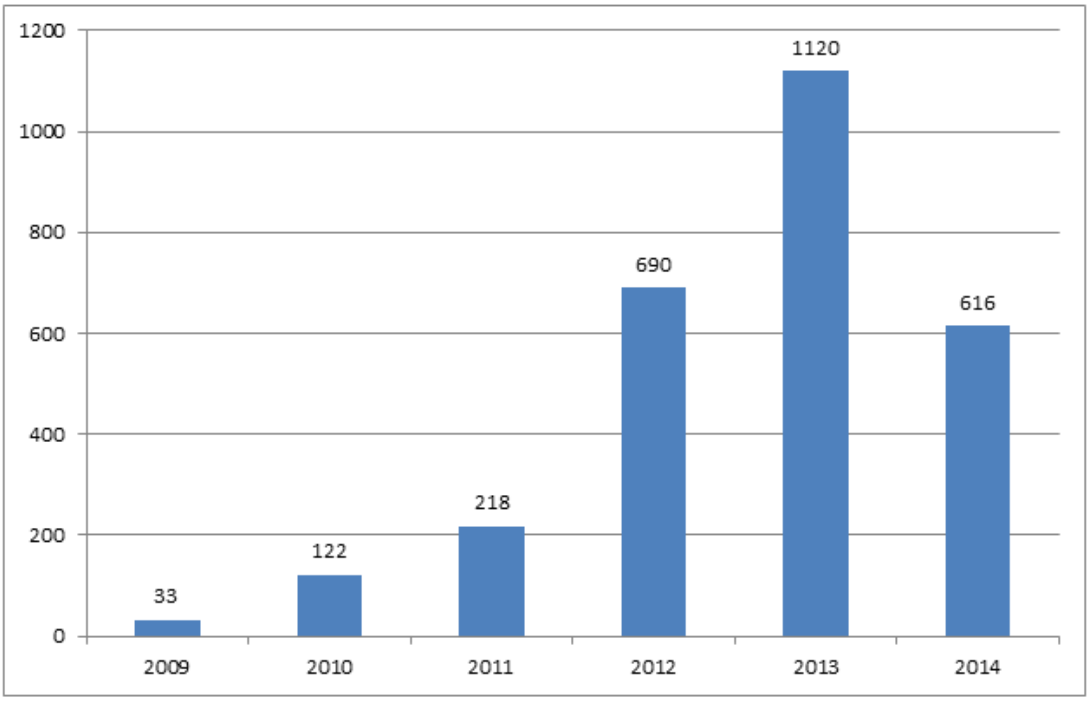
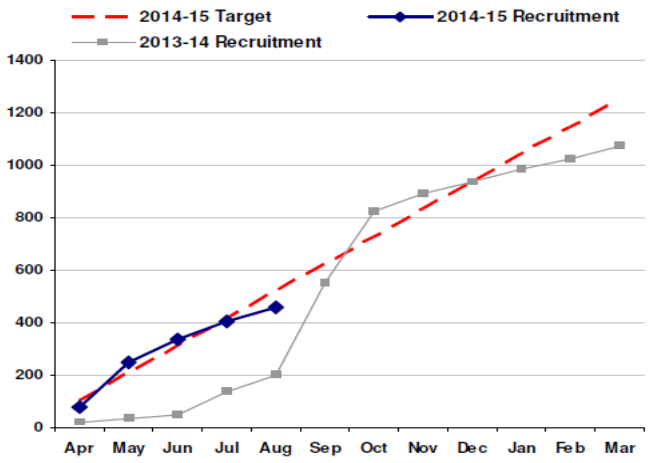


Fig 1 – ROH recruitment (all studies, calendar year)

The current target for recruiting to NIHR (National Institute for Health Research) adopted studies for this financial year is set at 1250 (Figure 2).

	This year Target	Recruitment	Last year
Apr	104	76	19
May	208	251	32
Jun	313	339	48
Jul	417	407	136
Aug	521	457	199
Sep	625		552
Oct	729		825
Nov	833		892
Dec	938		937
Jan	1042		985
Feb	1146		1026
Mar	1250		1074



Due to the average delay in studies uploading data, it is recommended to look back 1-2 months for a more accurate picture.

Figure 2 – recruitment for 2014/15 vs Target.

The NIHR recruitment target for this financial year will be challenging to meet (this was a purposefully ambitious target set by us). This is due to the fact that some large recruiting studies have now closed and the majority of NIHR studies that are open are led by a very small proportion of ROH staff.

PI Name	Study Name	Recruits	2011	2012	2013	2014	Total PI Recruits
Ed Davis	ISOS study	53				53	
Ed Davis	OT intervention for THR	26		19	7		
Ed Davis	SID Pilot	237			117	120	
Ed Davis	Simulated Patients Medical Students Study	397		227	170		
Ed Davis	Adipokines in OA	17			4	13	
Ed Davis	BUPA Obesity Study	106	72	18	12	4	
Ed Davis	Tissue engineered structure	10			6	4	
Ed Davis	TRIO popular	81				81	
Ed Davis	8 Studies		72	264	316	275	927
Rob Grimer	DENOSUMAB	19	7	9	1	2	
Rob Grimer	Fact Study	257			91	212	
Rob Grimer	Brightlight	8			4	4	
Rob Grimer	SOFI	133		133			
Rob Grimer	Vortex	26	10	6	10		
Rob Grimer	VORTEX BIO BANK	25	10	6	9		
Rob Grimer	6 Studies		27	154	115	218	468
Faye Moore	Expekt	238	26	212			
Faye Moore	1 Study		26	212			238
Ed Bache	UK FASHIoN	84		3	58	23	
Ed Bache	1 Study			3	58	23	84
Martyn Snow	PRP study	83	31	17	19	16	
Martyn Snow	1 Study		31	17	19	16	83
Narendra Siddaiah	SNAP Study	55				55	
Narendra Siddaiah	1 Study					55	55
Lee Jeys	Functional MR	32			16	17	
Lee Jeys	1 Study				16	17	33
Dean Muldoon	Arm Pain	12			11	1	
Dean Muldoon	1 study				11	1	12
David Rogers	PROVE	2				2	
David Rogers	1 study					2	2
Lucie Gosling	REJOIN	1				2	
Lucie Gosling	1 study					2	1

Figure 3 – NIHR Recruitment by Principal Investigator

In an attempt to meet this year's target, the R&D team are currently scanning the NIHR portfolio to identify NIHR studies that can be opened up at the Trust. Additionally, we have recently employed a 'grant writer' to support clinicians with the development of research protocols and grant applications, which will allow our in-house studies to become eligible for NIHR portfolio adoption.

Another possibility to increase the amount of research undertaken within the Trust would be to consider allowing specific protected time for clinicians to set up and deliver research studies.

The West Midlands Clinical Research Network: of which the Trust is a member organisation, are proposing an activity based funding model (ABF) for the next financial year, which means that funding will follow research activity, and for the Trust to continue to increase its share of the NIHR funding available to our region, then an increase in research activity is needed to achieve this.

Performance against other Specialist Orthopaedic Hospitals

It would be inappropriate to compare performance in relation to research activity against a regional specialist acute hospital, such as The University Hospitals Birmingham NHS Foundation Trust, due to the significant differences that exist between the two organisations. It would therefore be much more appropriate to compare the ROH to other specialist orthopaedic hospitals, such as The Robert Jones and Agnes Hunt in Oswestry and The Royal National Orthopaedic Hospital in Stanmore (Figure 4).

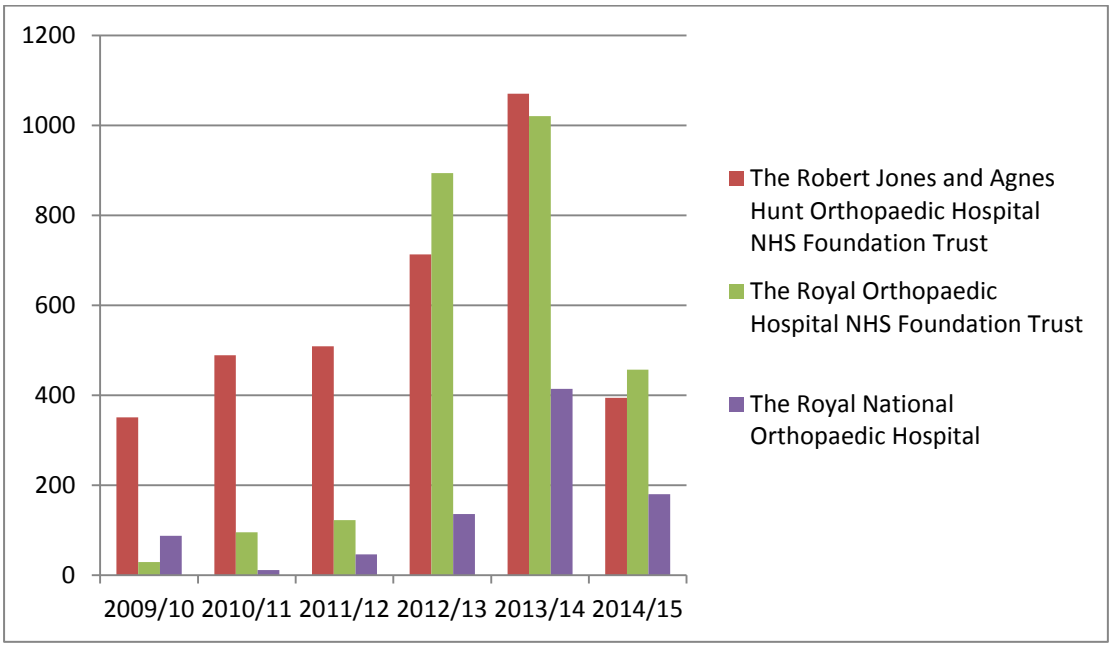


Figure 4 – ROH NIHR recruitment(financial year) compared with UK specialist orthopaedic hospitals

Current challenges

Accommodation

Although the R&D team are grateful to have office space on the ROH site, we are currently renting bedrooms in the Nurses Home from the Facilities department to use as offices at the cost of £15,000.00 per annum. The nurses home is not considered the most ideal location to house the R&D team, specifically because of the increasing amount of external visitors to the department who attend the Trust to discuss potential collaborative research projects.

The R&D team are unable to rent any further bedrooms within the Nurses Home and convert these into office due to the need to accommodate residential staff. Accommodation for staff within the Trust is currently at capacity and some members staff are unable to secure a room onsite and therefore have to source accommodation externally.

A possible solution to this current situation would be to rehouse the R&D team to a facility that encompasses Research, Innovation, Audit and Outcomes staff together in a centralised location. This would bring additional benefits and help facilitate joined up working, where skills and expertise can be shared and utilised for the benefit of the Trust.

Capacity and support from other departments within the Trust

To deliver clinical research studies effectively at the Trust, the R&D department relies heavily on other supporting departments within the hospital. Particularly areas such as; histopathology, radiology, outpatients and theatres. Although improvements have been made within these areas and they have increased their capacity to support research, there are still some limitations with the support that can be provided, which sometimes results in the R&D department having to outsource some of the research procedures to other providers.

Many of the above named departments are working at full capacity, providing a clinical service to the Trust. The R&D department has been able to increase the capacity in some of these areas by investing in staff time to support research within the organisation, such as; part funding the salary costs of a Phlebotomist in Outpatients and also a Biomedical Scientist within the Histopathology lab. A possible long-term solution to overcome the capacity issues within these areas is to consider further investment into these supporting departments, through non-commercial R&D funds and also commercial income from the private sector.

Innovation / IP

The department oversees the complex area of Intellectual property and innovation within the trust. The first intellectual property policy was developed in 2011 to give guidance on this area. Despite this being a complex area there is significant potential reputational and financial benefit in developing this area. The trust commissions support from MidTech for advice on the development of ideas from employees. Recently there has been a need to

further clarify the area and update the policy with recognition that different models of financial and reputational risk exist. The policy is under the process of being amended and staff groups consulted.

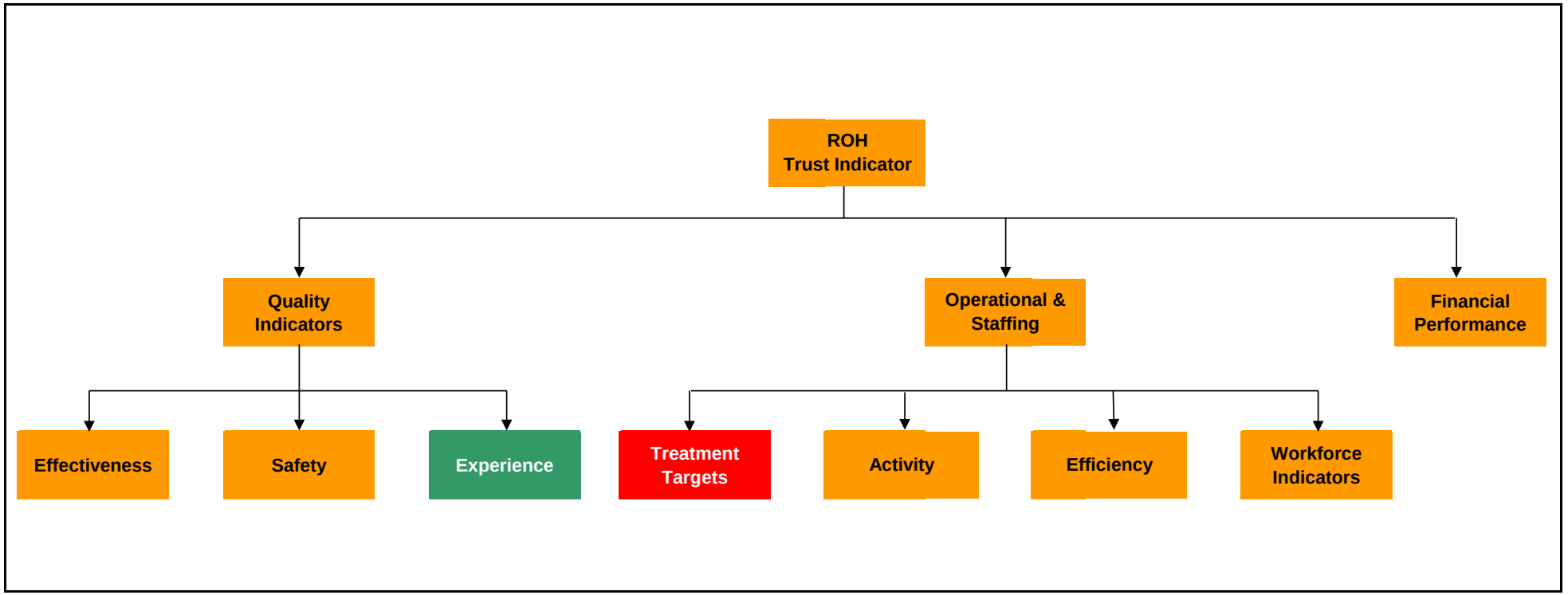
The R&D department does not presently have a dedicated innovation team as we have yet to generate any revenue from this area. The department would benefit from the possibility of some strategic investment in this area to provide support along with clarification of where pump priming investment might originate from to develop innovations. This area is currently being evaluated in the process of updating the policy.

The future

It is appreciated and fundamental that research and innovation are core elements built within the newly developed corporate strategy, which will allow the ROH to become the first choice for orthopaedic care. To support this, the R&D team are planning to develop and roll-out a "Research and Innovation Strategy" for the Trust, which will allow the hospital to become recognised as a world leader in orthopaedic research and innovation.

The first step to achieving this is to hold a listening and engagement event with staff (both active and non-active research staff) and external partners, including representatives from the NIHR, Academic Health Science Network (AHSN), academic and commercial organisations to help shape the strategy for the next five years.

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending 31st August 14



Quarterly Detailed Report
Executive Summary as at August 2014

Headlines

- For the year to date the Trust made a surplus before impairments of £279k compared to a planned surplus of £297k.
- All 3 RTT targets were met in month.
- The 62 day cancer waits target has been missed in month. However, current projections suggest that the quarter's result will still be achieved.

Monitor Compliance Framework Targets	Aug-14 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.24%	95.38%	0	6
Referral to treatment time - Admitted %	90%	91.57%	92.17%	0	6
Referral to treatment time - Incomplete Pathways %	92%	94.09%	94.57%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	71%	82%	1	6
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%	94%	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				

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

Key Trust Targets		Aug-14 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	3	↑	3
	Complaints	<=12	7	↑	4
	CQUINS	100%	100% (at Q1)	-	11
	Total Unexpected Hospital Deaths	0	0	→	5
Efficiency & Workforce	Total Backlog Patients	<400	434	↓	6
	Incomplete 14 - 18 Week Waiters	<450	471	↑	6
	Total Admitted Patient Care Patients vs Plan	100%	99.2%	↑	7
	Unused Theatre Sessions	<44	33	↑	8
	Sickness	4.1%	3.7%	↑	9
Financial	Surplus	£297k	£279k	→	10
	CIP	£633k	£675k	↑	10
	Agency Expenditure	£91k	£201k	↓	11
	Locum Doctor Expenditure	£46k	£128k	↓	11

Trust Summary

Total backlog has increased in month, driven by an increase in the admitted backlog.

All 3 RTT targets were met in month.

The 62 day cancer waits target has been missed in month. However, current projections suggest that the quarter's result will still be achieved.

For the year to date the Trust made a surplus before impairments of £279k against a planned surplus of £297k.

Elective and non elective activity are behind plan and amber rated. Day Cases and outpatients performed in excess of plan.

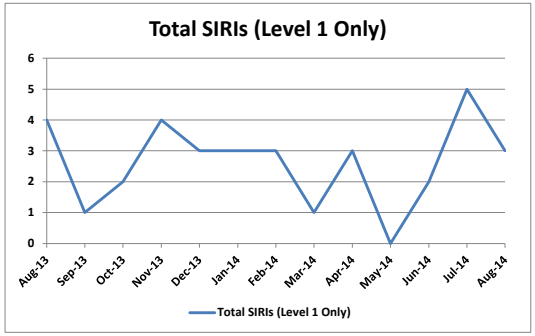
Sickness absence has remained to being green rated.

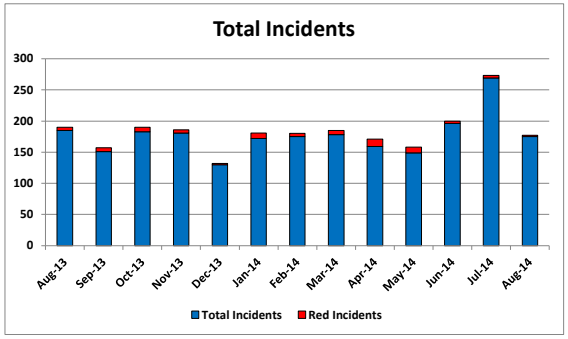
Quarterly Detailed Report
Safety Indicators as at August 2014

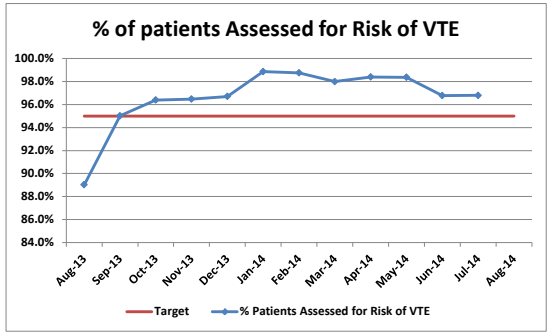
Headlines

- Medicine incidents reduced but are still red rated.
- Total incidents have reduced, with red incidents dropping from 4 to 2.
- Patient falls are still red rated, but have decreased from prior month.

	Monitor	National	CQC Standard		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	14/15 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)	4	1	2	4	3	3	3	1	3	0	2	5	3	13
			4,16	SIRI per 1000 bed days	1.27	0.36	0.62	1.39	1.01	0.90	0.85	0.27	0.89	0.00	0.56	1.68	1.10	0.80
			4,16	Total Incidents	185	151	183	181	130	172	175	178	159	149	196	269	175	189.6
			4,16	Incidents per 1000 bed days	58.96	54.12	56.82	62.70	43.61	51.71	49.30	47.94	47.04	41.98	54.87	90.45	63.96	58.48
			4,16	Red Incidents	5	6	7	5	2	9	5	7	12	9	4	4	2	31
			9,16	Total Medicine Incidents Reported	23	18	21	16	8	11	18	18	19	17	12	22	17	87
			9,16	Medicine Incidents Reported per 1000 bed days	7.33	6.45	6.52	5.54	2.68	3.31	5.07	4.85	5.62	4.79	3.36	7.40	6.21	5.37
				Medicine Incidents with Harm	1	4	1	3	2	1	3	3	3	2	4	7	6	22
		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	89.02%	95.02%	96.40%	96.48%	96.71%	98.87%	98.76%	98.00%	98.40%	98.38%	96.78%	96.80%		97.58%
			9	Incidence of Hospital Related VTE	0	1	1	0	1	1	1	1	1	0	1	2	2	6
			4	Patient Falls - Inpatients	9	2	4	8	6	3	6	12	6	7	5	6	5	29
			4	Patient Falls per 1000 bed days	2.87	0.72	1.24	2.77	2.01	0.90	1.69	3.23	1.78	1.97	1.40	2.02	1.83	1.79
				Avoidable Patient Falls with Harm									0	0		2	2	4
			4,16	% Harm Free Care	97.85%	98.70%	97.00%	98.90%	97.50%	97.41%	100.00%	97.71%	89.90%	99.02%	96.91%	95.88%	97.37%	96.27%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

There have been 3 SIRIs reported in month, down from 5 in July.

Total incidents have decreased from 269 to 175.

There have been 2 red incidents in month, compared to 4 in July.

Medicine incidents have reduced from 22 to 17, but are still red rated.

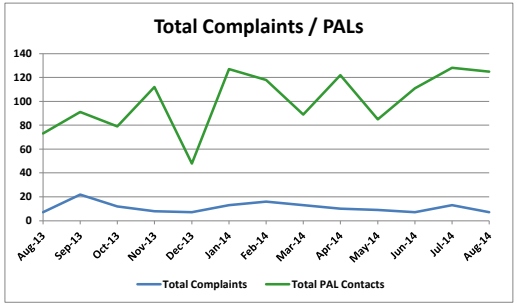
Additional information on all of the above is included in the Quality Report.

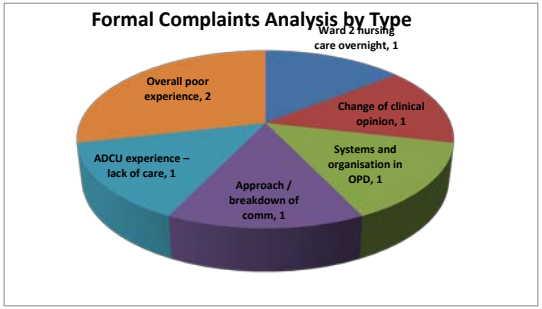
Quarterly Detailed Report
Experience Indicators as at August 2014

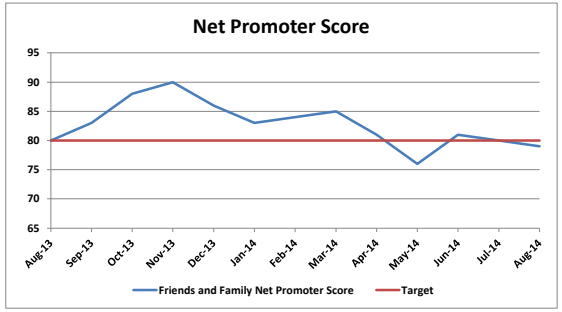
Headlines

- Complaints are down from 13 in July to 7.
- PALs contacts decreased from 128 in July to 125, with a lower percentage being complaints compared to last month.
- The real time food survey results increased from 94.2% last month to 95% satisfaction.

	Monitor	National	CQC Standard		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	14/15 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:46	1:14	1:34	1:16	1:63	1:37	1:27	1:42	1:46	1:48	1:60	1:31	1:73	**1:49**
			17	Total Complaints	7	22	12	8	7	13	16	13	10	9	7	13	7	**9**
			17	Complaints reverted to informal <48 hrs	3	3	0	1	0	0	0	0	0	0	0	0	0	**0**
			17	Formal	4	19	12	7	7	13	16	13	10	9	7	13	7	**46**
			17	Complaints per 1000 bed days	2.23	7.89	3.73	2.77	2.35	3.91	4.51	3.50	2.96	2.54	1.96	4.37	2.56	**2.84**
				Complaints Response Time (Average No of Days)	39	30	35	53	49	45	53	25		46	59	41	24	42.50
			17	Total PAL Contacts	73	91	79	112	48	127	118	89	122	85	111	128	125	**571**
			17	PALS Contacts per 1000 bed days	23.27	32.62	24.53	38.80	16.10	38.18	33.24	23.97	36.09	23.95	31.08	43.04	45.69	**35.22**
				Total PALS Concerns						65	65	56	80	59	49	88	73	349
			17	Total Compliments	320	298	409	124	440	481	439	552	455	436	423	409	511	**2234**
			17	Compliments per 1000 bed days	101.99	106.81	127.00	42.96	147.61	144.62	123.66	148.67	134.62	122.85	118.42	137.53	186.77	**137.81**
				Food - Real Time Patient Survey	92.40%	90.00%	90.60%	92.00%	96.60%	95.00%	93.00%	98.20%	97.20%	90.60%	97.70%	94.20%	95.00%	**94.94%**
			17	Friends and Family Net Promoter Score	80	83	88	90	86	83	84	85	81	76	81	80	79	**79**
				Friends and Family Response Rate	54.0%	54.0%	49.0%	51.0%	44.0%	40.0%	43.0%	46.0%	53.0%	39.0%	40.0%	53.0%	52.0%	**47.4%**







Experience Commentary

PALS
Number of contacts this month was 125, which is down from prior month, but represents a higher number per 1000 bed days than last month.
Of the contacts, 73 were concerns (58%), down from 69% in July.

COMPLAINTS
The number of complaints received this month is 7, down from 13 in July.

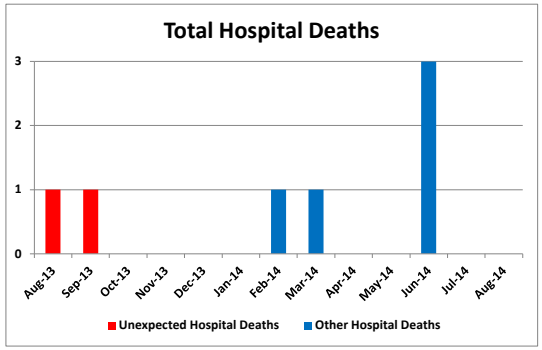
COMPLIMENTS
The number of compliments received this month is 511, which is significantly up from last month's total of 409.
Real time patient food survey at 95% shows an improvement from 94.2% last month.

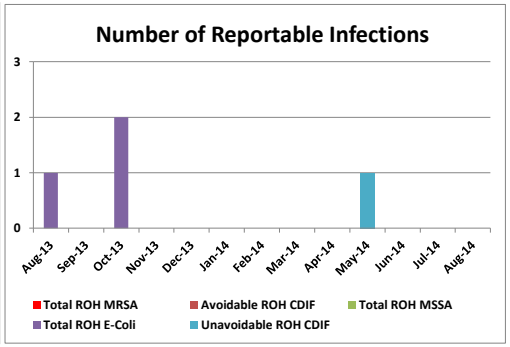
Quarterly Detailed Report
Effectiveness Indicators as at August 2014

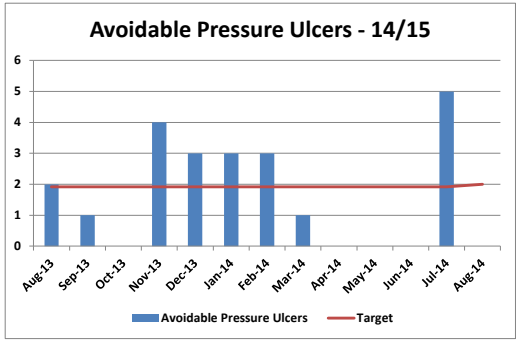
Headlines

- There continue to be no MRSA and avoidable Cdiff cases for 2014/15
- There were 4 Grade 1/2 avoidable pressure ulcers in July
- There were no patient deaths in month

	Monitor	National	CQC Standard		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	14/15 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	1	1	0	0	0	0	1	1	0	0	3	0	0	3
			4,18	Hospital Deaths per 1000 bed days	0.32	0.36	0.00	0.00	0.00	0.00	0.28	0.27	0.00	0.00	0.84	0.00	0.00	0.19
			4,18	Unexpected Hospital Deaths	1	1	0	0	0	0	0	0	0	0	0	0	0	0
				Other Hospital Deaths	0	0	0	0	0	0	1	1	0	0	3	0	0	3
			8	MRSA % Screened	127.51%	146.00%	132.00%	114.30%	100.10%	135.40%	102.00%	109.00%	115.00%	118.00%	126.00%	122.20%	107.00%	120%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
				Avoidable ROH CDIF										0	0	0	0	0
				Unavoidable ROH CDIF										1	0	0	0	1
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	1	0	2	0	0	0	0	0	0	0	0	0	0	0
			8	HCAIs not attributable to ROH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	1	0	0	2	1	0	0	0	0	0	0	1	0	1
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	1	1	0	2	2	3	3	1	0	0	3	4	4	11
			4	Avoidable Pressure Ulcers per 1000 bed days	0.64	0.36	0.00	1.39	1.01	0.90	0.85	0.27	0.00	0.00	0.84	1.68	1.46	0.49
				% Completion of WHO Checklist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.69%	96.88%	97.88%	96.23%	TBC	98.69%







Effectiveness Commentary

There were 4 avoidable grade 1 & 2 presure ulcers this month, which is in line with last month, but is still red rated.

There were no reportable infections this month.

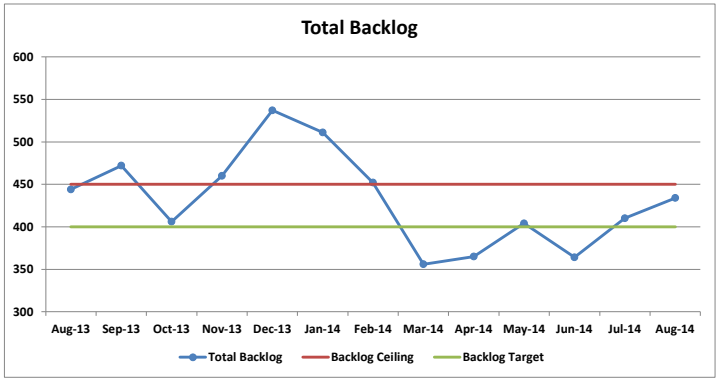
Further information on effectiveness is included in the Quality Report.

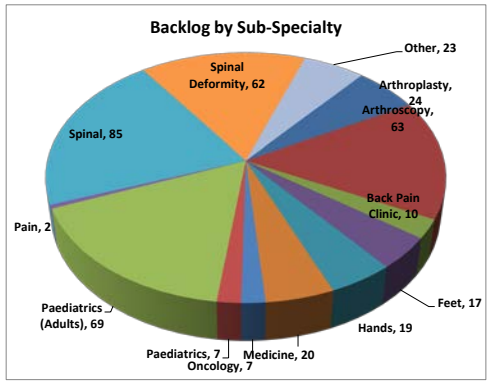
Quarterly Detailed Report
Treatment Targets as at August 2014

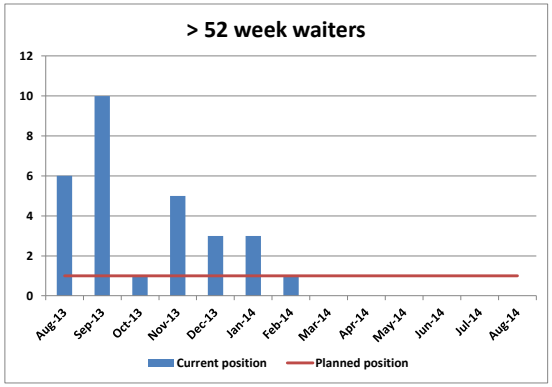
Headlines

- Total backlog has increased in month, driven by an increase in the admitted backlog.
- All 3 RTT targets were met in month.
- The 62 day cancer waits target has been missed in month. However, current projections suggest that the quarters result will still be achieved.

	Monitor	National	CQC Standard		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	14/15 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	6	10	1	5	3	3	1	0	0	0	0	0	0	3
				Referral to treatment waits over 45 weeks	15	16	7	9	6	6	5	7	5	4	5	4	4	4
	M	N	4	Referral to treatment time - Non Admitted %	95.78%	95.42%	95.24%	95.13%	95.12%	95.13%	95.00%	95.01%	95.32%	95.48%	95.15%	95.75%	95.24%	95.39%
	M	N	4	Referral to treatment time - Admitted %	90.33%	90.19%	90.09%	88.12%	83.25%	83.65%	88.76%	88.37%	91.12%	92.51%	91.74%	93.21%	91.57%	92.03%
	M	N	4	Referral to treatment time - Incomplete Pathways %	93.71%	93.33%	94.00%	93.33%	87.49%	92.71%	93.21%	94.63%	94.75%	94.43%	95.10%	94.52%	94.09%	94.58%
			4	Non admitted Backlog - Pathways waiting >18 wks	159	163	160	167	259	260	199	152	156	211	174	173	168	176
			4	Admitted Backlog - Pathways waiting >18 wks	285	309	246	293	278	251	253	204	209	193	190	237	266	219
			4	Total Backlog - 18 week pathways waiting >18 wks	444	472	406	460	537	511	452	356	365	404	364	410	434	395.4
			4	Incomplete 14 -18 Week Waiters	630	654	565	640	721	721	520	475	379	574	547	536	471	501.4
				Non Admitted Median Wait (Weeks)	8.41	8.81	8.56	7.98	7.96	8.54	8.53	7.91	7.80	8.46	8.90	8.39	8.46	8.40
				Admitted Median Wait (Weeks)	8.83	9.67	10.24	10.07	11.06	11.23	10.67	9.95	9.20	9.29	9.49	9.54	9.69	9.44
				Incomplete Median Wait (Weeks)	6.73	6.58	6.04	6.61	7.09	7.10	6.02	5.62	5.90	6.65	5.71	5.81	6.24	6.06
	M	N	4	Cancer 2 week (all cancers)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.10%	100%*	97.87%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.00%	83.30%	100.00%	85.70%	66.70%	81.80%	100.00%	100.00%	100.00%	100.00%	90.90%	93.1000%	71.40%	96.30%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.09%	99.70%	99.43%	99.36%	99.37%	98.90%	99.82%	99.57%	99.15%	99.58%	99.15%	99.09%	TBC	99.25%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	1	0	0	0	0	0	0	0	0	0
			1,21	Data Quality on Ethnic Group - Inpatients	95.22%	98.35%	95.65%	95.70%	95.47%	96.19%	96.16%	96%	95.58%	95.50%	96.00%	95.75%	94.27%	95.64%







Treatment Targets Commentary

Total backlog has increased in month, driven by an increase in the admitted backlog. A paper to supplement the Corporate Performance Report has been produced for Board to demonstrate in a greater degree of detail the future threats and challenges facing the Trust regarding Backlogged long waiting patients.

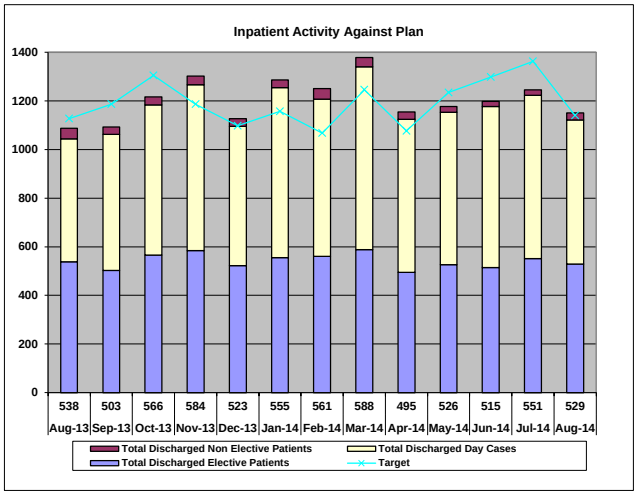
All 3 RTT targets were met in month.

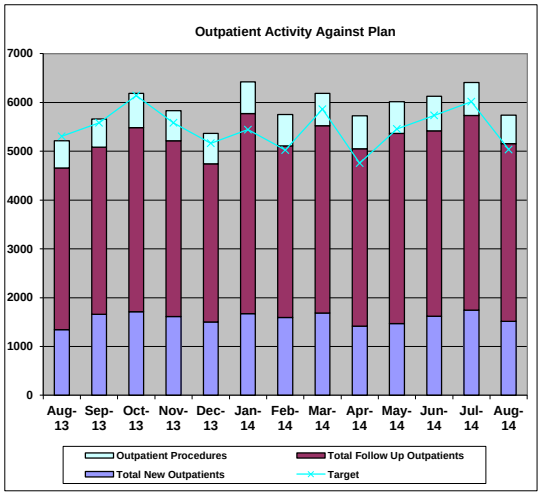
Quarterly Detailed Report
Activity Targets as at August 2014

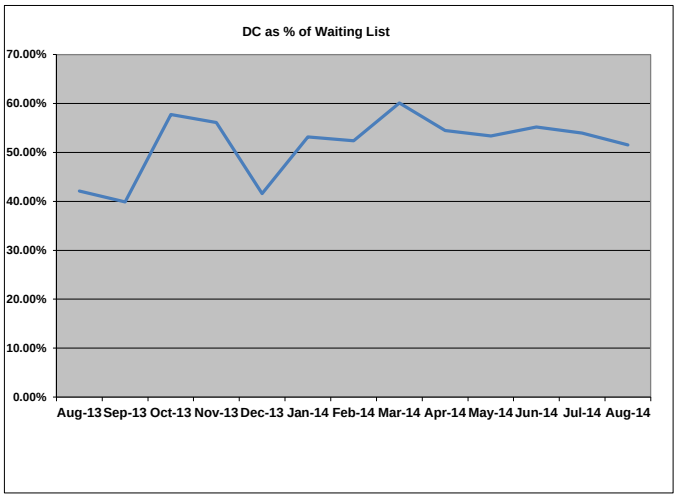
Headlines

- Day Case activity is 103% of plan.
- Elective and non-elective activity is below plan, but amber rated instead of last month's red rating.
- Outpatient activity remains strong.

	Monitor	National	CQC Standard		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	14/15 Full Year Position
Activity			4	Total Discharged Elective Patients	538	503	566	584	523	555	561	588	495	526	515	551	529	**2616**
			4	Total Discharged Non Elective Patients	44	30	33	35	31	32	43	38	31	23	22	23	29	**128**
			4	Total Discharged Day Cases	506	560	618	683	573	700	647	753	629	628	662	672	593	**3184**
			4	Total New Outpatients	1343	1659	1709	1614	1503	1672	1593	1682	1415	1467	1618	1742	1512	**7754**
			4	Total Follow Up Outpatients	3314	3428	3778	3600	3237	4101	3519	3840	3636	3902	3802	3993	3644	**18977**
			4	Outpatient Procedures	560	575	697	618	627	652	643	663	675	646	707	671	585	**3284**
				DC as a % of WL	42.10%	39.86%	57.76%	56.08%	41.58%	53.15%	52.39%	60.10%	54.46%	53.36%	55.21%	53.93%	51.52%	**53.71%**
			4	Elective as % Against Plan	93.7%	83.2%	85.1%	96.6%	93.5%	94.2%	103.1%	92.6%	98.4%	91.2%	84.8%	86.5%	99.2%	**91.6%**
			4	Non Elective as % Against Plan	120.6%	78.1%	78.1%	91.2%	87.3%	85.5%	124.5%	94.3%	110.7%	71.9%	64.7%	63.9%	96.7%	**80.0%**
			4	Day Cases as % Against Plan	97.9%	103.0%	103.3%	125.6%	113.9%	132.0%	132.2%	131.9%	115.2%	100.3%	100.6%	97.4%	102.6%	**102.8%**
			4	% New Outpatients Against Plan	99.8%	117.2%	109.7%	114.0%	114.8%	121.1%	125.0%	113.1%	107.9%	97.5%	102.3%	105.0%	108.8%	**104.1%**
			4	% Follow Up Outpatients Against Plan	99.3%	97.6%	97.8%	102.5%	99.6%	119.7%	111.3%	104.1%	124.8%	116.8%	108.2%	108.4%	118.1%	**114.8%**
			4	% Outpatient Procedures Against Plan	89.9%	87.7%	96.7%	94.3%	103.4%	102.0%	109.0%	96.3%	127.0%	106.0%	110.3%	99.9%	104.0%	**108.9%**







Activity Commentary

Seasonal variation affected some of the patient availability in month with patients electing to be treated after the summer holiday period.

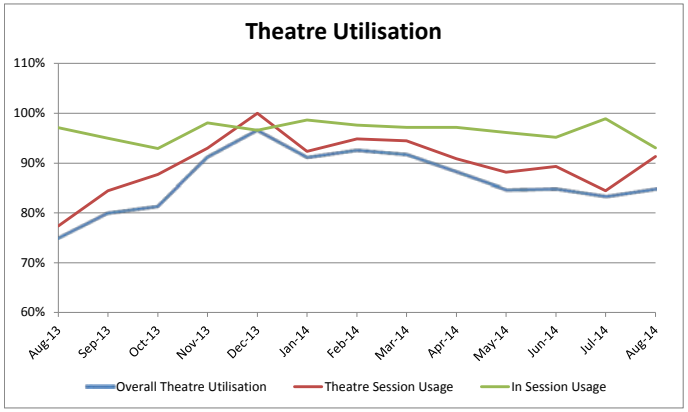
The Trust continues to experience some theatre capacity staffing fluctuation which is being addressed in partnership with Human Resources.

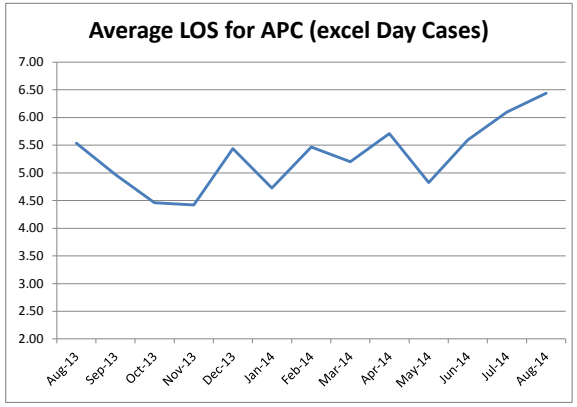
Quarterly Detailed Report
Efficiency Indicators as at August 2014

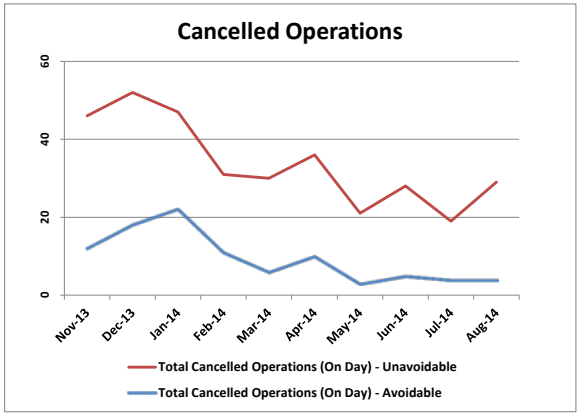
Headlines

- Overall cancelled operations remains red rated.
- AVLOS remains red rated, and is the highest it has been for at least a year.
- There were 33 unused theatre sessions in June, a reduction on July, and resulting in a green rating.

	Monitor	National	CQC Standard		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	14/15 Full Year Position
Efficiency			4	Overall Theatre Utilisation	75.15%	80.19%	81.51%	91.23%	96.58%	91.13%	92.59%	91.74%	88.30%	84.76%	84.98%	83.48%	84.97%	85.30%
			4	Theatre Session Usage	77.38%	84.42%	87.73%	93.02%	100.00%	92.37%	94.88%	94.44%	90.88%	88.17%	89.30%	84.42%	91.29%	88.81%
			4	In Session Usage	97.11%	94.99%	92.92%	98.07%	96.58%	98.66%	97.59%	97.14%	97.16%	96.14%	95.16%	98.88%	93.07%	96.08%
			4	Unused Theatre Sessions	102	67	61	30	0	36	21	25	33	51	46	74	33	237
			4	Number of Cases per Theatre Session	2.95	2.91	2.67	3.09	2.97	2.83	3.10	3.11	3.31	2.98	2.98	2.97	3.08	3.06
			4	Total Cancelled Operations (On Day or Day Before)	58	62	82	120	84	78	71	58	67	53	61	54	56	291
			4	Total Cancelled Operations (On Day) - Avoidable				12	18	22	11	6	10	3	5	4	4	26
			4	Total Cancelled Operations (On Day) - Unavoidable				34	34	25	20	24	26	18	23	15	25	107
			4	Total Cancelled Operations by Hospital (On Day)	14	4	2	11	10	9	3	5	5	8	6	8	8	35
			4	% Cancelled Operations by Hospital	1.36%	0.38%	0.17%	0.89%	0.94%	0.73%	0.25%	0.38%	0.46%	0.71%	0.52%	0.67%	0.75%	0.62%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.54	2.36	2.33	2.35	2.30	2.58	2.44	2.50	2.75	2.74	2.48	2.45	2.48	2.58
			4	Pain Review-To-New Ratio	4.24	1.89	3.59	2.70	3.38	3.72	3.85	3.64	4.55	4.16	3.79	2.48	4.00	3.80
			4	Outpatient DNAs	9.33%	8.49%	8.46%	8.51%	8.61%	9.59%	8.18%	8.65%	8.42%	8.40%	8.48%	8.78%	9.22%	8.66%
			4	Bed Occupancy - Adults	76.26%	71.19%	83.58%	86.36%	79.80%	83.60%	88.61%	80.72%	80.32%	81.21%	86.15%	86.40%	80.63%	82.94%
			4	Bed Occupancy - Paediatrics	46.77%	40.28%	58.60%	59.72%	53.18%	63.80%	65.87%	82.80%	69.26%	50.87%	54.44%	89.96%	88.17%	70.54%
			4	Bed Occupancy - HDU	85.15%	77.01%	90.67%	85.92%	84.62%	87.45%	86.89%	91.40%	69.88%	75.10%	77.05%	69.85%	63.64%	71.07%
			4	Bed Occupancy - Private Patients	63.13%	66.19%	71.89%	77.62%	64.94%	80.28%	68.88%	78.80%	65.52%	81.57%	83.25%	84.33%	76.04%	78.24%
			4	Admissions on the Day of Surgery	374	371	417	405	386	421	415	445	358	383	396	392	389	1918
			4	AVLOS for APC (excl day cases)	5.54	4.97	4.46	4.42	5.44	4.72	5.47	5.20	5.71	4.83	5.60	6.10	6.44	5.73







Efficiency Commentary

Directorate management teams have refreshed the Theatre User Group committee to take forward localised service operational issues with directorate stakeholders.

Further work around Outpatient DNA management is being taken forward by the Director of Operations to strengthen a reduction in patient DNA's.

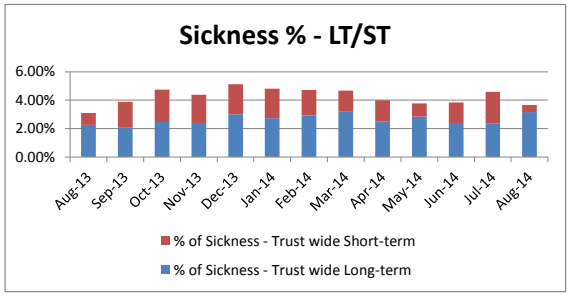
The Trust is taking forward a broader piece of work to develop longer term planning assumptions around future capacity and demand.

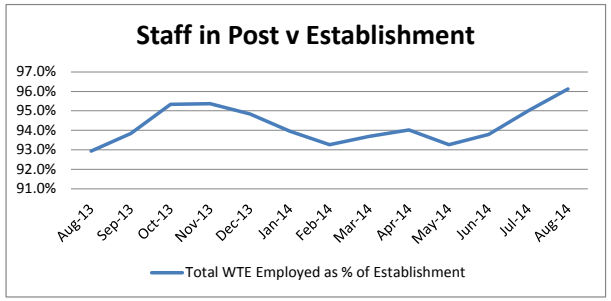
Monthly Report
Workforce Indicators as at July 14

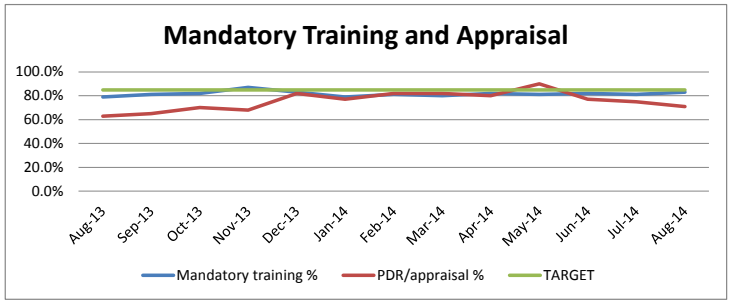
Headlines

- Sickness absence back to a green level of 3.65%
- Vacancy position still green for the 12th consecutive month
- PDR fell again in month for the third consecutive month

	Monitor	Contract	CQC Standard		Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	14/15 Full Year Position
Workforce				Total WTE Employed as % of Establishment	92.9%	93.8%	95.3%	95.4%	94.8%	94.0%	93.3%	93.7%	94.0%	93.3%	93.8%	95.0%	96.1%	94.4%
				Staff Turnover (%) - Unadjusted	12.5%	12.7%	12.8%	12.9%	13.1%	12.2%	11.8%	11.3%	11.6%	11.3%	11.9%	12.7%	12.8%	12.0%
				Staff Turnover (%) - Adjusted	8.6%	8.8%	8.7%	8.4%	8.6%	8.0%	7.4%	7.1%	7.7%	7.7%	9.5%	8.4%	8.4%	8.3%
				% of Sickness - Trust wide	3.1%	3.9%	4.8%	4.4%	5.1%	4.8%	4.7%	4.7%	4.0%	3.8%	3.8%	4.6%	3.7%	4.0%
				% Staff received mandatory training last 12 months	79%	81%	82%	87%	83%	79%	81%	80%	82%	81%	82%	81%	83%	81.8%
				% Staff received formal PDR/appraisal last 12 months	63%	65%	70%	68%	82%	77%	82%	82%	80%	90%	77%	75%	71%	78.6%
				Staff Friends & Family Test - Care & Treatment														
				Staff Friends & Family Test - Great Place to Work														







Workforce Commentary

Sickness absence has fallen by almost 1% last month due to a decrease in short-term absence.

The vacancy position taken from the ledger suggests a vacancy level of just over 5%. The Trust has been grren on this indicator for some 12 months now.

The turnover figure has increased slightly in each of the last 3 months. However, the adjusted turnover figure has remained the same as last month and is lower than the corresponding August 2013 position.

The appraisal position worsened for the third consecutive month. This is a cause for concern.

Mandatory training increased slightly to maintain the Trust's status at "amber". This has been the case for each of the last 7 months.

Monthly Report

Finance Dashboard as at 31st August 2014

	Surplus £'000	Cash £'000	Capital spend £'000
Plan	297	19,158	2,028
Actual	279	16,944	1,791
Forecast for next month (YTD)	(18)	17,144	2,085

	Year to date		
	Actual	Plan	Risk Rating
Capital Servicing Capacity	2.7	2.7	4
Liquidity Ratio	65.0	64.5	4
Overall Continuity of services ratio			4

The capital balance is slightly behind plan due to undepends against the estates plan in relation to the general site improvements budgets. Work is still planned however the timing is expected to be in the last quarter of the financial year.

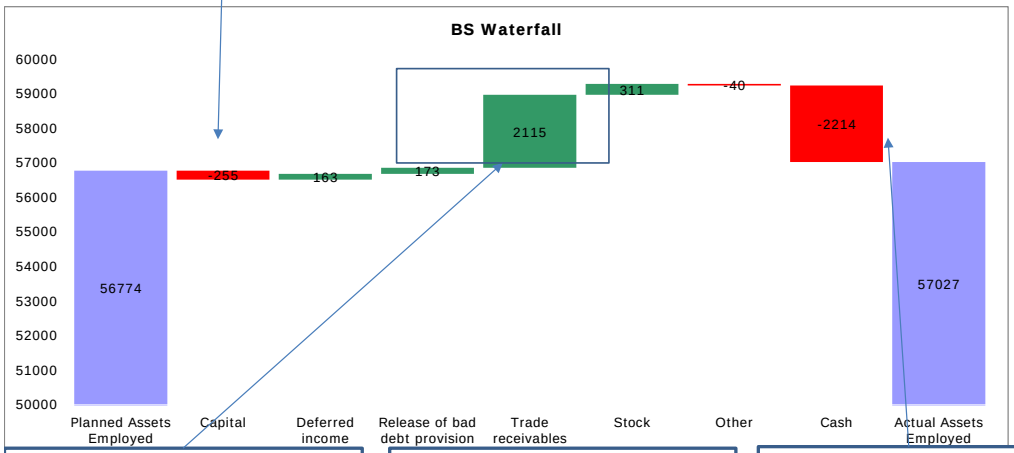
Both the Trust's Capital Servicing Capacity and Liquidity Ratio are 4 for the month. The Trust is therefore on track to achieve an overall Continuity of Services Ratio of 4 at the end of Q2, as forecast in the Annual Plan submitted to Monitor.

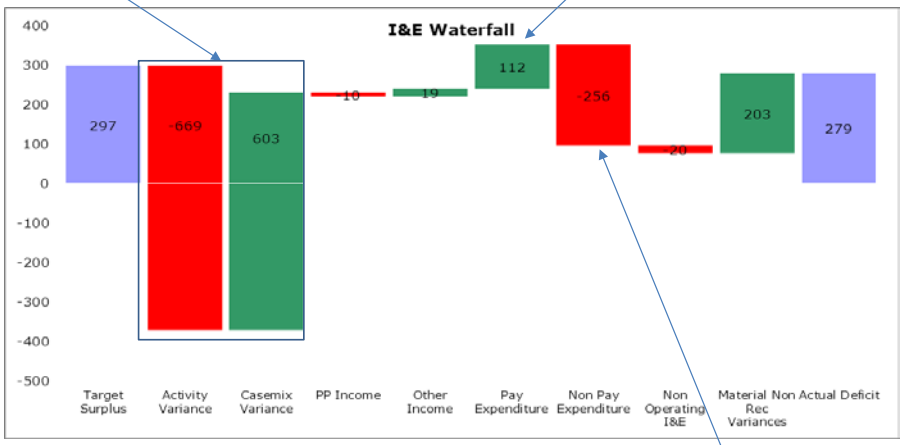
Activity was again behind plan in August for both Electives and Non-electives, although the shortfall was a lot lower than it had been in the previous two months.

This continues to be offset by a richer case mix reducing the overall income shortfall.

The pay expenditure is below the Monitor plan by £112k. This is due to some of the organisational development funds and the growth reserves being allocated against pay in the Monitor plan, but they have yet to be used.

When compared to base budget, the underlying pay is higher than expected (budget does not include the above funds). Bank pay (£170k) has reduced from prior month but is still high, whilst locum pay (£128k) and agency (£201k) have both increased.In August the Trust used 13 locums instead of 11 in July. Agency spend was higher due partially to August being a holiday month for our substantive staff, and therefore it is difficult to get bank uptake (as seen in the reduction in bank spend). In addition, theatres currently have over 20 vacancies, and have been using a significant volume of agency staff, and CSS have been using agency physios to reduce the backlog and meet activity plans.





Debtors are higher than plan as a result of;
- £848k of partially completed spells which were assumed to have been cleared in the plan. In reality, whilst the balance was cleared, it has been replaced by a similar size partially completed spells debtors balance, and so a movement in debtors would not be expected.
- £1.2m of Q4 2013/14 balances which were expected to have been paid at this point by the commissioners. To date these have not been paid, although agreement has now been reached.

NOTE: The waterfall is based on a revised plan rather than the plan submitted to Monitor. This was amended to reflect the differences between the actual and planned outturn for 2013/14, and allows the Trust to provide a clearer picture of the actual variations in balances against where they would be expected to be.

Cash is lower than expected largely as a result of debtors being higher than plan for the reasons explained.

There is mixed performance against contracts at present. The largest overperformance is with Specialist Commissioners (£149k), and the largest underperformance is with Walsall CCG (£154k).

Theatres and large joints have the largest overspends at present, with management and paediatrics having the biggest underspends.

There has been an overspend in non-pay costs against plan.

Spinal implants and drugs have been higher than expected and can be difficult to plan for.

In addition, included within non-pay costs is an accrual for £50k of patient fees in relation to the emergency care of a overseas private patient.

Monthly Report

CIP Dashboard as at 31st August 2014

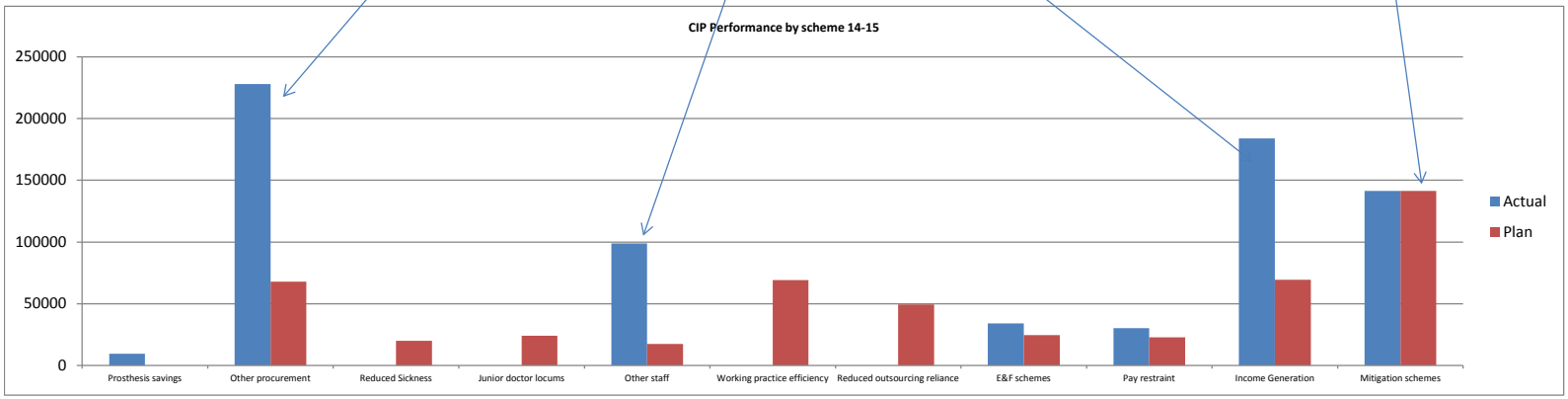
Plan for YTD	£633k
Actual for YTD	£675k
Difference	£42k

Negotiation of better rates on SLAs accounts for the majority of this performance, with £58k of the £186k relating to agreeing a lower PACs service contract, and £47k relating to the Orthotics contract.

A significant proportion of this saving relates to a review of job plans in Oncology and reduction in NED costs under management, in addition to a number of other smaller individual schemes.

A significant proportion of the performance in this area is as a result of the increase in car parking and catering charges.

The mitigation CIP recognised to date relates to improvements in cancellations, in addition to pay restraint savings.

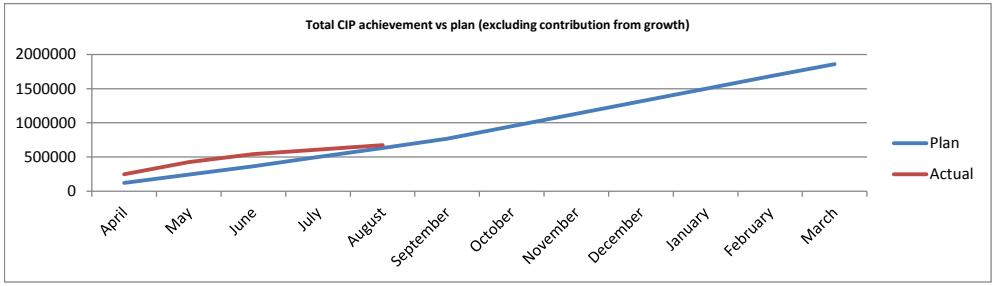


Overall performance against plan has remained positive in M5, with the strongest performance in 'other procurement', 'income generation', 'other staff' and the 'mitigation schemes'.

Performance in the first few months of the year was significantly in excess of plan, with performance now slowing, a pattern seen in previous financial years.

However, at M5, performance remains ahead of plan.

Directorates and management will need to keep a strong focus on CIP performance to ensure it continues to meet plan over the remainder of the year



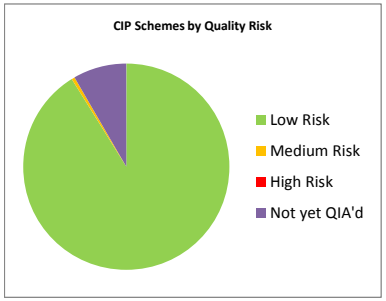
Overall performance by category

	£'000
Completed recurrent	363
Completed non-recurrent	171
Completed mitigation scheme	141
Planning/Implementation	337
Scheme Ideas	353
Mitigating Schemes	497
Total CIP target	**1862**

CSS continues to have the strongest performance to date in terms of completed schemes, with theatres still having the largest unidentified balance.

The finance department continue to work on methods of accurately measuring performance against the mitigating schemes. Other mitigating schemes included in 2014/15 include reducing sickness, reducing prosthesis costs, and reduced reliance on outsourcing.

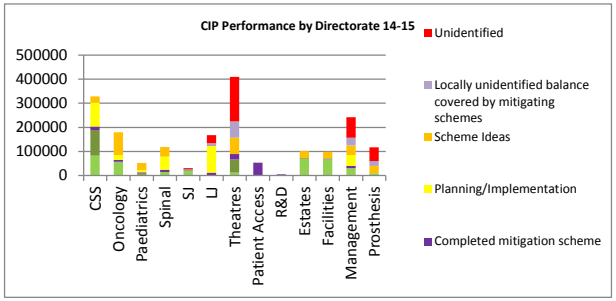
To date, performance against the pay restraint and reduced cancellation schemes have been able to be measured and recognised.



92% of schemes have been QIA assessed, with all those in the 'completed' categories having been QIA'd.

The Director of Nursing and Governance and the Medical Director are due to have a meeting with Theatres on the 1st October to agree their schemes.

The remaining QIAs outstanding are spread over a number of directorates, and are due to be completed over the coming weeks.



There is a gap between the CIP target for the year, and those schemes currently identified locally, or felt to be achievable as a mitigating scheme.

The CIP Board on 1st October will be challenging the individual Directorates in detail on their local schemes and plans.

In addition, the Director of Operations is currently reviewing activity plans with Directorates in order to identify areas of further growth in addition to what has been delivered so far this year.

It is important to note that the income targets for the year to date have been met, despite activity targets being missed, and thus there may be the opportunity to recognise some income CIP.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24th September 2014 ENCLOSURE NUMBER: 5a

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Jonathan Lofthouse
SUBJECT:	Referral To Treatment Historic Backlog & Future Performance Threat

SUMMARY

This report provides an additional level of context in support of the Corporate Performance Report. It seeks to offer a greater degree of clarity around performance threats directly related to backlog patients.

IMPLICATIONS

To ensure Board Members are sighted on emergent threats with regards to performance in relation to current national policy and are offered the opportunity to fully consider mitigation options.

RECOMMENDATIONS

The Board is asked to note the content of the report and discuss as appropriate.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to: Trust Board

Report of: Director of Operations

Purpose of Report: To advise the Board on an emergent threat to sustainable Referral to Treatment Time (RTT) performance

Recommendation: The Board is asked to consider issues threatening RTT performance

NATIONAL CONTEXT

The ROH is performance monitored by the commissioners on a monthly and subsequently quarterly basis for compliance against the 90% admitted referral to treatment time target. The ROH is monitored on a total admitted volume basis, not sub-speciality level. Consequently, ROH has a broad blend of sub-specialities, some perform very highly with short pathways, whilst others, consistently fail to achieve the 90% admitted performance target on a stand alone basis.

Nationally, over a number of years, there has been a capacity-demand imbalance across orthopaedics as a collective speciality. This has resulted in patients breaching the 18 week admitted pathway. Once a patient has breached the 18 week pathway, Trusts have used a process of blending breach activity with non-breach activity, as a means of maintaining 90% compliance against the target. Most general and acute hospitals have historically had lesser waits in areas such as general surgery and as such have sought to reduce waiting times whilst being able to tolerate some sub-speciality under achievement. This has resulted in a growing volume of patients waiting beyond 18 weeks, as 9 non-breach patients must be treated for every individual breach patient.

Earlier this year the Health Secretary announced that the Government would tolerate national under achievement of the 18 week admitted standard and also provide financial support to allow local providers to address historical backlog issues. This was with the aim of accelerating backlog clearance and addressing the longest waiting cohorts of patients. At that time, ROH applied for dispensation to be part of this national initiative, but were not supported by lead commissioners. The reason for this was that ROH was achieving 18 week RTT at a Trust level, and as such, was a lesser priority within the context of the health economy.

ROH CURRENT POSITION

Below is a table reflecting RTT 18 week admitted performance and corresponding admitted backlog volumes (performance year to date).

APRIL	MAY	JUNE	JULY	AUGUST
91.12%	92.51%	91.74%	93.21%	91.2 (UV)
209	193	190	237	268

Below is a table noting admitted breach volumes by sub speciality:

	18-24 wks	25-30 wks	30 wks >
Arthroplasty admitted backlog	16	7	-
Arthroscopy	27	6	1
Feet	1	-	-
Hand	4	3	
Medicine	6	2	2
Oncology	4	2	2
Paeds-Adult (Young adult hip)	33	13	11
Pain	1	-	-
Spinal	35	17	13
Spinal Deformity	10	17	30
Other	2	1	2
	139	**68**	**61**

The data shows that the largest patient groups of long waiters fall within Paediatrics and Spinal Deformity services. As a result, Consultant colleagues from these specialities have recently voiced clinical concerns on the risk and impact on these long waiting patients, particularly in spinal deformity. Foremost is their concern of a patient's condition deteriorating whilst awaiting treatment. In the most extreme cases, this may result in two operations being performed, where a single operation would have been originally appropriate.

Despite very open and recent dialogue with colleagues from Birmingham Children's Hospital, it has currently not been possible to secure additional operative sessions to meet our patient demands for Paediatrics and Spinal Deformity.

ROH COMMISSIONER DIALOGUE

The Executive made a further request to Commissioners during early September 2014, within the spirit of the Health Secretary's direction, to undertake a backlog clearance initiative. It was planned that ROH would consciously breach the 90% admitted target, focusing in-month efforts to reduce historic backlog during October, returning to national standard performance by the second week of November 2014. This would result in

ROH consciously failing the Q3 admitted performance target. Broad tolerance for such an initiative had been secured from Monitor. However, following discussions with both local and specialist Commissioning Authorities, support is once again not forthcoming. If ROH had undertaken such an initiative without the support of Commissioners, a contract fine of circa 87k could have been levied, a contract compliance query raised and specifically in regard to spinal patients, our specialist Commissioners would have withheld activity payments.

All of these factors converge to amplify a future delivery threat to ROH performance and patient experience:

- As a specialist orthopaedic supplier, ROH has developed a number of sub speciality backlogs resulting in a range of patients, predominately paediatric, waiting for treatment beyond national standard.
- There is a growing clinically held view point that the excessive wait of some patients may be having a detrimental effect to individual patient's conditions.
- There is an undesirable threat to patients exceeding the 52 week breach position, which is resulting in often frantic scheduling activity.
- Operative capacity is regularly required at Birmingham Children's Hospital in order to access both paediatric medical support and post operatively paediatric intensive care. This significantly constrains our agility to flex flow capacity.
- Specialist Commissioning colleagues are unwilling to commit funding for accelerated backlog clearance.
- Due to the technically demanding nature of our surgery, there are very few UK centres providing many of the services hosted by ROH and thus, our backlog issues are unlikely to change without direct intervention.

OPTIONS

Following detailed consideration there are a number of options to reduce the treat level.

- ROH could seek to close from 1st April 2015 the high risk waiting lists, with a view to reducing the long waiting lists. This would however have both a reputational and financial impact upon the Trust, opening the door to the competitor market and may also affect our authorisation licence.
- ROH could seek to grow its waiting times in high performing specialities, still within the tolerance of 18 weeks by temporarily suspending surgery. This would need to be risk assessed but may allow scope for theatre sessions to be reallocated to long waiting patients, and thus, increasing operational capacity. However, there would need to be robust breach tolerance calculations.
- ROH could seek to hire additional NHS capacity around the UK at centres currently providing PICU. This would require our surgeons

travelling to alternative units to operate at our cost, but is likely to positively impact on our backlog position.

- Due to lead in time, the hiring of temporary theatres, development of our own on site PICU and the recruitment of additional spinal deformity consultants, are not felt to be achievable within a reasonable time period.

CONCLUSION

The Trust continues to achieve its admitted performance standard however, the headroom of achievement is marginal, requiring constant validation and reassessment. As spinal and paediatric referral trends continue to grow, even at a slow rate, there is a clear and increasing threat of organisational underachievement. There is a growing clinical viewpoint suggesting a heightened clinical risk to our longest waiting patients. ROH is at risk of moving towards the new financial year with a high backlog of patients, when neighbouring units, supported by their Commissioners, have addressed such concerns.

As Director of Operations I would welcome a broad discussion around these concerns in order to formulate a clear structure of mitigation actions.

J Lofthouse
Director of Operations

September 2014

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24th September 2014 **Enclosure: 6**

DIRECTOR LEAD:	Helen Shoker, Director of Nursing & Governance
AUTHORS:	Lisa Pim, Interim Deputy Director of Nursing & Governance Alison Braham, Governance Manager
SUBJECT:	Patient Quality Report – August 2014

SUMMARY

This paper provides an update on patient quality, safety and experience activity during August 2014 and sets out the 2014/15 national, regional contractual and ROH NHSFT quality standards.

The quality of care we deliver, our patient's safety and their experience remains a high priority for the organisation and it is anticipated this report will assist the Trust Board in bringing together key quality issues for debate, assurance and information.

Proposed areas for future reporting:

- Blood safety (new section commencing October 2014)

Key areas of note this month:-

- A significant reduction in SSI has been seen at ROHFT over the past 5 years with a reduction of 65% in both primary Hips and Knees
- Number of compliments received this month is 511 up from last month's total of 409, an increase of 102 or 25%.
- There has been a 35% decrease in incidents reported in August, compared to the previous month.
- There were 4 avoidable pressure ulcers (grade 2) during August.
- The total number of WHO Checklists that met the standard for patient safety was 97.69%. This August figure is below the contractual requirement of 99%. This has resulted in a contract variation being served on the trust.
- A patient safety alert relating to the use of vacuum suction drains has breached the deadline for closure.

RECOMMENDATIONS

The Trust Board are asked to:

- **discuss** the Patient Quality Safety and Experience report
- **identify** areas of risk requiring further assurance
- **Note and accept**

1 PATIENT SAFETY

1.1 Serious Incidents - August 2014

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There were 3 Serious Incidents reported during August 2014. Appendix 1 outlines details of all current open Serious Incident investigations.

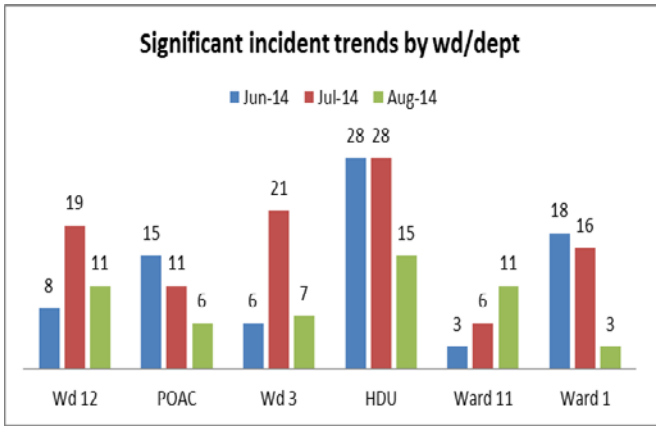
1.2 All other incidents requiring an investigation

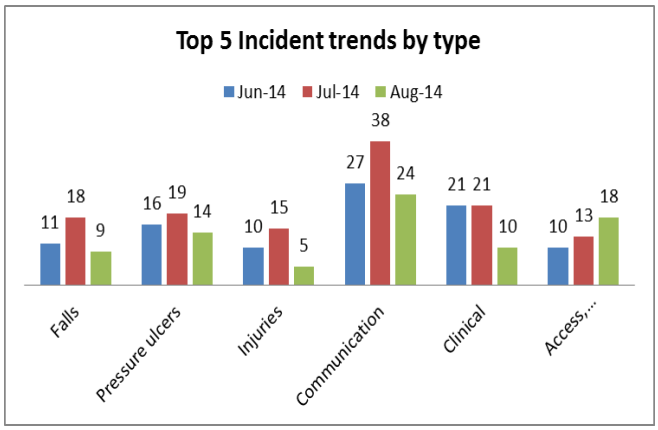
2 additional incidents were reported that subsequently required an RCA investigation to be undertaken (See Appendix 2).

A total of 175 incidents were reported during August, compared to 269 incidents reported during July. This is a significant reduction, and equates to 35% decrease in reporting. This continues to be monitored and the importance of incident reporting remains a priority.

Appendices 3a and 3b provide a breakdown of the types of incidents reported by ward/hospital department.

The graphs below indicate key incident trends by Ward and the Top 5 incident types:





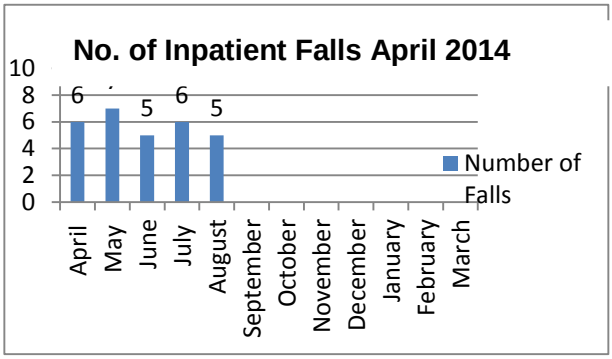
1.3 Deaths

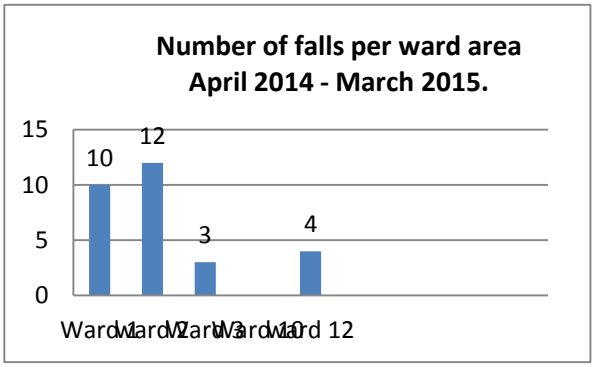
There were no deaths in the Trust during August.

1.4 Falls

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There have been 2 unavoidable (adult) inpatient falls and 3 avoidable inpatient falls for the month of August 2014.





All reportable falls have been individually reviewed. On individual review in the case of the 3 avoidable falls, inadequate risk assessment had taken place prior to the fall occurring. This was measured through the documentation process.

All 5 falls were unwitnessed by staff and all 5 occurred during the evening or overnight.
4 patients who fell had full mental capacity although 2 are known to have alcohol/drug dependency issues.
1 patient was suffering with post-operative confusion thought to be related to opiate use.

Falls Risk Assessments & Care Planning - Quality indicator requirements

Qu1.	Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	August 2014	96%
Qu2.	If the patient is identified as high risk is a care plan in place? Yes/ N/A	August 2014	92%
Target = 91% compliance per ward			

Actions for Improvement:

- The Throne Project review for ward 12 is now complete. Wards 1 and 2 will be available by the end of August. Ward 3 will be undertaken during September. This will continue to work around the entire organisation, focusing on bathroom and toilet areas. This will provide ward managers, matrons and department heads with evidence based assessments of how they can reduce risk of harm to their patients who sustain a fall in these areas by introducing simple environmental changes and will hopefully be presented at nurse leader's forum once all areas are complete in October.
- Ward 1 is now piloting the use of the "Tuft Box". If found to be beneficial, it is hoped this could be rolled out across all adult inpatient areas and for that purpose, further funding would be required.
- Piloting the use of a "falls grab bag" is about to commence on Ward 2 as the kit needed arrived at the time of this report. This is a potentially valuable resource if attending to a patient who has sustained a fall with harm; containing vital 1st aid supplies and other small clinical resources and small medical supplies in the event of a patient requiring urgent medical attention.

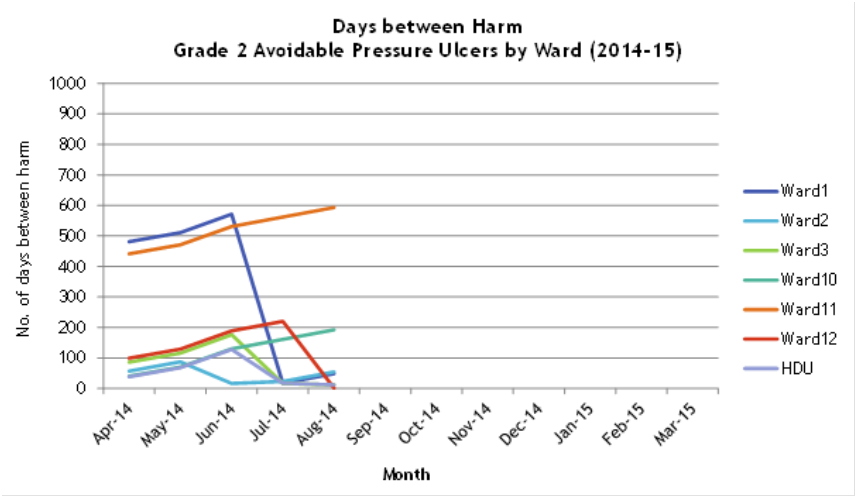
1.5 Infection Prevention and Control and Tissue Viability

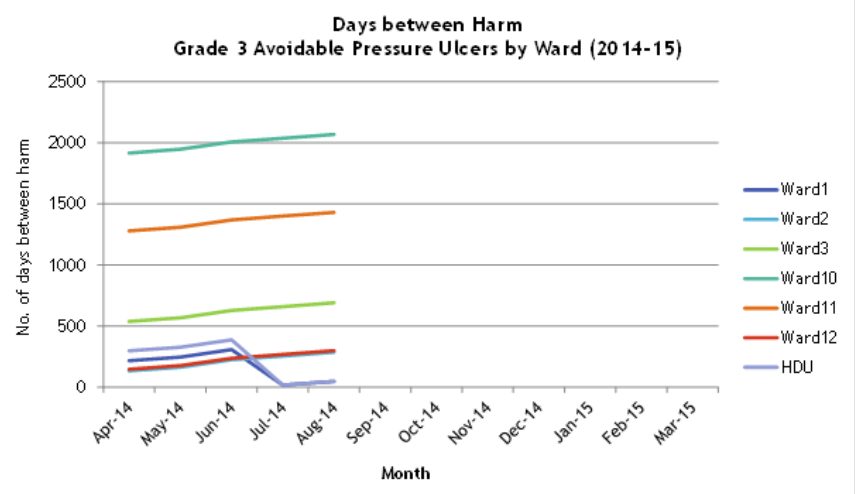
There have been no MRSA bacteraemias, apportioned cases of *Clostridium difficile* or any other cases of reportable organisms this month.

REPORTING REQUIREMENT: Contractual Quality KPI requirement, National Safety Thermometer CQUIN and National Reporting requirement

1.5.1 CQUIN Scheme: Safety Thermometer

Days between harm are reported in the following format, an upward trend demonstrates increasing days between harm.





This information along with the root cause analysis and patient harm meetings are utilised to ensure practice is scrutinised and improved wherever possible.

1.5.2 Tissue Viability

There were 4 avoidable pressure ulcers (grade 2) during August. The matrons and ward managers are aware and have reminded all staff of the need for early intervention - to escalate patients onto the correct type of mattress, or implement the correct use of equipment as soon as any issues with tissue integrity is noted.

A grade 2 was apportioned to Theatre 5 but theatres are not included in the table below. 2 cases were shared with HDU (1 from Ward 3 and 1 from Ward 12) and a further avoidable case occurred on Ward 11.

Table 1: Grade 2 Hospital Acquired Pressure Ulcers by Ward

Grade 2	Apr'14		May'14		Jun'14		Jul'14		Aug'14	
	A S	U S	A S	U S	A S	U S	A S	U S	A S	U S
Ward1							1	1		
Ward2					3		1			2
Ward3		1					2	1	1	
Ward10										
Ward11									1	
Ward12								1	1	
HDU							2	1	2	

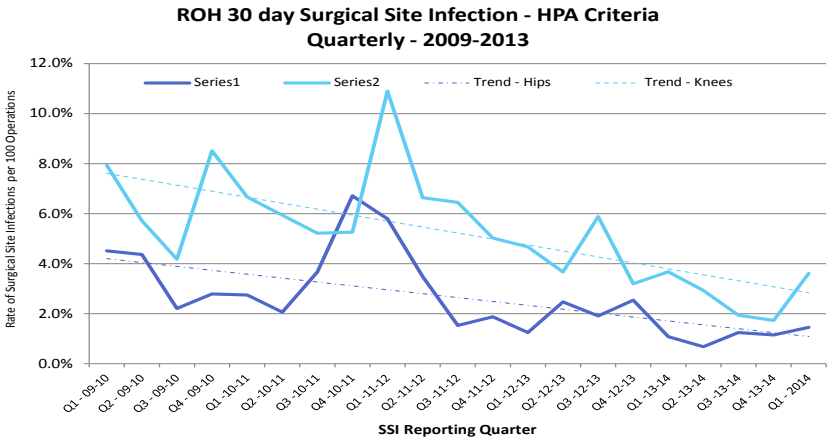
Key:	
	Avoidable
	Unavoidable
	Shared

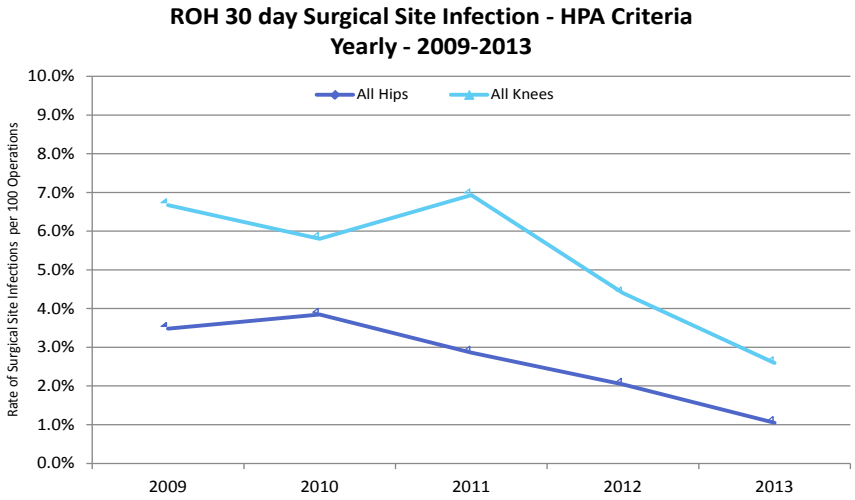
1.5.3 SSI surveillance

An appointment has been successfully made to expand the surveillance for all arthroplasty patients to 1 year post operatively. This will commence in September 2014.

Surgical Site Infection

A significant reduction in SSI has been seen at ROHFT over the past 5 years with a reduction of 65% in both primary Hips and Knees, the following graph details the downward trend:





Reporting of Quarter 2 of 2014 (surveillance follows the calendar year and not the fiscal year) will be possible at the end of September, but early indications show that the rate in hips is static but the rate in primary knees has dropped further.

After the scrutiny surrounding the apparent increase in SSI which was investigated thoroughly in May, the number of readmissions (for August) in patients who underwent surgery where infection was not present was zero for the first time this year.

Indicator	SSI - Total No. of Readmissions with Infection						
Current Performance : Aug'14	0	YTD Position	21	Target	-	Trend	
Target Details	Patients that are readmitted for washouts, debridement etc where infection was not present at the time of primary or initial surgery.						
Commentary	No patients were readmitted following surgery where infection was not present at the time of surgery. 3 patients were readmitted - all of whom were BIU complex patients.						
Actions	Post Infection Reviews (PIR) are undertaken for all readmissions with infection from August 2014.						
Source	In house IPC Monitoring. Trend data from Apr'13 onwards						

1.6 Safeguarding Adults and Children

REPORTING REQUIREMENT: Contractual Quality KPI requirement and National Reporting requirement

The information outlined below provides an update of Adult and Children Safeguarding Training as of August 2014:

Adult Safeguarding Training

- Adults Level 1 (Basic Awareness) - 100%
- Level 1 Safeguarding Adults (includes SG, MCA, DoLs, Learning Disabilities) MCA 89.42%, DOLS 89.42%
- Level 2 – Enhanced (External provider) – 86%
- Level 3/4 – For Leads = 100%

Incidents reported = 2
Deprivation of Liberties application submitted – 1

Children Safeguarding Training

- Children's Level 1 (Basic Awareness) - 100%
- Level 2- Enhanced Child Protection – 90%
- Level 3/4 – For Lead and Named Nurse/Doctor – 100%

1.7 Patient Safety Alerts

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

A total of 8 Patient Safety alerts were closed during August 2014, requiring no further action by the ROH.

The Trust is currently assessing the relevance of the following alerts:

Reference	Alert Title	Issue Date	Response	Deadline
NHS/PSA/R/2014/015	Resources to support the prompt recognition of sepsis and the rapid initiation of treatment	02-Sep-14	Assessing Relevance	31-Oct-14
NHS/PSA/W/2014/014	Risks arising from breakdown and failure to act on communication during handover at the time of disc ...	29-Aug-14	Assessing Relevance	13-Oct-14
EFN/2014/39	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - BTH - JB721 - Circuit Breaker	27-Aug-14	Assessing Relevance	24-Sep-14
MDA/2014/033	Insulin syringe 1ml safety syringe 27G (for professional use). Product code: RN01/27i.	20-Aug-14	Assessing Relevance	18-Sep-14

Status of open alerts:

Reference	Alert Title	Issue Date	Response	Deadline
NHS/PSA/W/2014/009	Risk of using vacuum and suction drains when not clinically indicated.	**06-Jun-14**	**Action Required: Ongoing**	**04-Jul-14**
NHS/PSA/D/2014/006	Improving medical device incident reporting and learning	**20-Mar-14**	**Action Required: Ongoing**	**19-Sep-14**
NHS/PSA/D/2014/005	Improving medication error incident reporting and learning	**20-Mar-14**	**Action Required: Ongoing**	**19-Sep-14**

Actions taken:
NHS/PSA/W2014/009 – Awaiting feedback from a Trust Consultant who is aware of the deadline breach.

1.8 WHO compliance

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

The total number of WHO Checklists that met the 100% Standard for patient safety was 97.69% and represents a slight increase when compared to the previous month. This August figure is below the contractual requirement of 99%. This has resulted in a contract variation being served on the trust by our Commissioning partners, and this will mean greater scrutiny and the prospect of remedial action plans and possible fines applied to the trust.

Further work has been undertaken by the Theatre Manger to review and modify the WHO Checklist Document, to ensure its practical application.

1.9 CQUIN Schemes

REPORTING REQUIREMENT: National and Local CQUIN Requirement

All evidence for Q1 was submitted to Commissioners within prescribed deadlines and to date no feedback has been received. The CQUIN leads are currently working towards completion of actions required for CQUIN schemes during Q2. Of note there has been a failure to achieve the August target for Dementia Assessments. This should not impact on the Trust financially but will require close monitoring.

CCGs	% of 2.5%	Weighting within Category	Financial Value
National	**0.500%**		**£ 222,599**
Friends and Family Test (FFT)	0.167%	33%	£ 74,200
NHS Safety Thermometer	0.167%	33%	£ 74,200
Dementia	0.167%	33%	£ 74,200
Local	**2.000%**	**100%**	**£ 890,394**
Telephone follow up for Pain Management Injections	0.400%	20%	£ 178,079
AHRQ Patient Safety Culture Survey	0.400%	20%	£ 178,079
Reviewing the patient Journey	0.500%	25%	£ 222,599
Conservative and exercise treatment for knee conditions	0.400%	20%	£ 178,079

SSI Surveillance - Telephone follow up	0.300%	15%	£ 133,559
Total CQUIN Value	**2.500%**	**100%**	**£ 1,112,993**
£ 1,112,993			
Specialised Services	% of 2.5%	Weighting within Category	**Financial Value**
National	0.500%		**£ 89,698**
Friends and Family Test (FFT)	6.67%	33%	£ 29,899
NHS Safety Thermometer	6.67%	33%	£ 29,899
Dementia	6.67%	33%	£ 29,899
Local	2.000%		**£ 358,792**
Highly Specialised (PMBTS) Network Audit Workshop	20.000%		£ 89,698
Specialised Spinal Dashboard	5.000%		£ 22,425
Specialised Orthopaedics Dashboard	5.000%		£ 22,425
Specialised Orthopaedics Network MDT	50.000%		£ 224,245
Total CQUIN Value	2.500%		**£ 448,489**
£ 448,490			

2 PATIENT EXPERIENCE

2.1 PALs contacts, Complaints and Compliments

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

Please refer to Appendix 4 for year to date breakdown by Directorate

2.1.1 PALS

Number of contacts this month was 125 – down by 3 on last month's volume of 128.

Of the 125 contacts, 52 were general enquiries (42%) and 73 were concerns (58%) which is around 10 percentage points different to last month's split of general enquiries 30% and concerns 70%.

Greatest areas of concern were:

- Mainly Spinal –what's happening with care and treatment plans; lack of info/clarity; chasing update and progress; no follow up booked post-surgery etc.
- waiting lists long for injections and only one person able to book appointments which compounds patient frustration in not getting answer/update
- Appointments cancelled and patients not informed

Highest volumes of general enquiries were:

- Work experience
- PP enquiries
- Accommodation

- How to get referred here
- Research enquiries

2.1.2 COMPLAINTS

Number of complaints received this month is 7, down from 13 last month, a decrease of 46%.

Areas of concern:

- Ward 2 nursing care overnight
- Change of clinical opinion - ? resulted in brace being worn unnecessarily for a year
- Systems and organisation in OPD
- Approach / breakdown of comms and understanding around risks and benefits of surgery
- ADCU experience – lack of care
- Overall poor experience x 2 (both Oncology)

% of complaints resolved within timeline was 75% (3/4) against KPI of 80%.

Average length of time to close complaints due in August was 24 days reduced from last month's average of 41.

2.1.3 COMPLIMENTS

Number of compliments received this month is 511 up from last month's total of 409, an increase of 102 or 25%.

2.1.4 Friends and Family Test

The Friends and Family Test for August is 79 with a 52% return rate and meets the CQUIN requirements for the month. The detractor rate for the month is 2.4% which is low.

The Public and Patient Services Manager met with Senior Nurses to discuss the embedding of the processes into each ward area. The Ward Manager for Ward 2 has met with the Public and Patient Staff to discuss issues and challenges in more detail for all areas which has proved extremely valuable.

2.1.5 Child Patient Experience

Public and Patient Services in collaboration with Ward 11 collect Friends and Family data on all children admitted to the Trust, including those who are under the age of 16 (currently not a national requirement) The July FFT Score for Ward 11 (under 16) is 72 (compared to a Trust-wide score of 79). This is lower than the previous months and comments would suggest that environment factors in the refurbished Ward 11 may be partially the reason for this. A number of parents have indicated that they are unable to use the fold out beds in the 4 bedded parts of the ward as there is no room to open them. In addition the 'closing in' of the ward spaces and the addition of the new bathroom has resulted in the beds being closer together.

The questions on the Fabio Frog Survey are currently being reviewed by the team in order to ensure that patients are not overloaded with questionnaires and that the data is easily accessible for review.

2.2 Litigation

REPORTING REQUIREMENT: ROH NHSFT Good Practice

New Clinical Negligence Cases

Formal Proceeding Claim			
Ref	**Date of Incident**	**Details**	**Directorate**
T456	July 2014	In-patient fall	Large Joints

Potential Claims			
Ref	**Date of Incident**	**Details**	**Directorate**
T456	Jan-14 (2nd procedure)	Metal on metal hip replacement failed and replaced	Large Joints
T455	Oct-08	Spinal rod fusion	Spinal

Closed Cases: None
Coroner's Inquests: None

2.3 Single Sex Compliance

REPORTING REQUIREMENT: National Reporting Requirement & Contractual Reporting Requirement

There were no single sex compliance breaches during August.

2.4 Patient Reported Outcome Measures (PROMs)

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

During August the 90% target compliance rate for completed questionnaires for both hip (98.1%) and knee (96.8%) replacement surgery was achieved. The figures are based upon the actual theatre activity according to ORMIS and are checked against the patient details in PAS.

An update of the PROMS data has been released recently giving the finalised data for 2012/13 and provisional data for 2013/14. A full report can be made available to EMT and trust Board for further review if required.

3. EFFECTIVENESS OF CARE

3.1 National Joint Registry (NJR) Update

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

NJR Compliance Progress August 2014

	Jan 14	**Feb 14**	**March 14**	**April 14**	**May 14**	**June 14**	**July 14**	**Up to 28th Aug 14**
% Compliance	**100%**	**92%**	**91%**	**89.8%**	**91%**	**85%**	**95%**	**89%**

Note: All missing/incomplete forms are sourced and sent to be completed by the relevant clinician. The current state of compliance may also be affected by outstanding validation queries on components or other issues with submitting the forms, and must therefore be taken as a current snapshot. All outstanding queries are reported to the NJR and regularly reviewed and resolved.

NJR Consent Progress April to August 2014

	April 14	**May 14**	**June 14**	**July 14**	**Aug 14**
% NJR Consent compliance	80%	91%	93%	95%	96%

Overall for 2014 so far: 84% average.

Note:
From June 2014, the Pre-Operative Assessment Clinic (POAC) now record all patients who have signed a consent form on their database which is shared with the NJR hospital data manager to ensure accuracy of inputting. The NJR data manager sends letters to any patients not consenting at POAC.

3.2 Safety Thermometer
REPORTING REQUIREMENT: National Reporting Requirement

2014-15		August 2014
Pressure Ulcers	Old	0.88%
	New	0%
Falls		0.88%
CAUTI		1.03%
New VTE		0.88%
Total Harm Free		97.37%

3.3 Matron KPI
REPORTING REQUIREMENT: ROH NHSFT Good Practice

Ward, Unit and Department KPI's are currently being updated to reflect national, local and ROH standards. The mechanism of ward performance and patient harm meetings is under development into a formal review and escalation process. This will support teams and services to reflect, learn and proactively plan for the coming quarter. It is anticipated the new approach will be implemented to allow for review of quarter 2 and plan for quarter 3.

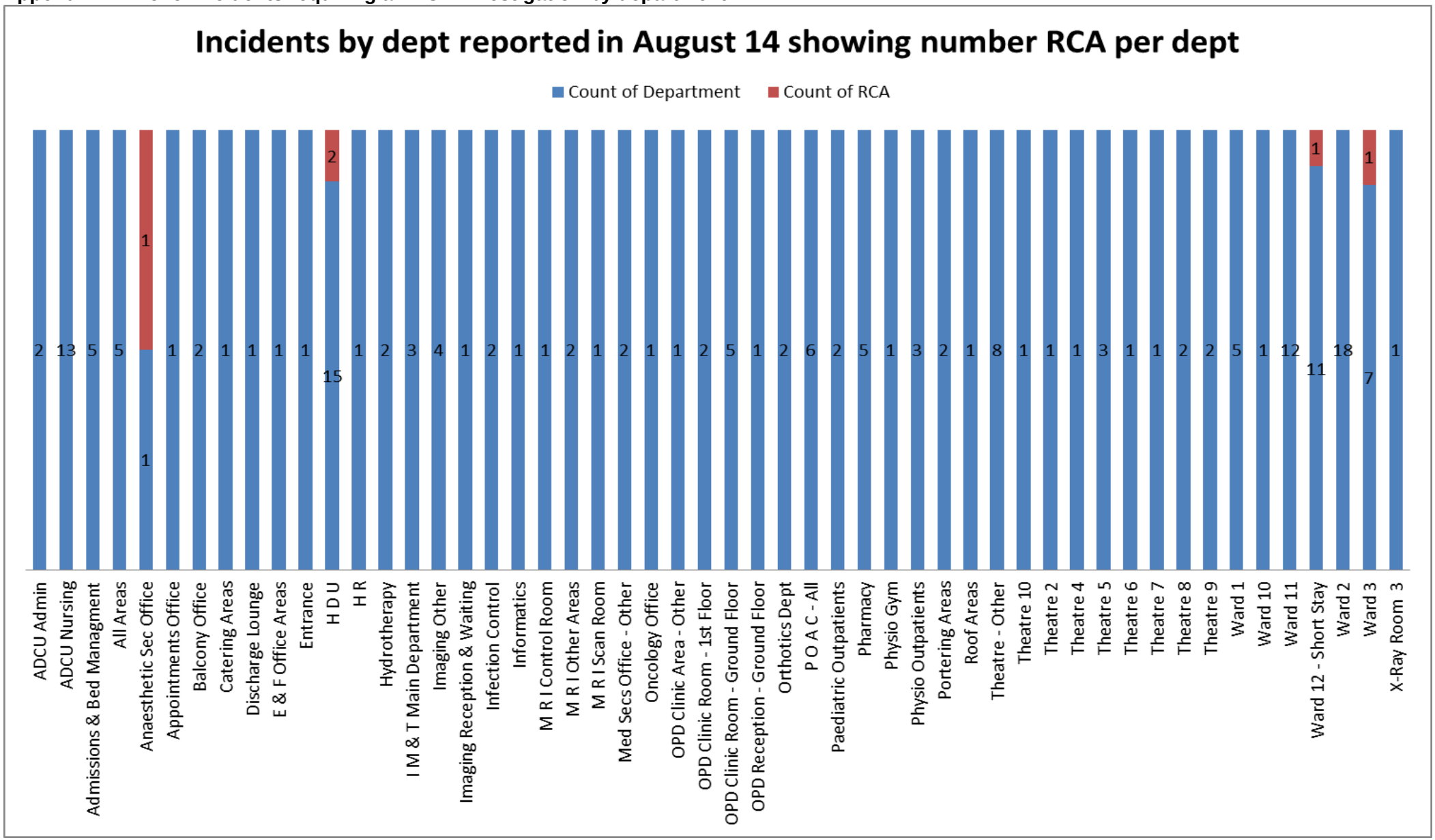
APPENDIX 1 – Ongoing Serious Incidents Requiring Investigation (SIRI) - August 2014

Ref	Incident date	Date raised to CCG	Type of incident	Level of harm (Prior to completion of RCA investigation)	Directorate	Status	Final RCA due
13520 STEIS 2014/26461	13/8/14	14/8/14	VTE	Moderate harm	Oncology	Investigation underway	17/10/14
13523 STEIS 2014/26463	9/8/14 (reported 14/8/14)	14/8/14	VTE	Moderate harm	Oncology	Investigation underway	17/10/14
13568 STEIS 2014/27185)	19/8/14	20/8/14	Treatment delay	Reported as minor harm	Theatres, Anaesthetics & Critical Care	Investigation underway	23/10/14
13211 STEIS 2014/21906	03/07/14	04/07/14	Wrong side block	Minor	Theatres, Anaesthetics & Critical Care	Investigation underway	08/09/14
13235 STEIS 2014/22223	02/07/14	08/07/14	Medication – wrong dose	Moderate	Large Joints	Investigation underway	10/09/14
13290 STEIS 2014/23040	13/07/14	15/07/14	Grade 3 pressure ulcer	Moderate	Spinal	Investigation underway	17/09/14
13205 STEIS 2014/24850	03/07/14	31/07/14	DVT	Moderate	Spinal	Investigation underway	03/10/14

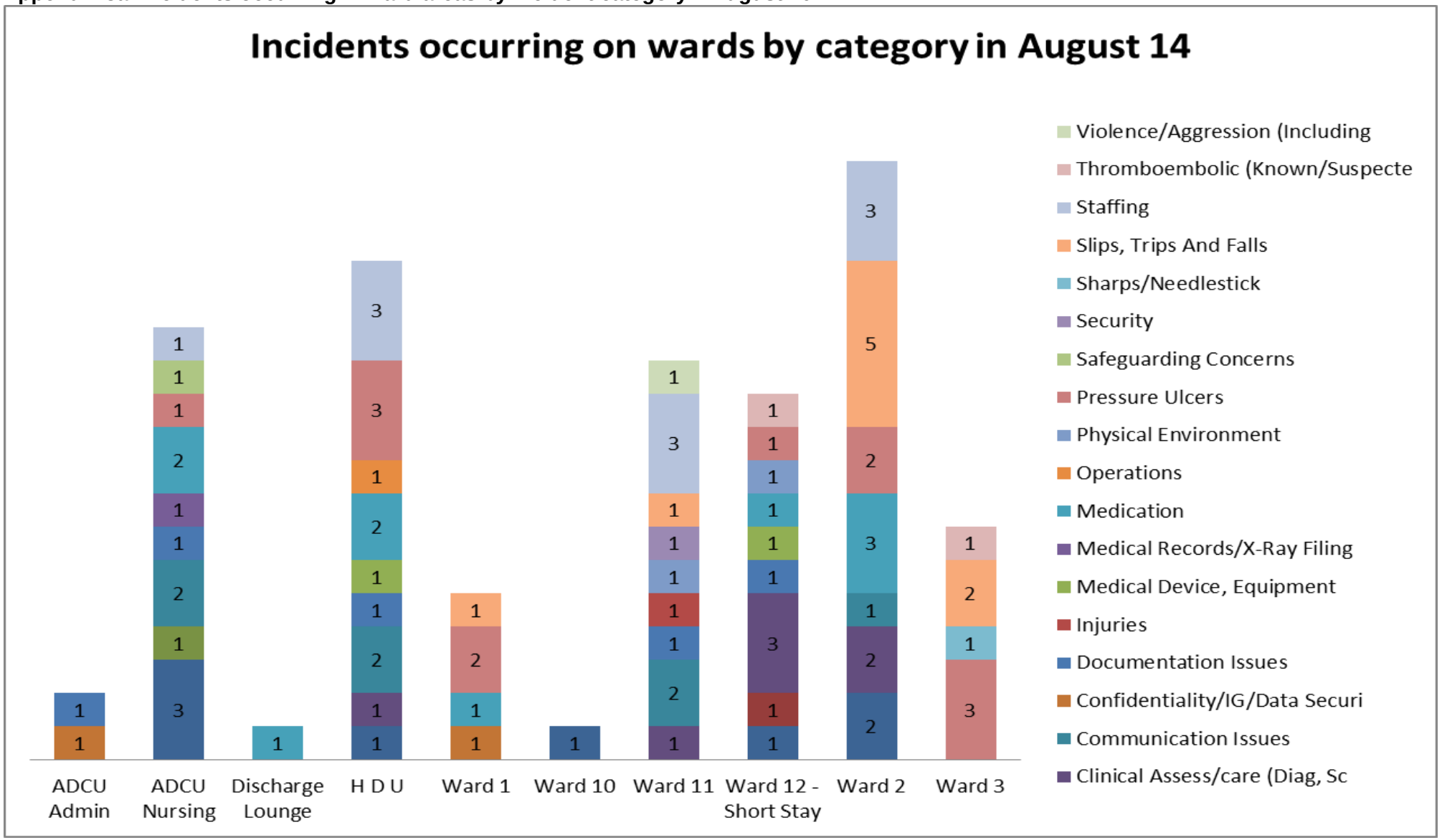
Closed Serious Incident investigations
NB. - Summary of learning from incidents requiring investigation is provided each quarter.

Ref	Incident date	Description	Directorate	Deadline for submission of RCA investigation report	Progress/ Date submitted
13028 STEIS 2014/23469	10/06/14	VTE/death	Large Joints	22/9/14	Report submitted 5/8/14.

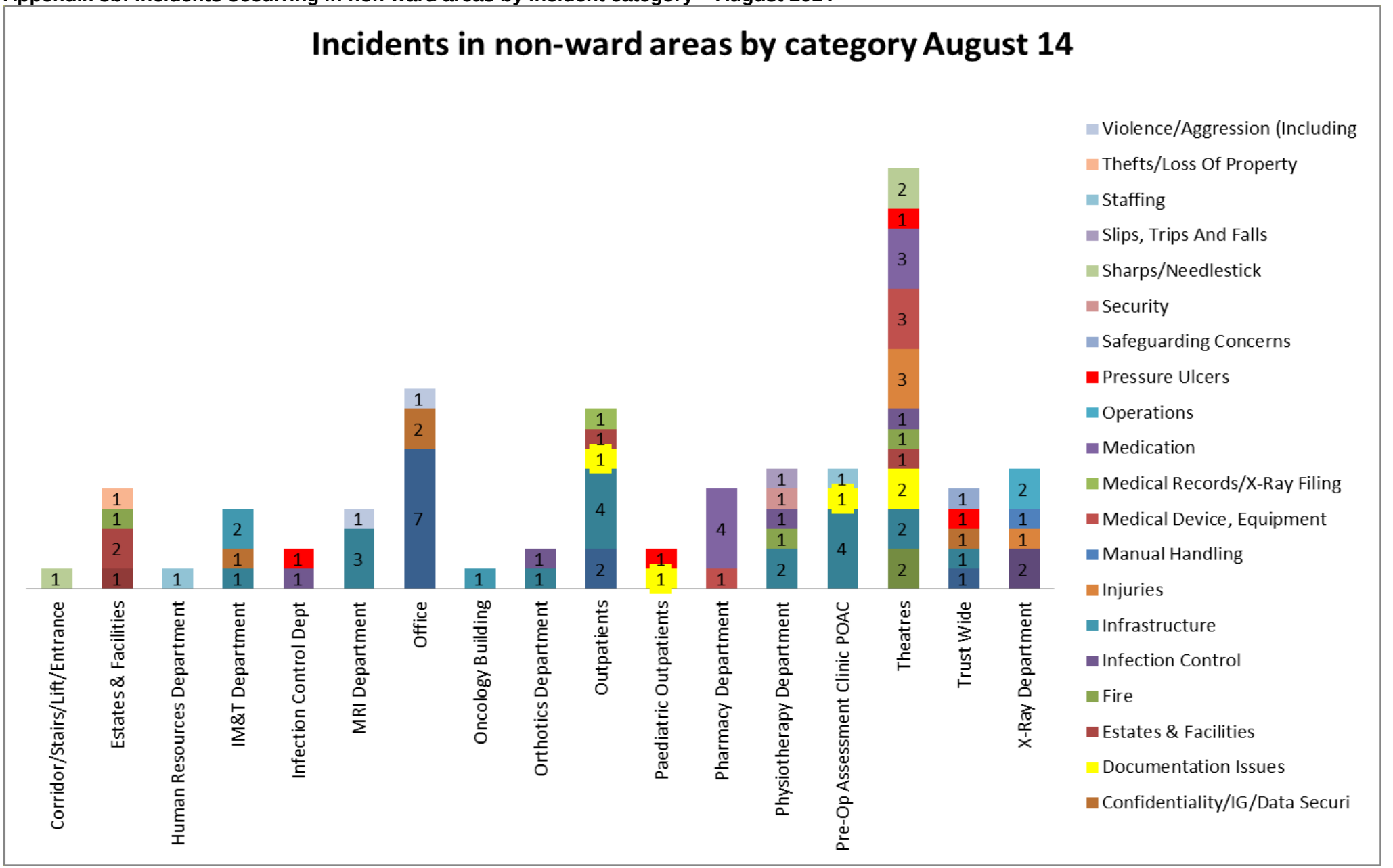
Appendix 2 – No. of Incidents requiring an RCA investigation by department



Appendix 3a: Incidents occurring in ward areas by incident category – August 2014



Appendix 3b: Incidents occurring in non-ward areas by incident category – August 2014



Appendix 4 – Year to date breakdown by Directorate (PALs, Complaints, Compliments, Concerns and Enquiries)

Directorate	PALS	General Enquiry	Concern	YTD Enquiry	YTD Concern	Complaints	YTD Complaints	Compliments	YTD Compliments
Clinical Support	20	9	11	36	83	1	9	47	131
Corporate	27	23	4	71	32	0	1	15	129
Large Joint	30	13	17	37	74	1	13	139	677
Oncology	6	1	5	9	27	2	3	37	117
Paediatrics	2	0	2	4	28	0	0	56	192
Small Joint	6	1	5	10	24	1	4	0	21
Spinal	30	5	25	16	98	1	12	102	405
Theatres	4	0	4	4	18	1	4	115	513
TOTAL	125	52	73	187	384	7	46	511	2234

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Board: 24th September 2014 **ENCLOSURE NUMBER: 7**

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**Safe Staffing – Summary - August 2014**

SUMMARY

In August there was SEVEN incidents reported relating to safe staffing. This demonstrates proactive use of incident reporting. Details as follows:-

13537 – HDU – Amber incident. 3 Agency Nurses did not attend the night shift. Patient Dependency High with 12 patients nursed on the unit, including 2 paediatric patients. Bleep-holder also not supernummary due to patient care requirements. On this occasion, this did breach minimal staffing levels.
13543 – Ward 2 – Amber incident. Bank nurse did not turn up for duty – unable to cover the shift at short notice. Did not breach minimal staffing levels.
13564- Ward 11 – Amber incident. Increased patient care requirements during the shift. This led to parent complaints at a local level. Did not breach minimal staffing levels.
13565 & 13566 – Ward 11 – Amber and Green incidents. Bank Nurse on shift who was not competent in managing patients POP. Due to increased patient care requirements staff nurse working several hours over shift. Did not breach minimal staffing levels.
13574 & 13616 - HDU – Green incidents. Increased patient care requirements meant that the bleep-holder could not be supernummary. HDU Matron and Directorate Leads are implementing a new bed booking process that will support earlier identification of patient/nurse ratio requirements.

Twice weekly Matron/Senior Nurse Quality Debriefs continue. Additional information is requested at these briefings around bank/agency usage.
Monthly Safe Staffing Briefings continue to develop knowledge and awareness across the nursing team.
ROH NHSFT completed the NHS England Safe Staffing UNIFY data uplift on for the month of August on time. Safe Staffing data has been published for all NHS providers within NHS Choices website since May 2014.

IMPLICATIONS

Patient safety and experience, Staff satisfaction, Organisational reputation

RECOMMENDATIONS

Trust Board asked to:-

- Note the continued progress made by ward teams, Matrons and project lead
- Recognise and acknowledge the importance to ROH NHSFT of the national guidance in regards to our patient welfare and future strategy
- Be assured

APPENDIX ONE – EMT & Trust Board September 2014

Safe Staffing – Ward Review- Action Plan

Key - Level of Assurance	Colour
Completed	
No delays, expect to complete on time	
Slight delays, complete on time	
Slight delays, delayed completion	
Significant delays, delayed completion	
Activity not yet commenced	

Subject& Recommendation Reference	NQB Ref No CQC Ref	Lead	Current Position	Review Date	Timeline for delivery	Level
The Board receives a report every six months on staffing capacity and capability which has involved the use of evidence based tool. **This report:** **• Draws on expert professional opinion and insight into local clinical need and context** **• Makes recommendations to the Board which are considered and discussed** **• Is presented to and discussed at the public Board meeting** **• Prompts agreement of actions which are recorded and followed up on**	**1,3,7** **CQC A**	**HS Matron**	**Board received paper in May** **EMT and CGC receive monthly reports**	**Monthly**	**Six Monthly**	
Clearly display information about the nurses present and planned in each clinical **setting on each shift. This should be visible, clear and accurate.** **Significance of**	**8** **CQC B**	**HS SL Matron**	**Staffing boards on display within wards in place, stating staff on duty and Nurse in Charge** **Posters of staff uniforms displayed on wards** **Entrance to ward notice boards in place** **ROH standard format of ward entrance notice boards designed by Matrons/Senior Nurses**	~~**June**~~ **August**	~~**June**~~ **July**	

different uniforms and titles used. **To summarise, the displays should:** **• Be in an area within the clinical area that is accessible** **to patients, their families and carers** **• Explain the planned and actual numbers of staff for each shift (registered and non-registered)** **• Detail who is in charge of the shift** **• Describe what each role is**			**ROH ward entrance notice boards data trial on Ward 3, aim for all wards by end of July**			
The Board receives an update containing details and summary staffing **• Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap** **• Evaluates risks associated with staffing issues** **• Seeks assurances regarding contingency planning, mitigating actions and incident reporting** **• Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience** **• Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly area of the website**	**1,7** **CQC C**	**HS**	**EMT and CGC paper to July Committees** **Twice weekly Quality Debrief continues** **Active shift management by Senior Sisters, Sisters and ward staff** **Bank and Agency use report received each month**	**May** **Monthly**	**Monthly ongoing**	
The Trust will ensure that the published monthly update is available to the public via not only the Trust's website but also the relevant	**1,7** **CQC A, D**	**HS** **WP** **Comms**	**Report to be published following May Trust Board** **UNIFY data uplift completed in July for June data with assistance from Informatics** **Date to be published on NHS Choices, ROH NHSFT rated as Green**	**Monthly**	**June**	

hospital(s) profiles on NHS Choices.			**for second consecutive month Website publication to be developed**			
The Trust: • Reviews the actual versus planned staffing on a shift by shift basis • Responds to address gaps or shortages where these are identified • Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care	**2 CQC E**	**Matron HS**	**Wards & HDU completed daily acuity and staffing tool, commenced 1st April Project Manager support for data collection, inputting and analysis (WP) Weekly analysis Bi weekly Quality Debrief continues Matrons and Senior Sisters proactive management of each shift daily Two safe staffing incidents reported in May, HDU GREEN rating Bank and Agency monthly report provided to DoN/Matrons showing fill rate and RN/HCA usage**	**Bi weekly**	**April**	
Safe Staffing Policy, to include escalation process	**N/A**	**HS**	**Draft policy completed in April Circulation and comments through May & June to stakeholders To EMT and Trust Board in August for approval**	**June**	**~~July~~ ~~August~~**	
Ward based safe staffing risk assessments	**N/A**	**Matron**	**Safe staffing and minimum staffing levels confirmed**	**Quarterly**	**April**	
Acuity Tool, Safer Nursing Care Tool development	**CQC A**	**HS AG WP**	**Initial development of the tool undertaken in January Trialled by wards March Officially commenced 1st April Feedback from Senior Sisters and Matrons received Refinements to tool undertaken in May Final version commenced use in mid May**	**Monthly**	**June**	
Staff awareness	**N/A**	**HS Matron WP LP**	**National Quality Board report circulated to all Matrons and Ward Teams Nurse Leaders Forum discussions 6C's@ROH events programme commences May EMT and Trust Board monthly reports Audit Committee presentation July and October**	**Monthly**	**Ongoing**	

Quality Debrief	**N/A**	**HS LP Matron AM**	**Bi weekly Quality Debrief continues (commenced January)** **Provides forum to reflect and plan over the week for matters associated with the day to day patient safety/experience and safe staffing** **Summary email sent to all Senior Nurses and DOps** **Provides forum to escalate issues to DoN & DOps**	**Six monthly review of effectiveness**	**Bi weekly**	

HS	Helen Shoker
SL	Stuart Lovack
WP	Wendy Prestage
AG	Alex Gilder
LP	Lisa Pim
AM	Amanda Markall

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24th September 2014 **ENCLOSURE NUMBER: 8**

NAME OF DIRECTOR	Helen Shoker, Director of Nursing and Governance
SUBJECT	EMT Risk Register and BAF Report
AUTHORS	Lisa Pim, Deputy Director of Nursing and Governance Alison Braham, Governance Manager Jane Moore, Litigation Assistant and Governance Facilitator

SUMMARY

EMT has taken the following actions this month:-

1. Reviewed the non-BAF risks managed via the EMT committee

2. Reviewed the BAF themes and updates of which:
   - 1 new risk(s) added to the BAF/TRR: Risk 270 Tariff, which has escalated from amber to red
   - Closed risk: Risk 8 Increasingly complex patients - now merged with Risk 27, Temporary/Agency Medical Staffing
   - No increasing risk(s) noted
   - Decreasing risk(s) Risk 27, Temporary/Agency Medical Staffing

Trust Board is asked to note the Trust Risk Register progress report (Appendix 1).

Work continues to develop the external risks and those of the BAF themes (Appendix 2).

Work shop events are continuing during September and October to support learning across the Directorates of how to manage risk, risk registers, TRR and BAF.

IMPLICATIONS

Patient Safety, Contractual, Legal, Reputational

RECOMMENDATIONS

Trust Board is asked to:
- Note the paper
- Discuss

Appendix 1

Date added to BAF	BAF Theme	Risk	Consequence	Lead Director	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
Sept 2014	Business Continuity	(i.d. 270) Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	The Trust will not be adequately recompensed for its work increasing the risk to the organisations long term financial viability	Dir of Fin	• Effective	15	15		NEW: escalated to BAF Sept 204 CEOs & DoFs met with Monitor and NHS England on 2nd September to discuss proposed tariff impact. Little confidence received that Monitor understood or acknowledged issues. Efforts around lobbying and evidence gathering for required changes has been intensified	EMT
August 2014	Business continuity	(i.d.666) 18 week info not up to date.	Cannot manage 18 week pathway internally, failing 18 week target, breach of contract	Dir of Ops	• effective	16	16		Technical staff fix issues as they arise. Informatics Manager is covering technical issues when short staffed. Longer term - infrastructure needs reviewing. Medium term - upgrade SQL. Investigation and amendment to 18 week tracker to improve robustness and performance.	EMT

Date added to BAF	BAF Theme	Risk	Consequence	Lead Director	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
									Review Extra Manager. Extra member of staff (fix term) to enable additional actions to be completed	
June 2014	Standards of Care	(i.d.7) Long waiting times for spinal deformity	Risk to patients of deterioration in condition whilst waiting. Increased complaints & litigation. Risk of Financial penalties levied by Commissioners for breach of 52 weeks	Dir of Ops	• Safe • Effective	20	12	Managed via risk 12 on 'KPIs' until escalation and re-opened as single risk Retained on BAF as 'high' Amber until update on mitigation received..	Whilst no patients have breached 52 weeks since Feb 14, there remains an ongoing risk. Discussions with theatres indicate that spinal skill mix has reduced currently due to vac fac and sickness. Private sector options for adult patients are being explored and a further mitigating plan from theatres team is expected at end of August.	EMT
tbc	Business continuity	(id 27) temporary/ agency medical staffing		MD	• Well led • Safe • Effective	20	16	Current risk rating decreased from 20 to 16.	**Completed Actions:** • immediate action to avoid further unplanned expenditure • ensure consultants do not insist junior doctors work beyond rota time complete.	EMT

Date added to BAF	BAF Theme	Risk	Consequence	Lead Director	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
									New Planned Assurances • Opportunities being explored to engage and train other workers to provide care e.g. Physicians Assistants, Fellows. • Exploring taking Physicans Assistants from Autumn 2015 (DWF&OD and MD) • Expressed interest in additional posts from HEWM (Rachel Ingham-Jones progressing)	
March 2014	Manage-ment of Change	(i.d. 582) management of change	Care for patients that is less than the best; Lack of organisational sustainability	WFOD	• Well led • Safe • Effective				EMT decision to engage external partner to review barriers and enablers to engagement of doctors in leadership roles and activities. 3 providers bid for work. Decision taken on 17th September to proceed with Kings Fund Substantive appointments made to Director of Strategy	EMT

Date added to BAF	BAF Theme	Risk	Consequence	Lead Director	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
									and Transformation and Director of Operations posts. Postholder for transformation to take up post in November	

BOARD ASSURANCE FRAMEWORK 2013/14 (updated: 18.8.14)

This table maps all Trust-wide high level (red) risks against the 8 new 2013/14 BAF themes. Details of the 8 strategic BAF themes are given on the attached summary sheets.

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	TBC	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
				Leading Committee	CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
	Trust-wide risks with a red/amber risk rating		RAG status	Exec Lead								
I.D.	RISK	CONSEQUENCES										
32	Higher than expected rates of 30 day SSI within arthroplasty		16	Medical Director (As DIPC)	Lead Committee				Supporting Committee			
33	Insufficient assurance around robust implementation of infection prevention strategies in theatres.		16	Medical Director (as DIPC)	Lead Committee				Supporting Committee			
27	Inability to control the use of unfunded medical temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2	lack of continuity of patient care; On going locum and agency costs. potential successful banding claims Pre-monitoring exercise has highlighted potential breaches of national New Deal standards.	16	Medical Director	Supporting Committee			Lead Committee		Supporting Committee	Supporting Committee	Supporting Committee
7	Long waiting times for spinal deformity	Risk to patients of deterioration in condition whilst waiting. Increased complaints & litigation. Risk of Financial penalties levied by Commissioners for breach of 52 weeks	12	Director of Operations				Lead Committee				
178	Poor completion of WHO safety procedure. Mitigation: Working partly in place, reviewing whole process. Daily WHO Audits undertaken and published. Poor Practice highlighted	Patient safety through their their experience of the operating department may be compromised, at the mosts severe a never event may occur.	12	Director of Nursing & Governance	Lead Committee							

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	TBC	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
669	Assurance that existing point of care testing (POCT) equipment is fit for purpose and compliant with regulations. Lack of unified procurement process, inventory, quality assurance, protocols and training.	Patient safety/care being compromised.	16	Director of Operations				Lead Committee				
666	There is a risk that the 18 week monitoring of patient cannot happen so effectively if information is not up to date. Cannot manage 18 week pathway internally, failing 18 week target, breach of contract	Cannot manage 18 week pathway internally, failing 18 week target, breach of contract	16	Director of Operations				Lead Committee				
New or Recently Upgraded Risks August 2014												
270	Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	The Trust will not be adequately recompensed for its work increasing the risk to the organisations long term financial viability	15	Director of Finance								Lead committee
Risks downgraded- to be monitored												
414	ROH shows low position for health improvement as measured by PROMs on national Information Centre figures	Patient experience Reputational damage	12	Medical Director	Lead committee			Supporting Committee	Supporting Committee			Supporting Committee

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	TBC	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			RAG status	Exec Lead								
I.D.	RISK	CONSEQUENCES										
12	Contractual KPIs: Trust is required to sign up to SLA contracts with our material commissioners, including performance clauses in line with national and local requirements	Quality of care reduced leading to fines and financial loss. Reputational damage.	8	Director of Nursing & Governance (changed from Director of Finance)	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			
269	Failure to deliver activity targets	creates a lower in year surplus and a lower base to contract from in 2013/14 thus shrinking the organisation. Lack of	8	Director of Operations (changed from Director of Finance)	Supporting Committee			Lead Committee				Supporting Committee
275	Inability to consistently demonstrate learning from serious events/ claims/ complaints is embedded in practice	poor quality patient experience	9	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee		Supporting Committee
625	Spinal database relating to outcomes and CQUINS held in R& T - data corrupted.	Adversely impacts upon delivery of quarter 4 CQUINS report and potential financial loss to Trust	12	Director of Finance	Supporting Committee				Lead Committee			Supporting Committee

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	TBC	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
621	Delays in MRI imaging and reporting	potential delay in diagnosis and treatment. Ineffective outpatient consultations . Repeat visits. Potential complaints/claims	12	Director of Operations (changed from Director of Finance)	Lead Committee							
51	Medical Records: Non compliance with Information Governance/ data protection regulations.Retention of records unnecessarily. Insufficient destruction of medical records in line with policy. Mitigation: policy updated with justification for retention of records; policy to follow ratification process	Potential financial penalty due to data protection/IG breaches.	12	Director of Operations	Supporting Committee			Lead Committee				

	1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
Ulysses risk register i.d.	643; 260	261	262	263	265	665	582	440
	Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term

643; 260	**261**	**262**	**263**	**265**	**665**	**582**	**440**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24 September 2014 **ENCLOSURE NUMBER: 9**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	Update on Five Year Strategic Plan

SUMMARY

To update Board on the current position and future actions with regard to the Five Year Strategic Plan and initiation of the Transformation Programme designed to deliver the Trust's strategic initiatives

IMPLICATIONS

To deliver the 5 year strategic plan the Trust must reorganise its resources and bring new capacity and capability into the organisation. Additionally, new information systems will be required. Commissioners continue to develop a longer-term view of the local health system. Recruitment and reorganisation take time and to reduce the risk of implementation delays part time interim support is assisting the establishment of programme governance.

RECOMMENDATIONS

To note the progress to date and actions planned for the next period.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update Board on current position and future actions with regard to the Five Year Strategic Plan and initiation of the Transformation Programme designed to deliver the Trust's strategic initiatives
Recommendation	To note the progress to date and actions planned for the next period.

1.0	**Summary/Background** Following the agreement of the Trust's 5 Year Strategic Plan in June 2014 this report is intended to update the Board on implementation of the plan and transition from existing activities. The report also provides an update on progress to establish the Transformation Committee.
2.0	**Progress Made to Date** The strategic plan was submitted to Monitor on 30 June 2014 in line with national requirements. On 2 September 2014 an initial review meeting took place with Monitor and no major concerns were identified based on the assumptions in the plan. It was noted, however, that the proposed tariff changes for 2015/16 introduced new risks which would need to be reviewed as the tariff is finalised. Formal feedback will be received from Monitor at the end of September to inform any changes considered necessary for the next planning round. Some of the key actions taken so far have been as follows: • **Strategic Engagement and System Planning** The Trust continues to work with its strategic partners such as Birmingham Children's Hospital and through the Specialist Orthopaedic Alliance on issues relevant to our services and to explore opportunities for sustainable service improvement. The Birmingham, Sandwell and Solihull 'Unit of Planning' meetings continue to explore the 15 year vision for the three health economies. The population for the area is forecast to continue to rise (based on 2030 projections), with an increase in the older population predicted, with the highest relative change occurring in the over 85 age group.

Using a variety of forecasting methods the general picture is one of a continuing rise in elective and emergency spells, a reducing length of stay (more moderate in elective spells), a reduction in overnight beds and a steady state for day beds. These projections, whilst high-level and across all service areas, correlate well with the assumptions that we have included within the 5 year strategic plan.

The priority continues to be the redesign of the urgent care system, however, work on future service models for elective care and specialised services is likely to involve services that the Trust provides and our engagement in the overall process will remain key to our understanding of how commissioners may want to meet patients' needs in the future.

There is a Unit of Planning Chief Officers development day on 16 October, facilitated by the University of Birmingham Health Services Management Centre (HSMC) to support the development of joint working and system leadership across Birmingham and the Unit of Planning. This will build on the Birmingham and Solihull Partnership Compact agreed in March 2012 and to which the ROH is a partner.

- **Strategic Organisational Design**

Now that the 5 year strategic plan has been approved by the Board the Executive Team has started to consider how the resources available to the Trust can be best organised to deliver the transformation set out. In the short term interim support has been commissioned to bring either additional capacity or new capabilities into the organisation pending a longer-term solution. Any substantial change to the current design would require appropriate consultation with staff and our target date for any changes is 1 April 2015.

- **Appointments**

Professor Phil Begg has been appointed to the role of Director of Strategy and Transformation and will take up his post on 1 November 2014; this role will incorporate Programme Director responsibilities for the transformation initiatives.

To ensure that time is not lost until Professor Begg commences at ROH on 1 November interim arrangements have been put in place to establish the programme structure and governance arrangements in conjunction with the Non-Executive chairman of the Transformation Committee. Interim cover to the Programme Director element of the role is being provided on a part time basis by Karen Yates, an experienced OD specialist with extensive experience of programme delivery and change management.

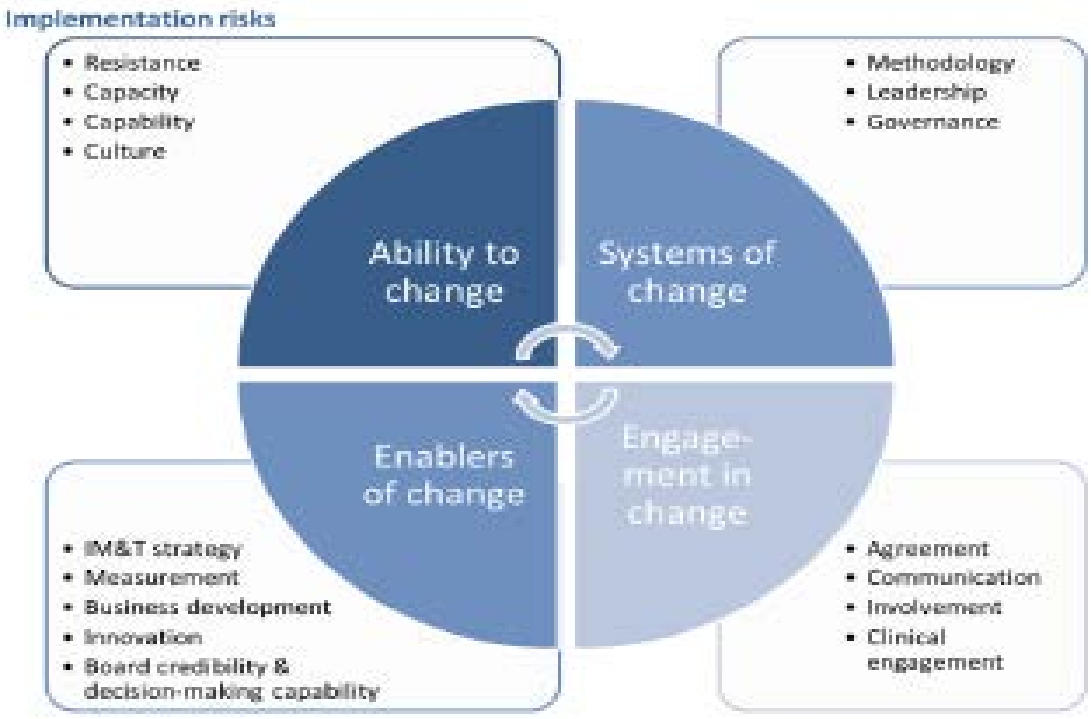
Existing projects covered by the current Clinical Programme Board are in the process of being reviewed and mapped across into the new transformational workstreams to enable assimilation and prioritisation to take place. It will be important during this transition phase to ensure that progress continues to be made on current activities.

It is intended that the programme structure and terms of reference for the Transformation Committee will be agreed and in place by 1 November. Further investment in programme management and project team resources will be made later in the year.

- **Systems & Processes Review & Development of our Programme Management Model**

As set out in the strategic plan the Programme Management function will be responsible for the following:

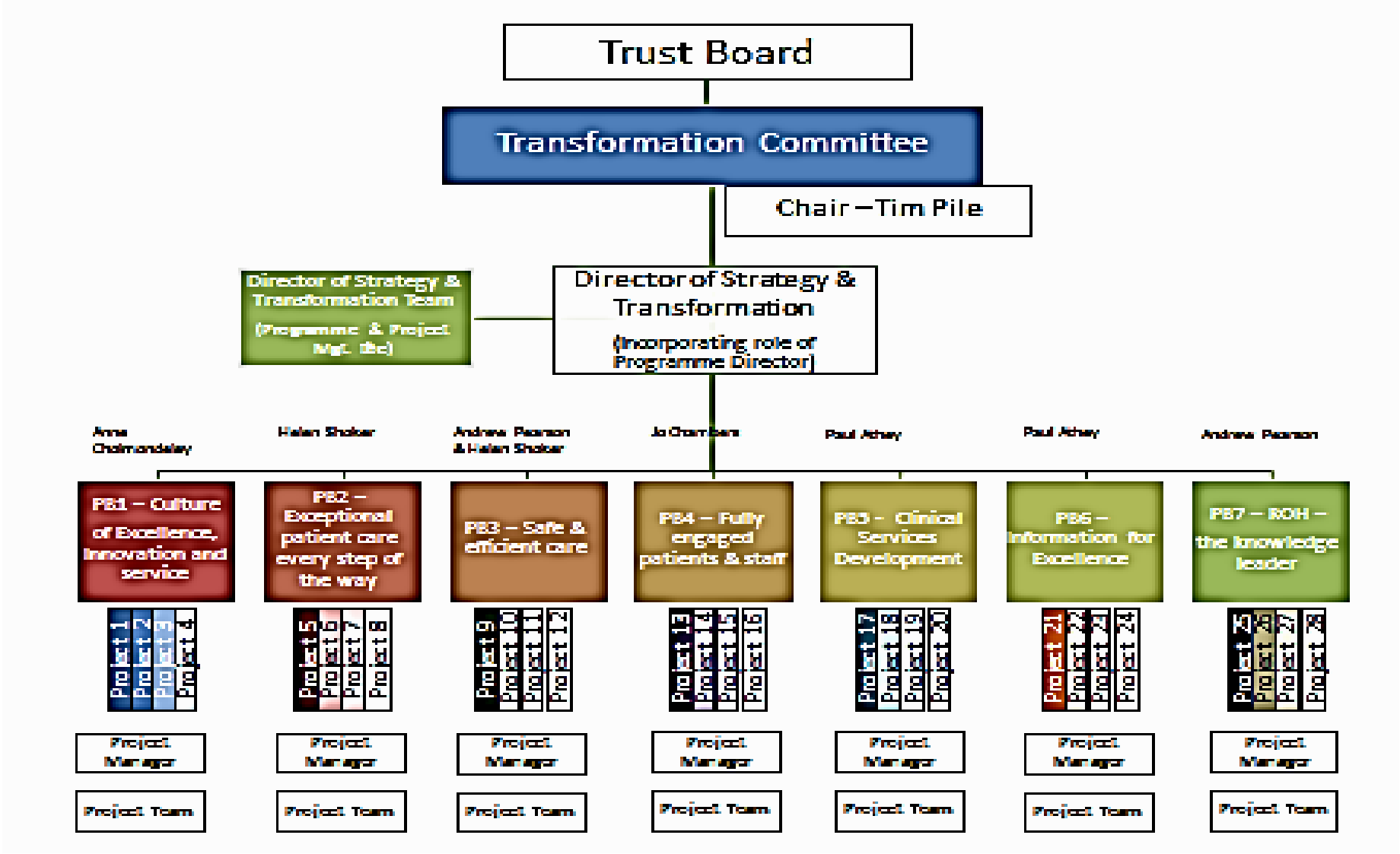
- Oversee strategy implementation
- Horizon scan for technology developments
- Monitor and manage progress
- Escalate issues
- Manage Risks and ensure benefits *delivery (implementation risks identified in the model below)*
- Manage external stakeholders
- Provide support and challenge to all those involved in Strategy implementation.



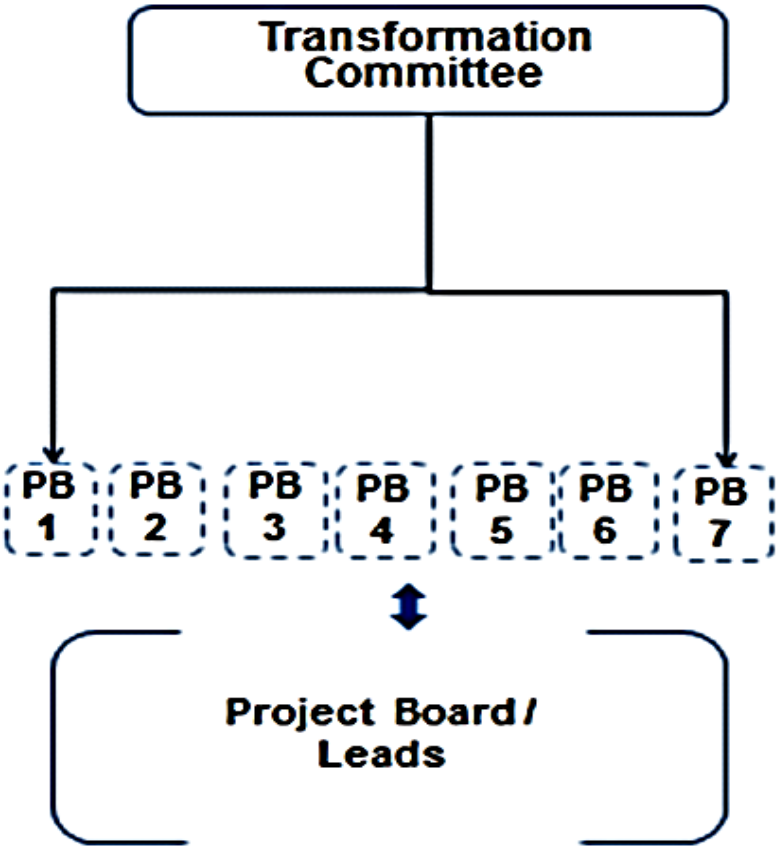
	The Trust will build on its existing programme management structure to ensure that there is an evidence based approach to programme management across the whole organisation enabling the delivery of our objectives, ensuring pace is maintained and risk is managed in a consistent way. During August the Interim Programme Director has been meeting people from across the Trust (Directors, Senior Managers and Project Managers) to understand what is in place already, what has been successful (or otherwise) in the past, and reviewing systems, tools and processes. This process is also helping to pull together a picture of people's attitude and approach to change; what motivates different groups of people (and individuals) within the Trust to want to deliver change. This intelligence will help to inform the approach going forward. A clear part of the Interim Programme Director's role is to ensure that we learn from previous experience at the ROH and best practice elsewhere in order to adopt a model of programme management that engages clinicians and other frontline staff, whilst ensuring delivery. Gradually a locally sensitive programme management model is being formulated with input from a range of people across the Trust. As outlined in the strategy the programme management structure will be overseen by a committee of the Board, the Transformation Committee, to be chaired by a Non-Executive Director (Tim Pile). The role of the committee will be to provide additional assurance to the Board. The Transformation Committee will ensure that plans are rigorous with formal processes both for reviewing the overall transformation strategy and responding to underperformance in delivery of the individual initiatives. It will receive monthly reports about progress and key risks and ensure that support strategies such as organisational development and leadership development are appropriately aligned and mutually reinforcing. Appendix 1 is an outline of the overall programme structure being developed, recognising that workstreams will be of differing scale, scope and pace. Below the Transformation Committee will be a number of Programme Boards established to deliver the transformational initiatives with appropriate membership. Work started during August to identify and map existing projects across to the seven strategic initiatives. This process will also highlight where current projects do not align directly to the new strategy, so that these can then be discussed and considered in more detail with the appropriate managers. Draft Terms of Reference for the Transformation Committee and the Programme Boards are currently being developed Appendix 2 identifies the key responsibilities proposed within the programme structure. Previous work done, during the autumn of 2013, on developing a small suite of project management tools and processes provides an excellent platform to build upon to ensure that there is an element of standardisation and consistency across the whole organisation.

	• **Capacity & Capability to Deliver** As part of the development of our local programme management model we are also reviewing where current project / programme management skills and expertise lie within the Trust and how these will be best played in to the new structure when it is in place. Initial work indicates that, as had already been recognised in the strategy phase, internal capacity and capability to deliver a programme management approach is scarce. Training and development of key individuals will need to be put in place to support the improvement and change agenda. The final configuration of programme and project management posts will be determined as part of the wider organisational design considerations. Board members have a crucial role to play in leading the strategic change programme and bring additional skills and capacity to the plan; non-executive members in particular are able to bring a wealth of experience from outside the NHS to support progress. The Chairman has signalled an intention for the Board to review and evaluate its ability to support and, where appropriate, drive the strategy as part of Board development work in November. There are preliminary discussions with a potential external partner with a strong track record in working with organisations to deliver change and efficiency improvements; this option will bring expertise into the Trust to work alongside our own staff on the transformation initiatives. If we commission a diagnostic this will provide an opportunity to better define and prioritise key areas of transformation and this is option is being explored currently. • **Summary** The early engagement work in developing this initiation plan has shown that people from across the Trust are both aware of the new ROH Strategy and the seven initiatives and also are keen to start work on delivery. It is clear is that there is some learning from previous programme approaches and we must ensure that we build upon the existing tools and templates. The desired approach is to have rigorous, but light-touch systems which support clinicians and managers to deliver change together and the model must be systematic not bureaucratic.
3.0	**<u>Next Steps</u>** During September and October work will continue to develop the final details of the programme management model to be used to ensure that we continue to build momentum towards delivering our strategic initiatives. Some of the key actions for September and October will include:

	• Review and continued development of the emerging draft programme management structure with the Executive Team (and other relevant staff) • Development of a communications strategy for our programme management model to staff at all levels (the how and the why). To include 'branding' and key messages that focus less on the 'how' of PMA and more on the 'why' – this must be seen as useful; credible and practical in its approach • Wider communication and testing of the proposed programme management model to be used • Development of suite of tools and templates to be used (based on existing tools, with clear guidance on when and how to use) • Agreement of the programme management structure with Transformation Committee Chair and Director of Strategy & Transformation • Agree the change management model to be used (potentially the NHS Change Management Model) • Roll out of communications • Membership of the Transformation Committee and its Programme Boards agreed • Dates set for initial meetings of the Transformation Committee & Programme Boards (with pre-defined initial agendas to include: agreement of TOR) • Agreement of a migration plan for the existing projects and initiatives into the new reporting / programme management framework • Plan for the population of key roles within the programme (realignment of staff; identification of gaps, and agreement on solutions)
4.0	**<u>Conclusion and Recommendations</u>** The Board is asked to note this update.


Trust Board
Transformation Committee
Chair – Tim Pile
Director of Strategy & Transformation Team
(Programme & Project Mgt. etc)
Director of Strategy & Transformation
(Incorporating role of Programme Director)
Anna Chalmondeley
Helen Shaker
Andrew Pearson & Helen Shaker
Jo Chambers
Paul Athey
Paul Athey
Andrew Pearson
PB1 – Culture of Excellence, Innovation and service
PB2 – Exceptional patient care every step of the way
PB3 – Safe & efficient care
PB4 – Fully engaged patients & staff
PB5 – Clinical Services Development
PB6 – Information for Excellence
PB7 – ROH – the knowledge leader
Project 1
Project 2
Project 3
Project 4
Project 5
Project 6
Project 7
Project 8
Project 9
Project 10
Project 11
Project 12
Project 13
Project 14
Project 15
Project 16
Project 17
Project 18
Project 19
Project 20
Project 21
Project 22
Project 23
Project 24
Project 25
Project 26
Project 27
Project 28
Project Manager
Project Team

The Transformation Committee will oversee the Programme's Overall Progress – via up to 7 Programme Boards



Transformation Committee – Key Activities:

- Hold the Programme Boards to account for delivery of the 7 STIs
- Escalate issues to Trust Board as appropriate
- Provide assurance to the Trust Board on Programme Delivery

Existing Programme Boards:

- Clinical, IMT and CIP Projects/ Programme Boards – will map across in to the new STI Programme Boards

Programme Board(s) – Key Activities:

- Hold the Project Leads to account
- Track delivery of key milestones, ensure benefits are realised , risks mitigated & interdependencies managed including workforce and quality
- Escalate issues as appropriate
- Provide assurance to the Transformation Committee on the delivery of the Programme
- Issue resolution at programme level
- Key Decision making
- Authorising gateways

Programme Support – Activities:

- CQUIN, Income/CIP, Patient Journey, Service Support Programmes
- Develop programme delivery, monitoring and reporting mechanisms
- Maintain High level Programme milestone map,
- Maintain Interdependencies
- Maintain Benefits Tracker
- Support Best Practice project management
- Risk Management – (Ulysses System used)

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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24 September 2014 **ENCLOSURE NUMBER:9a**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Paul Athey Director of Finance**
AUTHOR(S)	**Paul Athey**

TITLE	**Briefing Note – 2015/16 Tariff consultation**

SUMMARY

On 15th August 2014, the ROH responded individually and as part of the Strategic Orthopaedic Alliance to Monitor's sense check consultation on the draft tariff prices for 2015/16. The consultation response highlighted that the trust would see a reduction in income of £5.4m (12%) based on the proposed tariffs. This was broadly in line with the percentage reductions being modelled across the other specialist orthopaedic trusts.

The reduction was largely driven by 2 factors:

a) A reduction in the national quantum of costs attached to the Trauma and Orthopaedic chapter with the Payment by Results (PbR) tariff. £214m (5%) of funding was transparently removed from this chapter and reallocated to other PbR chapters. It was stated that this was line with national reference costs, representing the move from the previous cost base of 2010/11 to a new cost base of 2011/12.

b) Changes in the relativities between Healthcare Resource Groups (HRGs) with the Trauma and Orthopaedic Chapter. The additional 7% loss attributable to the ROH can only be explained by the fact that the procedures that we undertake have been disproportionately hit by the proposed tariff changes.

Following our submission, Monitor and NHS England agreed to meet with representatives of the Strategic Orthopaedic Alliance, including the Chief Executive and Director of Finance of the ROH, to discuss our concerns. As part of this meeting, we outlined our key concerns, namely;

- The decision to remove £214m from the Trauma and Orthopaedic Chapter without an apparent process of due diligence to access the underlying causal factors of this shift.
- The fundamentally destabilising effect that this course of action could have on the treatment of orthopaedic patients, with the biggest reductions being seen in the most complex sub-specialties where existing capacity constraints already create pressure on the service.
- The disparity between these pricing changes and the national direction of travel towards greater centralisation of specialist care, driven by an evidence base that shows significant better outcomes for patients where centralisation occurs.
- The quality of national reference costs, particularly in orthopaedics, is very poor. This fundamentally undermines the basis for calculating national tariffs.

The general feeling of SOA members at that meeting was that they was little flexibility on offer from Monitor's representatives to address of the problems that the proposed tariff would create at a local level. Whilst there was some limited acknowledgment of the issues, the general view from Monitor was that an appropriate process has been followed and that the costs were evidence based (in that they were derived from national reference costs). It was suggested that they had limited resource at their disposal to make fundamental changes to the draft tariff, however they did agree to consider any evidence that we could provide to support our case.

NHS England and the Information Centre did seem more open the working with the SOA to find a workable solution, and seemed uncomfortable with the position as it current stands.

Following on from this meeting, the SOA representatives agreed two clear actions:

1. An increase in lobbying of key individuals, including an escalation of our concerns to Adrian Masters, Managing Director of Monitor and Ric Marshall, Director of Pricing at Monitor.

   In addition to this, Peter Kay, the national clinical director for MSK services and Charles Greenough, the national clinical director for spinal services, have written to Bruce Keogh, Medical Director of NHS England to express their concerns at the direction of travel.

2. The development of a more detailed evidence base to support our case. This included:

   a. Evidence highlighting the inadequacies of the 2011/12 reference cost as a basis for setting national tariffs. This focused on the concept that many of the key cost drivers in orthopaedic care (particularly implant costs) are not always recorded at a patient level. In General Hospitals, this often leads to these costs being spread across a number of specialties, inflating the tariffs in other specialities at the expense of orthopaedics.

      As an example, we were able to highlight from our benchmarking tool that Nottingham University Hospital, which undertakes over 15,000 T&O procedures per year had allocated only £10,000 of implant costs to its entire T&O service. To put the shortfall in context, in their 2012/13 costs this increased to £12.7m.

      In other example, Guys & St Thomas' had allocated only £8,000 of implant costs to their 13,000 T&O procedures.

   b. Evidence highlighting problems with individual tariffs, and the relativities between tariffs. This included patient level costing showing the difference between the real cost of certain procedures and the proposed tariffs under the 2015/16 PbR system.

As a result of their actions, Monitor have agreed to meet again with Directors of Finance on Tuesday 23rd September to work through the detail of our response and consider the options available over the next four weeks. A verbal update on this meeting will be given to the Trust Board.

It is anticipated that the final version of the 15/16 tariff will be released on 23rd October for formal consultation, at which point no further changes are expected.

RISK & IMPLICATIONS

The impact of the proposed changes places a fundamental risk on the delivery of the Trusts strategic intentions and, should this impact remain over a number of years, places a risk on the financial viability of the Trust.

RECOMMENDATIONS

Trust Board are asked to note the information provided in the briefing note, and to support the Executive in continuing to lobby for further adjustments to the 15/16 tariff.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24th September 2014 ENCLOSURE NUMBER: 10

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Acting Company Secretary**
SUBJECT:	**Constitution**

Since the meetings of the Council of Governors and Trust Board in July 2014 the opportunity has been taken to update the Standing Orders for both the Council of Governors and Trust Board (Annexes 7 and 8 of the Constitution) , as well as making more minor amendments elsewhere within the Constitution.

The changes reflect the comments made by Trust Board members at their July 2014 meeting as well as individual discussions with the Chairman, Chief Executive Officer, Director of Finance and Chair of Audit.

IMPLICATIONS

Mills and Reeve, solicitors to the Trust, advise that the changes referred to above must be approved by the Council of Governors and the Board of Directors but will not require the approval of members at an Annual Members Meeting since they are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust.

The most important changes are summarised in Appendix 1, with the revised draft Constitution attached as Appendix 2. The changes seek to:

1. Simplify the Standing Orders and provide greater clarity regarding how they are to be applied
2. Update the Standing Orders having regard to the requirements of the current Foundation Trust Code of Governance and other current guidance, best practice advice from Monitor
3. Update the Standing Orders to remove any remaining anomalies which resulted from the Trust's Standing Orders being based on the Model Standing Orders for NHS Trusts
4. Provide greater flexibility for the conduct of business of the Council for example in relation to attendance at meetings by conference call

RECOMMENDATIONS

Under the Health and Social Care Act 2012, Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act.

Lawyers have been responsible for final review of the amended constitution attached at Appendix 2 and will assume responsibility for assuring the Trust of such compliance.

The Board is asked to approve in principle the amended constitution attached at Appendix 2 with the expectation (subject to any final changes suggested by it or the Council of Governors being incorporated within a final draft) that it will give formal approval at its meeting on October 29th 2014 and adoption immediately thereafter.

Appendix 1

This Appendix summarises proposed changes to the standing orders of the Council of Governors and Trust Board as well as more minor changes to the rest of the Constitution which have been incorporated in the amended draft Constitution in Appendix 2. They reflect the comments made by Board members at the July 2014 meeting as well as individual discussions with the Chairman, CEO, DoF and Chair of Audit.

While a number of typographical errors have been corrected throughout the document, together with clearer wording and minor improvements to processes, the main changes can be summarized in the table below:

Section	Para	Comment
Paragraph 35 of the constitution		Includes requirements for register of governors and directors.
Annex 6	5	Deleted provision dealing with term of office of governor elected to fill a vacant governor seat which has arisen due to unforeseen events as this is dealt with in paragraph 8.1.1 of Annex 9
Annex 7	4.12.5 and 4.13	Deals with what constitutes presences at a meeting and permits participation in meetings by conference call, telephone, computer or video link for the purposes of quorum and vote
Annex 7	4.16	Amended to reflect updated process for amending standing orders in accordance with paragraph 45 of the constitution.
Annex 7	5.8, 5.9	Preserves confidentiality of matters dealt with in committee of Council of Governors or reported to Council of Governors.
Annex 7	5.10	Provides that all decisions taken in good faith at a meeting of Council of Governors and committees of the Council are valid notwithstanding defect in calling the meeting or any vacancy or membership or defect in Governor's appointment. Having this provision in the constitution would have been useful in mitigating issues arising from vacancy of Lead Governor seat for example.
Annex 7	9	Details the interface between the Board and the Council.
Annex 8	2.1 (2)	Explains requirements for independence per the FT Code of Governance .
Annex 8	2.1 (5)	Details role of senior independent director in line with the FT Code of Governance
Annex 8	2.2-2.5	Details appointment and removal of Chairman, Non – Executive Directors and their remuneration and terms of office and the appointment and removal of the Chief Executive and other Executive Directors and other Executives and their remuneration and terms of office

		and the role of the nominations and remuneration committees of directors in this respect.
Annex 8	2.7.1	Explains the role of Members of the Trust Board in line with the FT Code of Governance
Annex 8	3.14	Amended to reflect updated process for amending standing orders in accordance with paragraph 45 of the constitution.
Annex 8	3.12(5) and 3.16 (1)	Permits participation in meetings by conference call, telephone, computer or video link for the purposes of quorum and vote
Annex 8	3.16 (2)	Provides that all decisions taken in good faith at meetings of Board of Directors and any committees of the Board are valid notwithstanding defect in calling the meeting or any vacancy or membership or defect in Director's appointment. Having this provision in the constitution would have been useful in mitigating issues arising from vacancy of Lead Governor seat for example.
Annex 8	4.8.1 and 4.8.2	Updates the list of Board committees and provides for their constitution and terms of reference for such committees to be agreed by the Board. Creates separate Remuneration and Nominations Committees.
Annex 8	7.1.2	Simplifies what interests must be declared as relevant and material by Directors for the Register of Board interests improving the focus on areas of possible conflict
Annex 8	7.3.3	Deletion of reference to the "waiver" procedure as adequately covered by Para 32.10 of the main constitution referring to authorisation of conflict of interest by the Board of Directors
Annex 8	7.4.2	Provides further clarification regarding Staff interests
Annex 8	9	Details the interface between the Board and the Council.
Annex 8	10	Sets out formal and informal means of communication between the Board and the Council. These provisions assist information flow between Council and the Board and will help Governors in their enhanced duties under the NHS 2006 Act, for example to hold the non-executive directors to account.
Annex 10		Updates reference to Members of the Council to include a reference to Trust values and to the protected characteristics under the Equality Act

CONSTITUTION OF THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

(Updated as per the Health and Social Care Act 2012)

www.roh.nhs.uk

17 September 2014

Constitution of The Royal Orthopaedic Hospital NHS Foundation Trust

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Paragraph

1. **Interpretation and definitions**

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph 11 of the constitution

constitution means this constitution and all annexes to it.

Monitor is the body corporate known as Monitor, as provided by Section 61of the 2012 Act.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. **Name**

The name of the foundation trust is The Royal Orthopaedic Hospital NHS Foundation Trust (the trust).

3. **Principal purpose**

3.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income

available in order better to carry on its principal purpose.

4. **Powers**

4.1 The powers of the trust are set out in the 2006 Act.

4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. **Membership and constituencies**

5.1 The trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency

5.1.2 the staff constituency

6. **Application for membership**

An individual who is eligible to become a member of the trust may do so on application to the trust.

7. **Public Constituency**

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. **Staff Constituency**

8.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

8.1.1 he is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the trust that he does not wish to do so.

10 Restriction on membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 9 – Further Provisions.

11. **Annual Members' Meeting**

The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

12. **Council of Governors – composition**

12.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13. **Council of Governors – election of governors**

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the trust's Authorisation are attached at Annex 5.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 45 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

13.5 In order to assist prospective governors in deciding whether to nominate themselves for election the Trust shall publish a description of the requirements of the role, which shall be reviewed by the Council of Governors from time to time.

14. **Council of Governors - tenure**

14.1 An elected governor may hold office for a period of up to 3 years.

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.3 An elected governor shall be eligible for re-election at the end of his term.

14.4 An appointed governor may hold office for a period of up to 3 years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.6 An appointed governor shall be eligible for re-appointment at the end of his term.

15. Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

15.4 Annex 6 makes provision for the removal of Governors.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

17.1 The Chairman of the trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26) or, in his absence, the Vice Chairman (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors unless they have a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.3 For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

19 Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

19.1.1 to act in accordance with its constitution, or

19.1.2 to act in accordance with provision made by or under

Chapter 5 of the 2006 Act.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust.

22 Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

23. Board of Directors – composition

23.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 up to 7 other non-executive directors; and

23.2.3 up to 7 executive directors.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer

23.5 One of the executive directors shall be the finance director

23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the executive directors is to be a registered nurse or a registered midwife.

24. **Board of Directors – general duty**

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

25. **Board of Directors – qualification for appointment as a non-executive director.**

A person may be appointed as a non-executive director only if –

25.1 he is a member of a Public Constituency, or

25.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university , and

25.3 he is not disqualified by virtue of paragraph 29 below.

26. **Board of Directors – appointment and removal of chairman and other non-executive directors**

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the trust and the other non-executive directors.

26.2 Removal of the chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

27. **Board of Directors – appointment of vice chairman**

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a vice chairman.

28. **Board of Directors - appointment and removal of the Chief Executive and other executive directors**

28.1 The non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other

executive directors.

29. **Board of Directors – disqualification**

The following may not become or continue as a member of the Board of Directors:

29.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

29.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

30. **Board of Directors – meetings**

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

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. **Board of Directors – standing orders**

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8.

32. **Board of Directors - conflicts of interest of directors**

32.1 The duties that a director of the trust has by virtue of being a director include in particular –

32.2.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust.

32.2.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that

capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2 The matter has been authorised in accordance with the constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, "third party" means a person other than –

32.4.1 The trust, or

32.4.2 A person acting on its behalf.

32.5 If a director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the director must declare the nature and extent of that interest to the other directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the directors appointed for the purpose under the constitution.

32.10 A matter shall have been authorised for the purposes of paragraph

32.2.2 above if:

32.10.1 The Board of Directors, in accordance with the requirements set out in this paragraph 32.10, authorise any matter or situation proposed to them by any director which would, if not authorised, involve a director (an "Interested Director") breaching his duty under paragraph 32.1.1 above to avoid Conflicts;

32.10.2 The matter in question shall have been proposed by any director for consideration in the same way that any other matter may be proposed to the Board of Directors under the provisions of this Constitution;

32.10.3 Any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interested Director; and

32.10.4 The matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

33. Board of Directors – remuneration and terms of office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

33.2 The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34. Registers

The trust shall have:

34.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of governors;

34.4 a register of directors; and

34.5 a register of interests of the directors.

35 **Admission to and removal from the registers**

35.1 Any person entitled to be a Member who, as appropriate, applies or is entitled to become a Member, shall have their name and the constituency or class to which they belong added to the register of Members.

35.2 The register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted (which may be the Secretary), their date of becoming a member of the Council of Governors, the anticipated length of their term and the date of their ceasing to be a member of the Council of Governors.

35.3 The Register of Directors shall list the names of Directors, their capacity on the Board of Directors and an address through which they may be contacted (which may be the Secretary)

36 **Registers – inspection and copies**

36.1 The trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the trust, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

37 **Transition**

37.1 With effect from the end of the 30th July 2014 (Effective Date) the following provisions of this paragraph 37 shall take effect:

37.1.1 Public members who on the Effective Date live in an electoral area comprised in a Birmingham public constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of

Annex 1 shall become members of the Birmingham and Solihull public constituency as described in Part B of Annex 1;

37.1.2 Public members who on the Effective Date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become members of the Rest of England public constituency as described in Part B of Annex 1;

37.1.3 Public governors who on the Effective Date live in an electoral area comprised in a Birmingham public constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of Annex 1 shall become governors in the Birmingham and Solihull public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.4 Public governors who on the effective date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become governors in the Rest of England public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.5 If the number of governors for any public constituency following implementation of the preceding provisions of this paragraph would exceed the number of governors allowed for that constituency, then the governors in that constituency shall draw lots to determine which of their number shall retire

38. Documents available for public inspection

38.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current constitution,

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by

members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40. Audit committee

The trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

40.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the trust's auditor.

41.4 The trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. Annual report, forward plans and non-NHS work

42.1 The trust shall prepare an Annual Report and send it to Monitor.

42.2 The trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

42.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about –

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must –

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the directors of the trust of its determination.

42.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the governors and members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the annual accounts;

43.1.2 any report of the auditor on them;

43.1.3 the annual report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Instruments

44.1 The trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The trust may make amendments of its constitution only if –

45.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

45.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

45.2 Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust) –

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

45.4 Amendments by the trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and significant transactions

46.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

46.2 The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

PART A (until the Effective Date – see paragraph 37)

There are five public constituencies reflecting the populations the Trust serves:

- South Birmingham
- Heart of Birmingham
- Eastern and Northern Birmingham
- Other West Midlands
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

South Birmingham Public Constituency:

Bartley Green
Billesley
Bournville
Brandwood
Edgbaston
Hall Green
Harborne
King's Norton
Longbridge
Moseley
Northfield
Quinton
Selly Oak
Weoley

Heart of Birmingham

Aston
Bordesley Green
Handsworth Wood
East Handsworth
Ladywood
Lozells
Nechells

Small Heath
Soho
Sparkbrook
Sparkhill
Springfield

Eastern and Northern Birmingham

Northern Birmingham:
Kingstanding
Perry Barr
Oscott
Sutton Four Oaks
Sutton New Hall
Sutton Vesey

Eastern Birmingham:
Acock's Green
Erdington
Hodge Hill
Kingsbury
Shard End
Sheldon
Stockland Green
Washwood Heath
Yardley.

Other West Midlands - comprising the metropolitan boroughs of:

Coventry
Dudley
Sandwell
Solihull
Walsall
Wolverhampton

Rest of England and Wales

Initially the Trust will utilise the details of patients from the Patient Administration System as information to support membership recruitment within the Public Constituency in addition to other recruitment efforts.

The Trust intends to develop membership numbers in the Public Constituency over time, however the minimum number of members in the public constituency described above is to be 100 persons split across the 5 constituencies as follows:

Public Constituency	Minimum Number
South Birmingham	41
Heart of Birmingham	9
Eastern and Northern Birmingham	13
Other West Midlands	31
Rest of England and Wales	6
Total	100

PART B (with effect from the Effective Date– see paragraph 37)

Two public constituencies reflecting the populations the Trust serves:

- **Birmingham and Solihull**
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

Birmingham and Solihull

The electoral areas listed in Part A of this Annex for the three former Birmingham constituencies plus Solihull.

Rest of England and Wales

The electoral areas in England and Wales not comprised in the Birmingham and Solihull constituency. The minimum number of members for each Public Constituency is as follows:

Public Constituency	**Minimum Number**
Birmingham and Solihull	67
Rest of England and Wales	33
Total	100

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

All Staff eligible for membership as described in paragraph 0 of the constitution will automatically become members of the Staff Membership Constituency upon Authorisation. Staff will have the right to opt out of automatic membership if they so wish.

There will be two classes of Staff Membership which will be determined based on Whitley Staff Groups:

- Clinical–comprising Medical, Nursing, Allied Health Professionals and Scientists

- Non-Clinical – comprising all staff not included in the clinical class.

There will be a minimum of 25% of total staff within each class, as specified below:

Staff Membership Class	Number of Staff in Post	Minimum Number in Constituency
Clinical	**468**	**117**
Non-Clinical	**339**	**85**

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust will not have a Patient Constituency, patients of the Trust may become members within the Public Constituency providing they fulfil the membership criteria.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 12.2 and 12.3)

PART A (until the Effective Date)

The Council of Governors is to comprise:

Elected Members

13 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
South Birmingham	5
Heart of Birmingham	1
Eastern and Northern Birmingham	2
Other West Midlands	4
Rest of England and Wales	1
Total	**13**

3 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	1
Total	**3**

In order to take into account the changing nature of the local health economy at the commissioning level, the Trust intends to retain the flexibility to increase the staff Members of Council and the Nominated Members of Council. Any increases in Staff Members of Council will require an increase in Public Members of Council in order to ensure that the relative proportion of Staff members to other Constituencies remain constant.

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
South Birmingham PCT	1
Heart of Birmingham (Teaching) PCT	1
Birmingham City Council	1
University of Birmingham	1
University of Central England	1
Patient Support Group Representative	1
Birmingham Council of Faiths Representative	1
Local Member of Parliament Representative	1
Bournville Village Trust	1
Total	**9**

PART B (with effect from the Effective Date – see paragraph 37

Elected Members

9 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
Birmingham and Solihull	5
Rest of England and Wales	4
Total	9

4 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	2
Total	**4**

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
Birmingham City Council	1
Birmingham City University	1
Local Member of Parliament Representative	1
University of Birmingham	1
Bournville Village Trust	1
Total	**5**

ANNEX 5 –THE MODEL ELECTION RULES

(Paragraph13)

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Part 6 – Counting the votes

Part 7–Final proceedings in contested and uncontested elections

Part 8–Disposal of documents

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Part 10 – Election expenses and publicity

Expenses

Publicity

Part 11 – Questioning elections and irregularities

Part 12 – Miscellaneous

Part 1 - Interpretation

1. Interpretation

(1) In these rules, unless the context otherwise requires:

"the Trust"	Means the Royal Orthopaedic Hospital NHS Foundation Trust;
"election"	Means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;
"Monitor"	Means the Independent Regulator for NHS foundation trusts; and
"the2006Act"	Means the National Health Service Act 2006.

(2) Other expressions used in these rules and in Schedule 7 of the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

(1) The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

(1) In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday; or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

(1) Subject to rule 64, the returning officer for an election is to be appointed by the Trust.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

(1) Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

(1) The Trust is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules; and

(b) such remuneration and other expenses as the Trust may determine.

7. Duty of co-operation

(1) The Trust is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

(1) The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(c) the details of any nomination committee that has been established by the Trust;

(d) the address and times at which nomination papers may be obtained;

(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer;

(f) the date and time by which any notice of withdrawal must be received by the returning officer;

(g) the contact details of the returning officer; and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

(1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer:

(a) is to supply any member of the Trust with a nomination paper; and

(b) is to prepare a nomination paper for signature at the request of any member of the Trust,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

(1) The nomination paper must state the candidate's:

(a) full name;

(b) contact address in full; and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

(1) The nomination paper must state:

(a) any financial interest that the candidate has in the Trust; and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

(1) The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

(1) The nomination paper must be signed and dated by the candidate, indicating that:

(a) they wish to stand as a candidate;

(b) their declaration of interests as required under rule 11, is true and correct; and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

(1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand;

(b) decides that the nomination paper is invalid;

(c) receives satisfactory proof that the candidate has died; or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election;

(b) that the paper does not contain the candidate's particulars, as

required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;

(d) that the paper does not include a declaration of eligibility as required by rule 12; or

(e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

(1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing; and

(b) the declared interests of each candidate standing, as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the Trust as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

(1) The Trust is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the Trust is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

(1) A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

(1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the Trust.

Part 5 – Contested elections

19. Poll to be taken by ballot

(1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper

(1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify:

(a) the name of the Trust;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) instructions on how to vote;

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and

(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter is the person to whom the ballot paper was addressed;

(b) that the voter has not marked or returned any other voting paper in the election; and

(c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter;

(b) the address of the voter;

(c) the voter's signature; and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(1) The Trust is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll

(1) The returning officer is to publish a notice of the poll stating:

(a) the name of the Trust;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency;

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post;

(f) the address for return of the ballot papers, and the date and time of the close of the poll;

(g) the address and final dates for applications for replacement ballot papers; and

(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer

(1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the Trust named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope;

(b) a declaration of identity (if required);

(c) information about each candidate standing for election, pursuant to rule 59 of these rules; and

(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

(3) The returning officer shall have the right to edit or not publish any election statement if it exceeds the permitted number of words or because it contains statements which he reasonably believes are factually inaccurate, offensive or libellous.

25. Ballot paper envelope and covering envelope

(1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and

(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed declaration of identity if required; and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote

(1) An individual who becomes a member of the Trust on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

(1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers

(1) If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter’s identity; and

(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”):

(a) the name of the voter; and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and

(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers

(1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she:

(a) is satisfied as to the voter’s identity;

(b) has no reason to doubt that the voter did not receive the original ballot paper; and

(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper

(1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration; and

(b) of the particulars of that member's qualification to vote as a member of the public or patient constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for:

(a) the name of the voter;

(b) the address of the voter;

(c) the voter's signature; and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents

(1) Where the returning officer receives a:

(a) covering envelope; or

(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper

(1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) put the declaration of identity if required in a separate packet; and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”;

(b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it the ballot paper;

(c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (public and patient constituency)

(1) Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to:

(a) mark the declaration of identity “disqualified”;

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the declaration of identity in a separate packet.

35. Sealing of packets

(1) As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;

(b) the declarations of identity if required;

(c) the list of spoilt ballot papers;

(d) the list of lost ballot papers;

(e) the list of eligible voters; and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

36. Interpretation of Part 6

(1) In Part 6 of these rules:

"continuing candidate"	Means any candidate not deemed to be elected, and not excluded;
"count"	Means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;
"deemed to be elected"	Means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;
"mark"	Means a figure, an identifiable written word, or a mark such as "X";
"non- transferable vote"	Means a ballot paper– (a) on which no second or subsequent preference is recorded for a continuing candidate, or (b) which is excluded by the returning officer under rule44(4)below;
"preference"	As used in the following contexts has the meaning assigned below– (a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference, (b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and (c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on;
"quota"	Means the number calculated in accordance with rule 41 below;

“surplus”	Means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both)exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value)of all transferable papers from the candidate who has the surplus;
“stage of the count”	means– (a) the determination of the first preference vote of each candidate, (b) the transfer of a surplus of a candidate deemed to be elected, or (c) the exclusion of one or more candidates at any given time;
“transferable paper”	Means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;
“transferred vote”	means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred; and
“transfer value”	Means the value of a transferred vote calculated in accordance with paragraph(4) or (7) of rule 42 below.

37. Arrangements for counting of the votes

(1) The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count

(1) The returning officer is to:

(a) count and record the number of ballot papers that have been returned; and

(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

39. Rejected ballot papers

(1) Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;
(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate;
(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or
(d) which is unmarked or rejected because of uncertainty,

Shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and soon, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

40. First stage

(1) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

41. The quota

(1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above(any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 44 has been

complied with.

42. Transfer of votes

(1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those papers for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1) (a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall beat a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those papers for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5) (a)to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at:

(a) a transfer value calculated as set out in paragraph (4)(b) above; or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11)`This rule does not apply at an election where there is only one vacancy.

43. Supplementary provisions on transfer

(1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule42 above:

(a) record the total value of the votes transferred to each candidate;

(b) add that value to the previous total of votes recorded for each candidate and record the new total;

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and

(d) compare

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule 42 or 44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be ,all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule 42 or 44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non- transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

44. Exclusion of candidates

(1) If:

(a) all transferable papers which under the provisions of rule 42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred; and
(b) subject to rule 45 below, one or more vacancies remain to be filled,

The returning officer shall exclude from the election at that stage the candidate with the lowest vote (or, where paragraph (12) below applies, the candidates with the lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph(1)above into two sub-parcels so that they are grouped as:

(a) ballot papers on which a next available preference is given; and

(b) ballot papers on which no such preference is given (thereby including

ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule 43 above, transfer each sub-parcel of ballot papers referred to in paragraph(2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule 45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and soon until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes; or

(ii) the total transfer value of votes transferred to each candidate;

(b) add that total to the previous total of votes recorded for each candidate and record the new total;

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total; and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule 42 and rule 43.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, there turning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

45. Filling of last vacancies

(1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall there upon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of anyone continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall there upon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

46. Order of election of candidates

(1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which the irrespective surpluses were transferred, or would have been transferred but for rule 42 (10) above.

(2) A candidate credited with a number of votes equal to, and not greater

than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, there turning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

47. Declaration of result for contested elections

(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the North Staffordshire Combined Healthcare NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust; or
(ii) in any other case, to the chairman of the Trust; and

(c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not;

(b) any transfer of votes;

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place;

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 39(1), available on request.

48. Declaration of result for uncontested elections

(1) In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the Trust; and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

49. Sealing up of documents relating to the poll

(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers;

(b) the ballot papers endorsed with “rejected in part”;

(c) the rejected ballot papers; and

(d) the statement of rejected ballot papers.

(2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;

(b) the declarations of identity;

(c) the list of spoilt ballot papers;

(d) the list of lost ballot papers;

(e) the list of eligible voters; and

(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the Trust to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

50. Delivery of documents

(1) Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, there turning officer is to forward them to the chair of the Trust.

51. Forwarding of documents received after close of the poll

(1) Where:

(a) any voting documents are received by the returning officer after the close of the poll; or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or

(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

There turning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the Trust.

52. Retention and public inspection of documents

(1)The Trust is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the Trust shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the Trust, and the Trust is to provide it, and may impose a reasonable charge for doing so.

53. Application for inspection of certain documents relating to an election

(1) The Trust may not allow the inspection of, or the opening of any sealed packet containing:

(a) any rejected ballot papers, including ballot papers rejected in part;

(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers;

(d) any declarations of identity; or

(e) the list of eligible voters,

By any person without the consent of the regulator.

(2) A person may apply to the regulator to inspect any of the documents listed in (1),and there regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;

(b) time;

(c) place and mode of inspection;

(d) production or opening,

and the Trust must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1):

(a) in giving its consent, the regulator; and

(b) and making the documents available for inspection, the Trust,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given; and

(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

54. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to their turning officer's satisfaction before the result of the election is declared that one of the

persons named or to be named as a candidate has died, then there turning officer is to:

(a) publish a notice stating that the candidate has died; and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and

(ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49(1)(a).

Part 10 – Election expenses and publicity

Election expenses

55. Election expenses

(1) Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

56. Expenses and payments by candidates

(1) A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

57. Election expenses incurred by other persons

(1) No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise; or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58. Publicity about election by the Trust

(1) The Trust may:

(a) compile and distribute such information about the candidates; and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the Trust about the candidates, including information compiled by the Trust under rule 59, must be:

(a) objective, balanced and fair;

(b) (as far as the information provided by the candidates so allows)equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election; and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the Trust proposes to hold a meeting to enable the candidates to speak, the Trust must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the Trust must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59. Information about candidates for inclusion with voting documents

(1) The Trust must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2) The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words (if supplied by the candidate); and

(b) a photograph of the candidate (if supplied by the candidate).

60. Meaning of "for the purposes of an election"

(1) In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

61. Application to question an election

(1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote; or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and

(b) be in such a form as the regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(7) The regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.

(8) The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the Trust, the applicant and the members of the constituency (or class with in a constituency) including all the candidates for the election to which the application relates.

(9) The regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

62. Secrecy

(1) The following persons:

(a) the returning officer; and

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the Trust who has or has not been given a ballot paper or who has or has not voted;
(ii) the unique identifier on any ballot paper; and
(iii) the candidate(s)for who many member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s)for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63. Prohibition of disclosure of vote

(1) No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification

(1) A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the Trust;

(b) an employee of the Trust;

(c) a director of the Trust; or

(d) employed by or on behalf of a person who has been nominated for election.

65. Delay in postal service through industrial action or unforeseen event

(1) If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24; or

(b) the return of the ballot papers and declarations of identity,

The returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the regulator.

66. Effect of administrative or clerical errors on election

(1) Elections shall not be invalidated by any administrative or clerical error on the part of the Trust or any acts or omissions of the returning officer acting in good faith on the basis of such error.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 22)

1. The Council of Governors will meet quarterly.

2. Any Member of Council judged by the Council of Governors to have acted in a manner which brings the Trust into disrepute will not be permitted to continue as a Member of Council.

3. NOT USED

4. The number of full terms of office for Elected Members of Council will be 3.

5. Under Clause 0, 75% of all the Members of Council have to be in support in order to remove the Chairman or Non-Executive Directors

6. The following may not become or continue as a member of the Council of Governors:

   6.1 They are a Director of the Trust, or a Governor, Member of Council or Director of another NHS Body, or of an independent/private sector health care provider whose activities compete with those of the Trust. These restrictions do not apply to Appointed Partnership Members of Council;

   6.2 they are under sixteen years of age;

   6.3 being a member of a public constituency, they were or were entitled to be a member of one of the classes of the staff constituency at any point during the preceding two years;

   6.4 being a member of one of the public constituencies, they refuse to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

   6.5 they are currently on the sex offenders register.

6.6 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, expiry of a fixed term contract, disability, ill health or age from any paid employment with a health service body. In other cases of dismissal, such as capability, an individual may be permitted to become a Member of Council, at the discretion of the trust, and subject to full disclosure of the relevant circumstances and facts concerning that dismissal;

6.7 they are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that

their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

6.8 they have had their name removed, by a direction under section 46 of the 1977 NHS Act from any list prepared under Part II of that Act or have otherwise been disqualified or suspended from any healthcare profession, and have not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable);

6.9 they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

6.10 they are an elected Member of Council and they cease to be a member of the constituency or class by which they were elected. This may include, but is not restricted to, the reasons for ceasing to be a member identified in Annex 9;

6.11 they are a Member of Council appointed by a partnership organisation and they cease to be sponsored by their partnership organisation;

6.12 they are a member of the Patient and Public Involvement Forum relating to this Foundation Trust or anybody succeeding it in this role;

6.13 they fail to or indicate that they are unwilling to act in the best interests of the Trust and in accordance with The Seven Principles of Public Life laid out by the Committee on Standards in Public Life in its First Report as amended from time to time;

6.14 they fail to agree (or, having agreed, fail) to abide by the values of the Trust set out in Annex 10.

7 A member of the Council of Governors shall immediately cease to be so if:

7.1 they resign in writing to the secretary;

7.2 they fail to attend at least half of the meetings of the Council of Governors in any financial year, unless the majority of the Council of Governors are satisfied that;

7.1 their absences were due to reasonable causes, and

7.2 they will be able to start attending meetings of the Council of Governors again within such a period as the majority of Members of the Council of Governors consider reasonable.

7.3 if any of the provisions in paragraph 6 above apply.

7.4 without good reason they fail to undertake any training

which the Council of Governors requires all members of the Council of Governors to undertake.

8. Members of the Council of Governors from elected staff who are subject to on-going formal disciplinary action in respect of their employment or engagement with the Trust, will be suspended from their membership of the Council of Governors pending the outcome of disciplinary action.

9. A Member of the Council of Governors may be removed from the Council of Governors by a resolution approved by not less than two-thirds of the remaining members of the Council of Governors present and voting at a general meeting of the Council of Governors on the grounds that:

   9.1 they have committed a serious breach of the Trust Principles set out in Annex 10, or

   9.2 they have acted in a manner detrimental to the interests of the trust, and

   9.3 the Council of Governors consider that it is not in the best interests of the trust for them to continue as a member of the Council of Governors.

10. Where a vacancy arises from any reason (other than expiry of term of office) amongst the appointed member of the Council of Governors the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

11. Vacancies amongst the elected members of the Council of Governors will be dealt with under paragraph 9 of Annex 9.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 18)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Standing Orders
Council of Governors

CONTENTS

1. INTRODUCTION

1.1 Statutory Framework

1.1.1 The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act").

1.1.2 The principal places of business of the Trust is:

- The Royal Orthopaedic Hospital, Bristol Road South, Northfield, Birmingham B31 2AP.

1.1.3 NHS Foundation Trusts are governed by, the 2006 Act as amended by the 2012 Act, their constitutions and their NHS provider licences issued by Monitor (Regulatory Framework).

1.1.4 The functions of the Trust are conferred by the Regulatory Framework. As a body corporate it has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.1.5 The Regulatory Framework requires the Council of Governors to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Company Secretary).

2.2 Any expression to which a meaning is given in the 2006 Act (as amended by the Health and Social Care Act 2012 Act) or in the Regulations or Orders made under the 2006 Act shall have the same meaning in the interpretation and in addition:

"**TRUST**" means the Royal Orthopaedic Hospital NHS Foundation Trust.

"**COUNCIL OF GOVERNORS**" means the Council of Governors of the Trust as defined in the Constitution.

"**BOARD OF DIRECTORS**" means the Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.

"**CHAIRMAN OF THE BOARD**" or "Chairman of the Trust" is the person appointed by the Council of Governors to lead the Board of Directors and

to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions “the Chairman of the Board” and “the Chairman of the Trust” shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is so otherwise unavailable.

“**CHIEF EXECUTIVE**” means the chief executive officer of the Trust.

“**COMMITTEE**” means a committee of the Council of Governors

“**CONSTITUTION**” means the constitution of the Trust.

“**COMMITTEE MEMBERS**” means the Chairman and the Members of Council or Directors formally appointed by the Council of Governors or Board of Directors to sit on or to chair specific committees.

“**EXECUTIVE DIRECTOR**” means a Member of the Board of Directors who holds an executive office of the Trust.

“**FT CODE OF GOVERNANCE**” means the NHS Foundation Trust Code of Governance issued by Monitor from time to time.

“**LEAD GOVERNOR**” means a Member of the Council elected by the Council of Governors to hold that office for a term determined by the Council of Governors who may also be removed from office by a resolution of the Council of Governors.

“**MEMBER OF THE COUNCIL**” means a Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the Chairman).

“**MONITOR**” means the body corporate known AS Monitor, as provided by Section 61 of the 2012 Act.

“**NON-EXECUTIVE DIRECTOR**” means a member of the Board of Directors who does not hold an executive office with the Trust.

“**OFFICER**” means employee of the Trust or any other person holding a paid appointment or office with the Trust.

“**SOs**” means these Standing Orders.

“**SCHEME OF DELEGATION**” means the schedule of matters reserved to the Board of Directors and the Delegation of Powers, as approved by the Board of Directors and reviewed from time to time.

“**SECRETARY TO THE TRUST**” means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board Governors and the Chairman and monitor the Trust’s compliance with the Regulatory Framework and these standing orders.

"**VICE CHAIRMAN**" means the Non-Executive Director appointed from amongst the Non-Executive Directors as Vice Chairman by the Council of Governors to take on the Chairman's duties in his capacity as chairman of the Council of Governors if the Chairman is absent for any reason.

"**CLEAR DAYS**" means in any period the duration of which is determined by a starting and finishing event, all complete days in that period excluding the day when the event referred to as starting the period occurs (for example sending out an Agenda) and the day on which the event referred to as ending the period occurs (for example the date of the meeting). For the avoidance of doubt clear days include weekends and public holidays. As an example an Agenda sent out on a Friday for a meeting on a Wednesday represents four clear days: Friday and Wednesday are excluded so that Saturday, Sunday, Monday and Tuesday are the four clear days.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council of Governors

3.1.1 In accordance with the Constitution of the Foundation Trust, the composition of the Council of Governors after the Effective Date shall be:

- 9 Public representatives
- 4 Staff representatives
- 5 nominated representatives comprising
- 1 University of Birmingham representative
- 1 Birmingham City University representative
- 1 Birmingham City Council representative
- 1 Member of Parliament representative
- 1 representative of Bournville Village Trust

3.2 Role of the Chairman

3.2.1 The Chairman is not a member of the Council of Governors. However under the Regulatory Framework, he/she presides at meetings of the Council of Governors and has a casting vote.

3.2.2 Where the Chairman of the Trust has died or has ceased to hold office, or where he/she has been unable to perform his/her duties as Chairman owing to illness or any other cause, the Vice Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his/her duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include references to the Vice Chairman.

3.3 **Role and Responsibilities of the Council of Governors**

3.3.1 The role and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust Constitution, are:

- To appoint or remove the Chairman and other Non-Executive Directors of the Foundation Trust at a members' general meeting (except for the initial Chairman and Non-Executive Directors)
- To approve (by a majority of members of the Council of Governors) the appointment by the Non-Executive Directors of the Chief Executive (except for the initial Chief Executive)
- To appoint or remove the auditor at a general meeting of the Council of Governors.
- To be consulted by the Trust's Board of Directors on forward plans and to have the Council of Governors' views taken into account
- To be presented with at a general meeting of the Council of Governors, the Annual Report and Accounts and the report of the Trust's auditor

3.3.2 The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its Directors. The Council of Governors does not have the right to veto decisions made by the Board of Directors.

3.3.3 The Council of Governors, and individual Members of Council, are not empowered to speak on behalf of the Trust, and must seek the advice and views of the Chairman concerning any contact from the media or any invitation to speak publicly about the Trust or their role within it.

4. **MEETINGS OF THE COUNCIL**

4.1 **Admission of the Public**

4.1.1 The public shall be afforded facilities to attend all formal meetings of the Council of Governors except where the Council resolves:

(a) That members of the public be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public; and/or

(b) That in the interests of the public order the meeting adjourn for a period to be specified in such resolution to enable the Council to complete business without the presence of the public.

4.1.2 Nothing in these Standing Orders shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

4.2 **Calling Meetings**

4.2.1 Ordinary meetings of the Council shall be held at such times and places

as the Council may determine and there shall be not less than 3 or more than 4 formal meetings in any year except in exceptional circumstances.

4.2.2 The Chairman of the Foundation Trust may call a meeting of the Council at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of Members of the Council, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at Trust's Headquarters, such one third or more Members of the Council may forthwith call a meeting.

4.3 **Notice of Meetings**

4.3.1 Before each meeting of the Council, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his/her behalf shall be delivered to every Member of the Council, or sent by post to the usual place of residence of such Member of the Council, so as to be available to him at least three Clear Days before the meeting.

4.3.2 Want of service of the notice on any Member of the Council shall not affect the validity of a meeting.

4.3.3 In the case of a meeting called by Members of the Council in default of the Chairman, the notice shall be signed by those Members of the Council and no business shall be transacted at the meeting other than specified in the notice.

4.3.4 Agendas will be sent to Members of the Council before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three Clear Days before the meeting, save in emergency. Failure to despatch the agenda and supporting papers within the above timescales shall not affect the validity of a meeting unless the consequences of such failure were to reduce attendance at the meeting below a level at which the meeting was quorate.

4.3.5 Before each meeting of the Council a public notice of the time and place of the meeting shall be displayed at the Trust's offices and on the Trust's website and the public part of the agenda shall be displayed on the Trust's website at least three Clear Days before the meeting, save in the case of emergencies.

4.4 **Setting the agenda**

4.4.1 The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2 A Member of the Council desiring a matter to be included on an agenda

shall make his/her request in writing to the Chairman at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5 **Petitions**

4.5.1 Where a petition has been received by the Trust, the Chairman of the Council shall include the petition as an item for the agenda of the next Council meeting.

4.6 **Chairman of Meeting**

4.6.1 At any meeting of the Council, the Chairman of the Trust, if present, shall preside, unless he/she has a conflict of interest. If the Chairman is absent from the meeting or has a conflict of interest the Vice Chairman, if he/she is present, shall preside, unless he/she also has a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

4.7 **Notices of Motion**

4.7.1 A Member of the Council desiring to move or amend a motion shall send a written notice thereof at least 10 Clear Days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

4.8 **Withdrawal of Motion or Amendments**

4.8.1 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.9 **Motion to Rescind a Resolution**

4.9.1 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding

six calendar months shall bear the signature of the Member of the Council who gives it and also the signature of four other Council Members. When any such motion has been disposed of by the Council, it shall not be competent for any member other that the Chairman to propose a motion to the same effect within six months, however the Chairman may do so if he/she considers it appropriate.

4.10 **Motions**

4.10.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.10.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Council to move:

- An amendment to the motion
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business(*)
- The appointment of an adhoc committee to deal with a specific item of business
- That the motion be now put.(*)
- A motion resolving to exclude the public under SO4.1.1.

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Member of the Council who has not previously taken part in debate and who is eligible to vote.

No amendment to the motion shall be admitted, if in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.11 **Chairman's Ruling**

4.11.1 Statements of Members of the Council made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.12 **Voting**

4.12.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Members of the Council present and voting on the question and, in the case of number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

4.12.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Council present so request.

4.12.3 If at least one-third of the Members of the Council present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Council present voted or abstained.

4.12.4 If a Member of the Council so requests, his/her vote shall be recorded by name upon any vote (other than paper ballot).

4.12.5 In no circumstances may an absent Member of the Council vote by proxy. A Member of the Council may only vote if present at the time of the vote on which the question is to be decided. A Member of the Council is considered to be present at a meeting in the circumstances outlined in Standing Orders 4.13 below.

4.13 Any Governor or member of a committee of the council of Governors may participate in a meeting of the council of Governors or such Committee by conference, telephone, computer or video link whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence, in person at such meeting and in the event of a vote count toward that vote..

4.14 **Minutes**

4.14.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

4.14.3 Minutes shall be circulated in accordance with the members' wishes.

4.15 **Suspension of Standing Orders**

4.15.1 Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, including one public Member of Council and that a majority of those present vote in favour of suspension.

4.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Members of the Council.

4.15.4 No formal business may be transacted while Standing Orders are suspended.

4.16 **Variation and Amendment of Standing Orders**

4.16.1 These Standing Orders shall be amended only if the variation proposed does not contravene the Regulatory Framework any statutory provisions, guidance or best practice advice issued by Monitor and is approved in accordance with paragraph 45 of the Trust's Constitution .

4.17 **Record of Attendance**

4.17.1 The names of the Chairman and Members of the Council present at the meeting shall be recorded in the minutes.

4.18 **Quorum**

4.18.1 No business shall be transacted at a meeting unless at least six Members of Council are present of which at least two are public Members of Council.

4.18.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned at the discretion of the Chairman and the Trust Secretary shall give or shall procure the giving of notice to all Members of the Council of the date, time and place of the adjourned meeting. Notwithstanding Standing Order 4.18.1 above, upon convening, those present shall constitute a quorum.

4.18.3 If a Member of the Council has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6, 7 or 8) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. **COMMITTEES**

5.1 Subject to the Regulatory Framework, the Council may appoint committees of the Council to assist the Council in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly of the Chairman and Members of the Council of Governors.

5.2 A committee appointed under this regulation may, subject to any restriction imposed by the Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees

established by the Council. In which case the term “Chairman” is to be read as a reference to the Chairman of the Committee as the context permits, and the term “Member of the Council” is to be read as a reference to a member of the committee also as the context permits.

5.4 Subject to Standing Order 5.5, each sub-committee shall have such terms of reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance for Governors issued by Monitor. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Council may not delegate any decision-making or executive powers to any committee or sub-committee.

5.6 The Council shall approve the appointments to each of the committees which it has formally constituted.

5.7 The committees and sub-committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

5.8 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

5.9 A Governor or a member of a committee shall not disclose any matter reported to the Council or otherwise dealt with by the committee notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

5.10 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of members of the Council of Governors attending the meeting.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.2 Declaration of Interests

6.2.1 The Regulatory Framework requires Council Members to declare interests which are relevant and material to the Council of which they are a Member. All existing Council Members should declare such interests. Any Council Members appointed subsequently should do so on appointment.

6.2.2 Interests which should be regarded as “relevant and material” are defined in the Trust’s Constitution as follows:

any pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors.

6.2.3 At the time Council members' interests are declared, they should be recorded in the Council minutes. Any changes in interests should be declared at the next Council meeting following the change occurring.

6.2.4 Council members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.2.5 During the course of a Council Meeting, if a conflict of interest is established, the Member of the Council concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.2.6 There is no requirement for the interests of Council members' spouses or partners to be declared. However Standing Order 7, which is based on the regulations, requires that the interests of Members of the Council's spouses, if living together, in contracts should be declared. Therefore the interests of Council Members' spouses and cohabiting partners should also be regarded as relevant.

6.2.7 If Council members have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3 **Register of Interests**

6.3.1 The Company Secretary to the Trust will ensure that a Register of Interests is established to record formally declarations of interests of Council Members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by Council Members, as defined in Standing Order 6.1.2.

6.3.2 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared will be incorporated.

6.3.3 The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.3.4 In establishing, maintaining, updating and publicising the Register, the Trust shall comply with the Regulatory Framework.

7. DISABILITY OF CHAIR AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chairman or another Member of the Council has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council may exclude the Chairman (or Member of the Council) from a meeting of the Council while any contract, proposed contract or other matter in which he/she has pecuniary interest, is under consideration.

7.3 For the purpose of this Standing Order the Chairman or Member of the Council shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she, is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.4 The Chairman or a member of the Council shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in a company, body or person with which he/she is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Member of the Council in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Member of Council:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

7.6 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Council and applies to a Member of the Council of any such committee or sub-committee as it applies to a Member of the Council.

8. STANDARDS OF BUSINESS CONDUCT POLICY

Members of Council should comply with the Trust Constitution, the NHS principles of conduct, the NHS Foundation Trust Code of Governance, published by Monitor, the requirements of the Regulatory Framework, and any guidance for Governors issued by Monitor.

8.1 Interest of Members of Council in Contracts

8.1.1 If it comes to the knowledge of a Member of Council that a contract in which he/she has any pecuniary interest not being a contract to which he/she is a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Company Secretary of the Trust of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.1.2 A Member of Council should also declare to the Company Secretary of the Trust any other employment or business or other relationship of his/hers, or of cohabitating spouse, which might reasonably be predicted could conflict with the interests of the Corporation.

8.2 Canvassing of and recommendations by Members of the Council in Relation to Appointments

8.2.1 Canvassing of Members of Council of the Trust or of any Committee of

the Council of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment.

8.2.2 A Member of the Council shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Member of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.2.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.3 **Relatives of Members of the Council or Officers**

8.3.1 Candidates for any staff appointment under the Trust, shall when making application, disclose in writing to the Trust whether they are related to any Member of the Board of Directors or Council of Governors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.3.2 The Chairman and every Member of the Council and officer of the Trust shall disclose to the Chief Executive any relationship between him/herself and a candidate of whose candidature that Member of the Council or Officer is aware.

8.3.3 On appointment, Members of the Council (and prior to acceptance of an appointment in the case of officer members) should disclose to the Council whether they are related to any other Member of the Council or holder of any office in the Trust.

8.3.4 Where the relationship to a Member of the Council of the Trust is disclosed, the Standing Order headed Disability of Chairman and Members of the Board in proceedings on account of pecuniary interest (SO 7) shall apply.

9. **MISCELLANEOUS**

9.1 **Interface between the Board of Directors and the Council of Governors**

9.1.1 The Board of Directors will co-operate with the Council of Governors in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:

(i) The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to Monitor.

(ii) The Directors are to present to the Council of Governors at a general meeting the annual accounts, any report of the Auditor on them, and the annual report. This requirement may be satisfied by at least one Executive Director being present at the relevant meeting to discharge these responsibilities

9.2 Standing Orders to be given to Members of the Council

9.2.1 It is the duty of the Secretary to the Trust to ensure that existing Members of the Council and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

9.3 Review of Standing Orders

9.3.1 Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 31)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Board of Directors

STANDING ORDERS

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, and subject to the Constitution at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Company Secretary to the Board of Directors, or in their absence the Chief Executive or Director of Finance

1.2 Any expression to which a meaning is given in the 2006 Act or in the Regulations and Orders made under the Act shall have the same meaning in these Standing Orders and Standing Financial Instructions, unless the context otherwise requires and in addition:

1.2.1 "**the 2006 Act**" is the National Health Service Act 2006 as amended by the 2012 Act.

1.2.2 "**the 2012 Act**" is the Health and Social Care Act 2012.

1.2.3 "**Accounting Officer**" means the person who from time to time discharges the Functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust it shall be the Chief Executive.

1.2.4 "**Board of Directors**" means the Board of Directors as constituted in accordance with the Constitution.

1.2.5 "**Chairman of the Board of Directors**" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions "the Chairman of the Board" and "the Chairman of the Trust" shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable. The Chairman is also the Chairman of the Council of Governors.

1.2.6 "**Chief Executive**" means the chief executive Officer of the Trust.

1.2.7 "**Clear Days**" means in any period the duration of which is determined by a starting and finishing event, all complete days in that period excluding the day when the event referred to as starting the period occurs (for example sending out an Agenda) and the day on which the event referred to as ending the period occurs (for example the date of the meeting). For the avoidance of doubt clear days include weekends and public holidays. As an example an Agenda sent out on a Friday for a meeting on a Wednesday represents four clear days: Friday and Wednesday are excluded so that Saturday, Sunday, Monday and Tuesday are the four clear days.

1.28 “**Clinical Governance** Committee" means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Trust has responsibility.

1.2.9 "**Committee**" means a formal committee or sub-committee created and appointed by the Board of Directors.

1.2.10 "**Committee members**" means members formally appointed by the Board of Directors to sit on or to chair specific committees.

1.2.11 “**Constitution**” means this constitution and all annexes to it.

1.2.12 " **Council of Governors**" means the Council of Governors of the Trust as constituted in accordance with Annex 4 of the Constitution.

1.2.13 "**Director of Finance**" means the chief financial officer of the Trust appointed to discharge the usual functions of its chief financial officer..

1.2.14 "**Executive Director**” means a member of the Board of Directors who holds an executive office of the Trust.

1.2.15 “**FT Code of Governance**” means the NHS Foundation Trust Code of Governance issued by Monitor from time to time.

1.2.16 “**Funds** held on trust” shall mean those funds which the Trust holds on incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under the Regulatory Framework. Such funds may or may not be charitable.

1.2.17 "**Member**" means Executive Director or Non-Executive Director of the Board of Directors as the context permits.

1.2.18 “**Monitor**” means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

1.2.19 “**Nominated Officer**" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.20 "**Non-Executive Director**" means a member of the Board of Directors who does not hold an executive office with the Trust and is appointed by the Council of Governors.

1.2.21 "**Staff**" means any employee of the Trust who is not a Director, or any other person who is the equivalent of an employee at the Trust and who in the discretion of senior management should be treated as an employee.

1.2.22 “**Regulatory Framework**” means the 2006 Act, the Trust’s NHS provider licence and the Trust’s constitution.

1.2.23 "**SFIs**" means Standing Financial Instructions approved by the Board of Directors and reviewed by it from time to time..

1.2.24 "**SOs**" means Standing Orders.

1.2.25 “**Scheme of Delegation**” means the schedule of matters reserved to the Board of Directors and the Delegation of Powers, as approved by the Board of Directors and reviewed from time to time.

1.2.26 "**Trust**" means the Royal Orthopaedic Hospital NHS Foundation Trust.

1.2.27 "**Trust Secretary**" means a person appointed by the Trust in accordance wtih the Constitution to be the Trust Secretary to act independently of the Board of Directors and the Council of Governors to provide advice relating to the governance of the Trust and monitor the Trust's compliance with the Regulatory Framework.

1.2.28 “**Vice Chairman**" means the Non-Executive Director appointed by the Council of Governors in general meeting from the Non- Executive Directors as Vice Chairman to take on the Chairman's duties in his capacity as Chairman if the Chairman is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

(1) The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the 2006 Act.

(2) The principal place of business of the Trust is Royal Orthopaedic Hospital NHS Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

(3) NHS Foundation Trusts are governed by the 2006 Act, their constitutions and their NHS provider licences issued by Monitor (the Regulatory Framework).

(4) The functions of the Trust are conferred by the Regulatory Framework.

(5) As a body corporate, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients property held by the Trust on behalf of patients

(6) The Regulatory Framework requires the Trust to adopt Standing Orders for the regulation of its proceedings and business.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

(8) The Scheme of Delegation and the Standing Financial Instructions provide a comprehensive business framework for the administration of the Trust's affairs and need to be read in conjunction with the Constitution. All Directors and Nominated Officers should be aware of the existence of these documents and where necessary familiar with the detailed provisions contained in them.

1.2 Monitor and the NHS Framework

(1) In addition to the statutory requirements, Monitor's provider licence requires the Trust to comply with best practice in the NHS.

(2) The Regulatory Framework requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board of Directors, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The framework also requires the establishment of audit and remuneration and nominations committees with formally agreed terms of reference.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers – Scheme of Delegation

The Trust has powers to delegate and make arrangements for delegation. Under SO5 (Arrangements for the Exercise of Trust Functions by Delegation) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Board of Directors of any of its functions by a committee of the Board of Directors or sub-committee appointed by virtue of SO 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit. Delegated Powers are covered in the Scheme of Delegation..

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERS AND TENURE

2.1 Composition of the Membership of the Board of Directors and principles for the appointment of members and role of the Nominations and Remuneration Committees

(1) In accordance with the Trust's constitution, the composition of the Board of Directors shall be:

(i) A non-executive Chairman who is also the Chairman of the Council of Governors;

(ii) Up to 7 Non-Executive Directors;

(iii) Up to 7 Executive Directors;

such that at least half the Board of Directors, (excluding the Chairman), shall be Non-Executive Directors.

(2) The Board will determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. Such factors will include whether the Director:

(i) has been an employee of the NHS Trust within the last five years;

(ii) has had within the last three years, a material business relationship with the Trust either directly, or as a partner shareholder, director or senior employee of a body that has such a relationship with the Trust;

(iii) has received or is receiving additional remuneration from the Trust apart from a director's fee, participates in the Trust's performance-related pay scheme, or is a member of the Trust's pension scheme;

(iv) has close family ties with any of the Trust's advisers, directors or senior

employees;

(v) holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;

(vi) has served on the board of the Trust for more than six years from the date of their first appointment.

(3) One of the Executive Directors shall be:

(i) the Chief Executive (whose appointment is to be approved by the Council of Governors except the initial Chief Executive);

(ii) the Director of Finance;

(iii) a Medical Practitioner

(iv) a Registered Nurse

(4) In consultation with the Council of Governors, the Board will appoint one of the Non-Executive Directors who is deemed by the Board of Directors to be independent by reference to FT Code of Governance to be the Senior Independent Director.. The term of office of the Senior Independent Director shall be specified by the Board of Directors on appointing him or her but shall not exceed the remainder of his or her term as a Non-Executive Director.

(5) The Senior Independent Director shall perform the role set out in the FT Code for senior independent directors and in SO10(2), and otherwise as summarised in a role description agreed between the Board of Directors and the Council of Governors which shall as a minimum include:

(i) providing a sounding board for the Chairman and serving as an intermediary for other Directors where necessary;

(ii) leading the Non-Executive Directors in the evaluation of the Chairman as part of process agreed with the Council of Governors;

(iii) Being available to governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Director of Finance has failed to resolve or for which such contact is inappropriate; and

(iv) Attending sufficient meetings with Governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of Governors.

The role description of the Senior Independent Director will be updated from time to time to reflect any changes to the role of Senior Independent

Governor in the FT Code from time to time.

2.2 Appointment, re-appointment and removal of the Chairman and Non-Executive Directors

As provided by paragraph 26 of the Constitution, the Council of Governors at a general meeting of the Council of Governors shall appoint, re-appoint or remove the Chairman of the Trust and the other Non-Executive Directors.

2.3 Remuneration and terms of office of the Chairman and Non-Executive Directors

(1) The Chairman and the Non-Executive Directors are to be appointed by the Council of Governors at a general meeting at which the Council of Governors shall decide (taking into account the views of the Council of Governors' Nominations and Remuneration Committee);

(i) the period of office;

(ii) the remuneration and allowances; and

(iii) the other terms and conditions of office of the Chairman and other Non-Executive Directors.

2.4 Appointment and removal of Chief Executive and other Executive Directors

(1) As provided by paragraph 29 of the Constitution, the Non-Executive Directors shall appoint or remove the Chief Executive, save that the appointment of the Chief Executive (other than the initial Chief Executive) shall require the approval of a majority of the Governors present and voting at a general meeting of the Council of Governors.

(2) The Nominations Committee of the Board of Directors shall appoint or remove the other Executive Directors

2.5 Remuneration and terms of office of the Chief Executive and the Executive Directors

(1) The Remuneration Committee of the Board shall decide:

(i) The period of office;
(ii) The remuneration and allowances; and
(iii) The other terms and conditions of office of the Chief Executive and other Executive Directors.

(2) The Trust may reimburse Directors' travelling and other costs and expenses incurred in carrying out their duties at rates determined by the Remuneration Committee of the Board above. These are to be disclosed in the annual report.

2.6 Appointment and Powers of Vice Chairman

(1) Subject to Standing Order 2.3(2) below, the Chairman and members of the Trust may appoint one of their number who is not also an Executive Director, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman. The Chairman and members may there upon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.3 (1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where he/she have been unable to perform his her duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case maybe; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

2.7 ROLE OF THE BOARD

2.7.1 Role of Members

(1) The Board is collectively responsible for the performance of the Trust. The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public.

(2) The Board of Directors will: .

(i) provide entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

(ii) be responsible for ensuring compliance by the Trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

(iii) develop and articulate a clear “vision” for the Trust which will be a formally agreed statement of the organisation’s purpose and intended outcomes which can be used as a basis for the organisation’s overall strategy, planning and other decisions.

(iv) set the Trust’s strategic aims at least annually taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the

NHS foundation trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.

(v) as a whole be responsible for ensuring the quality and safety of health care services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies.

(vi) ensure that the Trust functions effectively, efficiently and economically.

(vii) set the Trust's vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met

(3) All Directors:

(i) will take decisions objectively in the best interests of the Trust and avoid conflicts of interest.

(ii) have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.

(iii) have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

(4) Non-Executive Directors will scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They will satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. They are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing executive directors, and in succession planning.

2.7.2 Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and the Standing Financial Instructions and the Scheme of Delegation.

2.7.3 Chief Executive

The Chief Executive shall be responsible for the overall performance of

the executive functions of the Trust. They shall be the Accounting Officer for the Trust and shall be responsible to Monitor under the NHS Foundation Trust Accounting Officer Memorandum.

2.7.4 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7.5 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

2.7.6 Chairman

(1) The Chairman shall be responsible for the operation of the Board of Directors and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with their terms of appointment and with these Standing Orders.

(2) The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the debate and ultimate resolutions.

(3) The Chairman will also be the Chairman of the Council of Governors.

2.8 Corporate Approach to Trust Business

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.9 Schedule of Matters Reserved to the Board of Directors and Scheme of Delegation

The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall be read in conjunction with these Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Board Members

The Chairman will ensure that the designation of Lead roles or appointments of Board members as set out in any statutory or other guidance binding on the Trust will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may determine.

(2) The Chairman of the Trust may call a meeting of the Board of Directors at any time.

(3) One third or more members of the Board of Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forth with call a meeting.

(4) Ordinary meetings of the Board of Directors shall be held in public.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three Clear Days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any one member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

(5) Before each public meeting of the Board of Directors a notice of the time and

place of the meeting shall be displayed at the Trust's principal offices and on the Trust's website; and the public part of the agenda shall be displayed on the Trust's website at least three Clear Days before the meeting..

3.3 Agenda and Supporting Papers

The Agenda and supporting papers, will be sent to Members no later than three Clear Days before the meeting, save in emergency. Failure to despatch the agenda and supporting papers within the above timescales shall not affect the validity of a meeting unless the consequences of such failure were to reduce attendance at the meeting below a level at which the meeting was quorate.

3.4 Petitions

Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board of Directors wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

(2) The notice shall be delivered at least 10 Clear Days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

(i) Who may propose

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

(ii) **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board of Directors;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

(iii) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(iv) **Rights of reply to motions**

(a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(b) <u>Substantive/original motion</u>

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

(v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

(vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;

- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business (*);
- that the question should be now put (*);
- the appointment of an 'adhoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion resolving to exclude the public, including the press.

(*) In those cases where the motion is either that the meeting proceeds to the ‘next business’ or ‘that the question be now put’ in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who give sit and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Board of Directors it shall not be competent for any director other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive

3.9 Chairman of meeting

(1) At any meeting of the Board of Directors the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (if the Board of Directors has appointed one), if present, shall preside.

(2) If the Chairman and Vice-Chairman are absent, such member (who is not also an Executive Director of the Trust) as the members present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions)and their interpretation of the Standing Orders and Standing Financial Instructions ,at the meeting, shall be final.

3.11 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Members (including at least one Member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(2) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(3) If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, at the discretion of the Chairman the meeting shall stand adjourned and the Trust Secretary shall give or shall procure the giving of notice to all Members of the date, time and place of the adjourned meeting. Notwithstanding Standing Order 3.11(1) above, upon convening, those present shall constitute a quorum.

(4) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

(1) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.13 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote.

(2) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(3) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(4) If a member so requests, their vote shall be recorded by name.

(5) In no circumstances may an absent member vote by proxy. A Member may only vote if present at the time of the vote on which the question is to be decided. A Member is considered to be present at a meeting in the circumstances outlined in SO 3.16 below.

(6) A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

(7) A manager attending the Board of Directors meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or rules relating to the quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board of Directors are present (including at least one member who is an Executive Director of the Trust and one Non-Executive who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the decision to suspend Standing Orders shall be recorded in the Board's minutes.

(2) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

(3) Formal business can only be transacted while standing orders have been suspended with the written agreement of the Audit Committee.

(4) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall be amended only if the variation proposed does not contravene the Regulatory Framework any guidance or best practice advice issued by Monitor and is approved in accordance with paragraph 45 of the Trust's Constitution

3.15 Record of Attendance

(1) The names of the Chairman and Directors present at the meeting shall be recorded.

3.16 Participation in Meetings

(1) Any Director or Member of a Committee of the Board of Directors may participate in a meeting of the Board of Directors or such committee by telephone, computer or video link whereby all persons participating in the

meeting can hear each other participate in the meeting in this manner shall be deemed to constitute presence, to count towards a quorum and in the event of a vote count toward that vote.

(2) All decisions taken in good faith at a meeting of the Board of Directors or at any Committee of the Board shall be valid and shall not be invalidated even if it is discovered subsequently that there was a defect in the calling of the meeting, or by any vacancy of its membership or defect in a Director's appointment.

3.17 Minutes

(1) The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

(2) No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

3.18 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all public meetings of the Trust, but shall be required to withdraw upon the Board of Directors as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'-Guidance should be sought from the NHS Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

The Chairman (or Deputy-Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

- `That in the interests of public order the meeting adjourn for(the period to be specified)to enable the Board of Directors to complete

its business without the presence of the public'.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed' Items Taken in Private 'outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **(Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.19 Observers at Board of Directors meetings

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board of Directors' meetings and may change, alter or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

(1) Subject to the Regulatory Framework, the Board of Directors may appoint committees consisting of Directors.

(2) The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committees as the

context permits, and the term “member” is to be read as a reference to a member of other committees also as the context permits. (There is no requirement to hold meetings of committees established by the Board of Directors in public.)

4.3 Confidentiality

4.3.1 A Member of a Committee shall not disclose a matter dealt with, by, or brought before, the Committee without its permission until the Committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

4.3.2 A Director or a Member of a Committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or Committee shall resolve that it is confidential.

4.4 Terms of Reference

Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

4.6 Approval of Appointments to Committees

The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Regulatory Framework, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the relevant legislation.

4.8 Committees established by the Board of Directors

4.8.1 The committees and sub-committees established by the Board of Directors are:

(i) Remuneration Committee ;

(ii) Nominations Committee;

(iiii) Clinical Governance Committee; and

(iv) Audit Committee.

4.8.2 The constitution and terms of reference of Committees referred to in SO 4.8.1 shall be as set out in terms of reference to be agreed by the Board of Directors.

4.8.3 Other Committees

The Board of Directors may also establish such other committees as required to discharge the Trust's responsibilities

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 The Board of Directors may make arrangements for the exercise, on behalf of the Board of Directors, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 4,or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board of Directors has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board of Directors for noting.

5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by other committees or sub-committees, which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees, or sub-committees and their specific executive powers shall be approved by the Board of Directors.

5.4 Delegation to Nominated Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board of Directors. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance to provide information and advise the Board of Directors in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board of Directors as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall be read in conjunction with these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non- compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the Royal Orthopaedic Hospital NHS Foundation Trust. The

decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for the Royal Orthopaedic Hospital NHS Foundation Trust staff

- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;

- Human Rights Act 1998;

- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND STAFF UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to the Board of Directors

The Regulatory Framework requires members of the Board of Directors to declare interests which are relevant and material to the Board of Directors of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on

appointment. All interests should be “re-declared” at least annually

7.1.2 Interests which are relevant and material

(1) Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance and best practice advice issued by Monitor:

(i) Directorships, or equivalent held in private companies, public limited companies, (with the exception of those of dormant companies), NHS organisations, government departments, local authorities, charities or voluntary organisations. This includes positions of authority which are comparable to a director in a company, such as a trustee of a charity or voluntary organisation and partnerships (including membership of LLPs).

(ii) Subject to SO 7.3.(1) (iv) any pecuniary interest in a contract within the meaning of SO 7.3 (1) (iii) other than those pecuniary interests that are not regarded as such under SO7.3(1)(iv) (Exception to Pecuniary Interests).

(iii) Direct ownership or part-ownership of private companies, public limited companies, partnerships (including membership of LLPs) or sole trader businesses in the field of health and social care, for example pharmaceuticals, medical devices, and some consultancy or IT. For the avoidance of doubt interests held via pooled investments such as investment trusts, unit trusts and pension funds managed by an independent manager should be excluded under this heading.

(iv) Direct ownership or part-ownership of private companies, public limited companies , partnerships (including membership of LLPs) or sole trader businesses likely to do business with the Trust. For the avoidance of doubt interests held via pooled investments such as investment trusts, unit trusts and pension funds managed by an independent manager should be excluded under this heading.

(v) Any employment, volunteer position or fee generating relationship with an organisation in the field of health or social care.

(vi) Research funding/ grants that may be received by an individual or their employer or organisation of which they are a director to fund work that they are directly involved or which any private or public company, business or consultancy which is owned in whole or part by them is directly involved in.

(2) If any member of the Board of Directors comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member

should have declared their interest under 7.1.2 (1) (ii) but if they have not already done so, they should do so by giving notice in writing of such fact to the Trust as soon as practicable. In addition they should alert the Chairman of any such interest at the beginning of every Board meeting at which such contract is likely to be material to any Board discussion, notwithstanding that such interest has already been declared and recorded on the Register of Director's interests.

7.1.3 **Advice on Interests**

(1) If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Board of Directors or with the Trust's Company Secretary.

(2) Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

7.1.4 Recording of Interests in Board minutes

(1) At the time Board members' interests are declared, they should be recorded in the Board minutes.

(2) Any changes in interests should be declared at the next Board of Directors meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of declared interests in Annual Report

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of interest which arise during the course of a meeting

During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 **Register of Interests**

(1) The Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Board members. The Register shall include the names of each Director, whether he has declared any interests and, if so, the interests declared and details of the business of the organisations declared.

(2) These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding

twelve months will be incorporated.

(3) The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 **Exclusion of Chairman and Members in proceedings on account of Pecuniary Interest**

(1) Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest" subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

(a) they, or a nominee of theirs, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(b) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

(a) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or

(b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract, or

(c) those securities of any company in which they (or any person

connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one percent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph(c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the Board of Directors

(1) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contractor other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(2) The Board of Directors may exclude the Chairman or a member of the Board from a meeting of the Board of Directors while any contract, proposed contractor other matter in which they have a pecuniary interest is under consideration.

(3) Any remuneration, compensation or allowance payable to the Chairman or a Member in their capacity as Chairman or member of the Board of Directors as agreed by the Remuneration and Appointments Committee shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(4) This Standing Order applies to a committee or sub-committee as it applies to the Board.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and Guidance

Directors must comply with the Trust's Constitution, the requirements of the Regulatory Framework and any guidance and best practice advice issued by Monitor or any policies issued by the Trust.

7.4.2 Interests of Staff

(i) Any member of Staff of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the member of Staff shall declare their interest by giving notice in writing of such fact to the Company Secretary or Chief

Executive as soon as practicable.

(ii) Any member of Staff should also declare to the Company Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. This could include any significant opportunity for personal gain, financial or otherwise associated with the member of Staff's status as an member of Staff of the Trust and access to the Trust's resources, for example relating to IP, wider know how, brand and reputation.

(iii) The Trust will require interests, employment or relationships of members of Staff so declared to be entered in a register of interests of Staff. All declarations across the Trust should be "re-declared" at least annually. Trust management shall have discretion regarding which members of Staff or which staff groups are required to add an entry in the register of interests of Staff. For example management may decide that it is not a proportionate approach to risk management to require junior staff with no budgetary responsibility to add their entry to the register of interests of Staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

(i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust

7.4.4 Relationships of Directors or Officers

(i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Director or Officer of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(ii) The Chairman and every Executive and Non-Executive Director of the Trust shall disclose to the Board of Directors any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

(iii) On appointment, Non-Executive Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed "Disability of Chairman and members in proceedings on account of pecuniary interest" (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Company Secretary or a nominated manager by them in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 Register of Sealing

The Company Secretary shall keep a register in which they, or another manager of the Authority authorised by them, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

(1). The Board of Directors will co-operate with the Council of Governors in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:

(i) The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to Monitor.

(ii) The Directors are to present to the Council of Governors at a general meeting the annual accounts, any reports of the Auditor on them, and the annual report. This requirement may be satisfied by at least one Executive Director being present at the relevant meeting to discharge these responsibilities

10. COMMUNICATION AND CONFLICT

(1) These Standing Orders describe the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasizes the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

(2) Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides. The Senior Independent Director or Chairman will encourage informal methods of communication on behalf of the Board of Directors including: discussions between Governors and the Chairman, the Chief Executive or a Director, through the office of the Chief Executive or any other person appointed to perform the duties of the Chief Executive to the Board.

(3) Formal communications are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively. Communications initiated by the Council of Governors, and intended for the Board of Directors, will be conducted as follows:-

(i) Specific requests by the Council of Governors will be made through the Chairman, to the Board of Directors;

(ii) Any Governor has the right to raise specific issues at a duly constituted meeting of the Council of Governors through the Chairman. In the event of disagreement, two thirds of the Governors present must approve the request. The Chairman will raise the matter with the Board of Directors and provide the response to the Council of Governors.

(iii) Joint informal meetings will take place between the Council of Governors and the Board of Directors as and when necessary.

(4) The following formal methods of communication will also be used:-

(i) Provision of formal reports or presentations by Executive Directors to a meeting of the Council of Governors.

(ii) Reporting the views of the Council of Governors to the Board of Directors through the Chairman or Deputy Chairman.

(5) The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

(6) If through informal efforts the Chairman cannot achieve resolution of a disagreement or conflict, the Chairman will follow the dispute resolution procedure as described in Annex 9.

11 MISCELLANEOUS (see overlap with SFINo.21.3)

11.1 Standing Orders to be given to Board of Directors

It is the duty of the Company Secretary to the Trust to ensure that existing Board of Directors and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

11.2 Review of Standing Orders

Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph10.4)

1. Disqualification

1.1 A person may not become a:

1.1.1 member of the Trust if within the last five years they have been involved as a perpetrator in an incident of violence or abuse at any NHS hospitals or facilities;

1.1.2 against any NHS employees or other persons who exercise functions for the purposes of the NHS;

1.1.3 against registered volunteers;

1.1.4 against patients or the public on NHS premises.

2. Expulsion from membership of the Trust

2.1 A Member shall cease to be a Member if:

2.1.1 they resign by notice to the Company Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this Constitution;

2.1.4 they cease to be entitled under this Constitution to be a member of any of the Public Constituencies or of any of the classes of the Staff Constituency;

2.1.5 if after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a Member.

2.2 A Member may be expelled by a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors. The following procedure is to be adopted:

2.2.1 Any Member may complain to the Company Secretary that another Member has acted in away detrimental to the interests of the Trust, or is otherwise disqualified as set out in paragraph 2 above..

2.2.2 The Chair of the Council of Governors, assisted by the Company Secretary, will judge the manner in which the complaint should be managed.

2.2.3 If appropriate, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that the point of view of the Members involved is heard and may either:

2.2.3.1 dismiss the complaint and taken no further action; or

2.2.3.2 arrange for the complaint to be considered at the next meeting of the Council of Governors.

2.2.4 Details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the next meeting of the Council of Governors.

2.2.5 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

2.2.6 If the Member complained of fails to attend the meeting without reasonable cause the meeting may proceed in their absence.

2.2.7 The Council of Governors will take a view on the complaint and may decide to expel the Member from membership of the Foundation Trust. To effect expulsion from membership, the Council of Governors will adopt a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

2.2.8 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel the miscarried.

A member who is expelled may apply for re-admission to membership. This application is to be made in writing to the Chair, who will arrange for the application to be considered by the next meeting of the Council of Governors. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

3. Trust Secretary

3.1 The Trust may have a Trust Secretary, who shall be appointed and removed by the Chairman and Chief Executive acting jointly..

4. Indemnity

4.1 The Trust Secretary and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of

their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly and the Trust may also take out and maintain for their benefit insurance against such risks. Any costs arising in this way will be met by the Trust.

5. **Vacancies**

The validity of any act of the Trust is not affected by any vacancy among the Directors or the Members of Council or by any defect in the appointment of any Director or Member of Council.

6. **Directors**

6.1 If:

6.1.1 an Executive Director is temporarily unable to perform their duties due to illness or some other reason(the "Absent Director");and

6.1.2 the Board of Directors agree that it is inappropriate to terminate the Absent Director's term of office and appoint a replacement director; and

6.1.2 the Board of Directors agree that the duties of the Absent Director need to be carried out;

then the Chair (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting director as an additional director to carry out the Absent Director's duties temporarily.

6.2 For the purposes of paragraph 6.1 of this Annex, the maximum number of directors that may be appointed under paragraph 23 of the Constitution shall be relaxed accordingly.

6.3 The Acting director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint them under this paragraph notifies them that they are no longer to act as an Acting director.

6.4 An Acting director shall be an Executive Director for the purposes of the 2006 Act. They shall be responsible for their own acts and defaults and they shall not be deemed to be the agent of the Absent Director.

7. **Vacant Executive Director Positions**

7.1 If:

7.1.1 an Executive Director post is vacant ("Vacant Position");and

7.1.2 the Board of Directors agree that the Vacant Position needs to be

filled by an interim post holder pending appointment of a permanent post holder,

then the Chair (if the Vacant Position is the Chief Executive) or the Chief Executive (in any other case) may appoint a director as an interim director ("Interim Director") to fill the Vacant Position pending appointment of a permanent post holder.

7.2 The Interim Director will vacate office on the appointment of a permanent post holder or, if earlier, the date on which the persons entitled to appoint them under this paragraph notifies them that they no longer wish them to act as an Interim Director.

7.3 An Interim Director shall be an Executive Director for the purposes of the 2006 Act.

8. Vacant Council of Governor positions

8.1 When a vacancy arises for one or more elected Members of Council, the Council of Governors shall have the option:

8.1.1 to take from the list of members who stood for election at the most recent election of Members of Council for the class or constituency in question whichever member who was not elected as a Member of Council at the recent election but had secured the next most votes at that time. This procedure, which shall be an uncontested election for the purposes of the Model Rules for Elections as they apply to the trust, shall be available to the Members of Council on 2 occasions within 12 months of the previous election. Members of Council appointed in this way shall hold office for a minimum of 6 months from their appointment but, subject thereto, shall hold office until the earlier of the conclusion of the next election of Members of Council and (except where the vacancy arose through expiry of a term of office) the date on which would have expired the term of office of that Member of Council whose cessation of office gave rise to the vacancy;

8.1.2 to hold the post vacant until the next scheduled annual election of Members of Council; or

8.1.3 proceed to call an election for the vacant post.

ANNEX 10 – TRUST PRINCIPLES

Trust values

The Trust's values aim to create a culture of excellent patient care by ensuring all at the Trust:

- Respect and listen to everyone
- Have compassion for all
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Be open, honest and challenge ourselves to deliver the best
- Learn, innovate and improve to continually develop orthopaedic care

Members of Council

As to qualities of Members of Council:

- Honesty and integrity
- Demonstrates the Trust Values and is able to act and take decisions in accordance with the Trusts Equality and Diversity Policy and the Equality Act 2010 in particular to have due regard for factors in relation to the following protected characteristics as specified in the Equality Act of patients and staff:
- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.
- Representation of broad public constituency
- Awareness of community diversity and a willingness to be trained in that context

The Council of Governors may from time to time amend or vary such statement of principles as it thinks fit.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 24 September 2014 **ENCLOSURE NUMBER: 16**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Frances Kirkham** **Chair of Charitable Funds Committee**
SUBJECT:	**Charitable Funds Committee Update**

SUMMARY

To provide an update to the Board from the Chair of the Charitable Funds Committee

IMPLICATIONS

Provides assurance to the Board regarding the work of the Charitable Funds Committee

RECOMMENDATIONS

That the Board note this report

The Charitable Funds Committee met on the 15 September, matters to brief the Board are:

- Notwithstanding the general principle that creation of restricted charitable funds should be discouraged, it was agreed that a restricted fund be created to receive donations for the Staff League for the purpose of funding training for nurses.

- The standing orders need to be reviewed. Trustees are asked to comment by first week in October on the drafts which Paul and his team have prepared.

- We confirmed approval (previously given electronically) for expenditure on the following projects:
  (1) replacement doors for ADCU (completed at a cost of £10,262)
  (2) work to playroom (at a cost of £13,527)
  (3) a drug project with expenditure of just under £5,000.

- A request for funding for the purchase of bedside fans will be considered at a later meeting after further research has been undertaken.

- We discussed a request for funding for hand-held electronic devices to assist collection of data. We agreed the request in principle. Jo and Paul will consider the proposal in more detail and proceed with a pilot.

- We received a report of a project where funding was provided to purchase aquacel surgical dressings. The pilot was successful and it is likely that aquacel surgical dressing will be used more widely at ROH.

- Jo and Paul reported on proposals for the creation of an on-site research lab and other R&D possibilities for which charitable funding might be requested.

- The Staff League would be keen to support a major fund-raising event.

- We agreed to create a risk register. Trustees are asked to provide any comment to Paul.

- We also agreed to arrange for induction for new trustees and training for existing trustees.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enclosure 1

Minutes of the Trust Board Meeting
held in public on October 29th 2014 in the Boardroom

Present:
Trust Board
Dame Yve Buckland, Chairman
Mrs Jo Chambers, Chief Executive
Mr Jonathan Lofthouse, Director of Operations
Mr Paul Athey, Director of Finance
Mr Rod Anthony Non-Executive Director
Mr Tim Pile Non-Executive Director
HH Frances Kirkham, Non-Executive Director
Mrs Helen Shoker, Director of Nursing & Governance
Mr Andrew Pearson, Medical Director
Professor Tauny Southwood, Non-Executive Director

In attendance:
Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Julian Denney, (Interim Company Secretary)
Professor Phil Begg Director of Strategy and Transformation (Designate)
Mr Alan Last, Former Lead Governor
Ms Marion Betteridge, Public Governor
Ms Yvonne Scott, Public Governor
Mr Rob Talboys, Public Governor
Ms Karen Hughes, Staff Governor
Ms Marion Thompson, Appointed Governor

Apologies:
Ms Elizabeth Chignell, Non-Executive Director
Mr Roger Tillman Deputy Medical Director

Agenda No.	Agenda Item	ACTION
10/14/135	**Apologies and welcomes** Apologies were received from Elizabeth Chignell and Roger Tillman Luke Gibbin from Johnson and Johnson was welcomed as a member of the public	
10/14/136	**Declarations of Interest** Rod Anthony stated that he is acting as interim Director of	

	Finance of the Big Lottery Fund for c 3months It was noted that following a suggestion from Frances Kirkham, a "bible" of key documents was available for inspection including the Constitution and the registers of interest.	
10/14/137	**Minutes of the Trust Board meeting held on 24th September 2014** It was agreed that formal titles should be used in the list of those present , in attendance, and giving apologies **Resolved:** That with the above amendment the minutes of the above meeting be and are hereby approved as a true record.	
10/14/138	**Trust Board Action Points** The action notes were updated (see separate sheet):	

Action	Comment
03/14/44 Corporate Performance Report **(26.03.14)** FK asked that a report on paediatrics be given to a future meeting	Keep until November – then take off and build into Transformation Programme
05/14/88 Create Action Plan to address issues identified by the CGC	Still proceeding suggest review in November
07/14/93 The Board requested that a further discussion be held about the pre-operative pathway.	Will be brought back to the next full public Board meeting
07/14/98 The personal databases	Completed

	issue should be added to the risk register. The Medical Director agreed to resend his letter with a return copy to be returned signed by the individual clinician		
	07/14/100 Additional metrics relevant to patient concerns (e.g. waiting times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.	To be deferred to November	
	07/14/107B It was agreed that Tauny S should meet up with the key individuals carrying out the Research Stocktake.	Completed - close	
	07/14/108 It was noted that a number of suggestions had been made for further amendments to the Constitution	In progress – completion expected end October	
	09/14/121A FTN Conference: Elizabeth Chignell offered to attend and this was agreed and the CEO said that she would add her to the list.	Completed	
	09/14/121B	Completed	

	NEDs wished to know the dates of clinical audit meetings - . Roger Tillman agreed to ask Jane Jones to let all NEDs know the dates of the meetings.		
	09/14/124 The Board considers that, regarding the RTT backlog: •For adult patients the Trust should reallocate some theatre sessions to those clinicians with serious backlogs. This may also free up some clinicians to support the Transformation agenda •For paediatric patients the Trust should seek PICU beds from any realistic source; managing the consultant timetable will still be difficult even if these are found •The Board supports the Director for Operations in pressing the Commissioners to have a Clinical Senate debate where there are clear clinical risks for particular patients	On the agenda today	
	09/14/126 Regarding Safe Staffing an assessment will be made regarding how the level of incidents compares with other providers	To be deferred to November	

10/14/139	**Procedural Matters** Frances Kirkham and Tauny Southwood left the room for this item The Chairman reported that the Trust had previously asked Frances Kirkham and Tauny Southwood to continue to serve as Non-Executive Directors after January 2014. Due to an oversight on the Trust's part the Council of Governors did not make a formal approval of their appointment for a second term when their current term of office expired: on 31st January 2014 in the case of Tauny Southwood and 10th February 2014 in the case of Frances Kirkham. The Chairman further reported that both Tauny and Frances had nevertheless continued as if in office from that date to the current date and she thought that they had acted in complete good faith and had been doing an excellent job in an equivalent role to that of a Non-Executive Director. Members of the Council had agreed that had they been aware that Tauny's and Frances' terms of office had come to an end, they would have appointed them as non-Executive Directors at a general meeting of the Council prior to the expiry of their terms of office and they have formally appointed them for a second term of office at their meeting this morning. She noted that even if Tauny and Frances were excluded from the calculation of the Quorum of the Board since February 2014, all Board meetings since that time would have been quorate. She also noted however that the Tauny and Frances were members of the following Committees:	

	Remuneration& Nominations	CGC
FK	Member	Member
TS	Member	Chairman

	Frances Kirkham was also Chairman and Tauny Southwood a member, of the Charitable Funds Committee which is not a committee of the Board, but a committee of the ROH in its role as corporate trustee. The Trust considers that all business conducted at the above Committees was conducted properly and in good faith and hereby resolves to re-appoint Tauny and Frances to their respective roles on these committees (and in the case of the former Remuneration and Nominations Committee, its successor committees), to the maximum extent possible in law, as if they had been appointed prior to the expiry of the first term of office on 31st January 2014 in the case of Tauny Southwood and 10th February 2014 in the case of Frances Kirkham. However in order that there can be no doubt about the validity of business transacted and the legal effect of decisions taken at the above committee meetings between 1st February 2014 and the date of this Board meeting, the Board agrees that meetings of the following Committees will be convened immediately after this Board meeting to ratify the decisions taken during that period: Remuneration Committee Nominations Committee Clinical Governance Committee	
10/14/140	**<u>Appointment of Vice Chairman of the Trust Board</u>** Mr Tim Pile left the room for this item. The Chairman stated that Tim Pile has acted in the role of Vice Chairman on an informal basis and the purpose of the paper was to confirm his appointment formally. She also stated that Tim Pile has acted as Senior Independent Director. The appointment needs to be approved by both the Council of Governors and the Trust Board. **Resolved:**	

	The Trust Board hereby approves the appointment of Tim Pile as Vice Chairman of the Trust Board and Senior Independent Director	
10/14/141	**<u>Trust Board Committees</u>** The interim Company Secretary explained the rationale for the paper which proposed various changes in relation to the Trust Board's Committees in line with the latest revision to the Constitution, the Foundation Trust Code of Governance and the Trust's Strategy and the requirement to update the terms of reference of Committees on a regular basis. He drew Board members attention to the names of proposed Chairmen and Committee members as listed in Appendix 1. Points made in discussion: The appointment of Chairmen and Committee members as listed in Appendix 1 was approved with the following changes: • Frances Kirkham has not been a member of the Audit Committee in the past and will not be so in the future •The new NED is appointed by the Board to join the Audit Committee as soon as practicable after their appointment to the Board and the Board delegates to the Chairman of the Audit Committee and the Chairman of the Trust the authority to agree this date with the new NED and Elizabeth Chignell. •Elizabeth Chignell will continue to be a member of the Audit Committee until the new NED joins the Audit Committee •The changes associated with the appointment of the new NED will be confirmed by the Board as soon as the date is known •It was also agreed that all Committees should have the power to elect one of their members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman and their Terms of reference should be amended to reflect this. The membership of the Board's Committees is therefore as follows: 		Aud	Rem	Noms	CGC	Trans
---	---	---	---	---	---
YB		M	C		M
TP	M	M	M		C		

FK		M	M	M	
EC	M until new NED takes over	C	M	M	M
TS		M	M	C	
RA	C	M	M		M
New NED	M	M	M	M	M
CE			M	M	M
MD				M	M
DN				M	M
DF					M
DO					M

It was also noted that the old job title for the Director of Nursing and Governance had been used in the CGC TOR and that this would be corrected in the final version

Resolved:

The Trust Board hereby:

1. Agrees that all Committees should have the power to elect one of their members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman and their Terms of reference in the appendices 2a to 2e below should be amended to reflect this and subject to this change hereby:

2. Approves the replacement of the existing Nominations and Remuneration Committee with a Nominations Committee with terms of reference in Appendix 2a and a Remuneration Committee with terms of reference in Appendix 2b
2.Approves the abolition of the Investment Committee
3.Approves the creation of a new Transformation Committee with terms of reference in Appendix 2c
4.Approves the revised terms of reference of the Audit Committee as detailed in Appendix 2d
5.Approves the revised terms of reference of the Clinical Governance Committee as detailed in Appendix 2e subject to the change in wording referred to above

	and subject to the amendments in the "Points made in discussion" section and associated summary table above hereby approves the appointment of Chairmen and Committee members as listed in Appendix 1	
10/14/142	**<u>Chairman and NEDs' update including update on CQC inspection</u>** Dame Yve Buckland, Chairman invited the CEO to provide an update for the Board as follows: ***Update on CQC inspection*** •Overall the "Requires Improvement" recommendation is accepted. There were no substantive points raised that had not already been identified by the Trust. •Some of the most significant areas for improvement have already been discussed at the Board for example long waits in Outpatients. Some early work will be done, buying and using scheduling tools to create some early improvements while recognising that this activity is part of a long term improvement journey •There were some safety issues in HDU which the Trust challenged – nonetheless steps have been taken to strengthen the provision of equipment in HDU and the Trust is confident that the CQC concerns have been addressed •The Trust is inviting CQC to come back in 6 months for a limited scope inspection focusing on the services giving greater concern. This inspection creates the opportunity for those services to be rerated. •The Trust intends to push for some of the ground breaking surgical work to be recognised as outstanding over the longer term. •A Board agreed action plan will be created and submitted to CQC (this will be circulated to Board members by email circulation). The action plan will be shared with Audit Committee ***Strategy*** •There are a number of streams of work carrying on. These include defining priorities in more detail and sequencing those priorities based on dependencies between one activity and another and mapping existing activities to programme workstreams. The afternoon Board workshop will focus on this activity.	**HS**

	•Regarding governance of the programme a Committee of the Board chaired by Tim Pile will be set up to oversee the transformation. •Phil Begg has been appointed as director of strategy and transformation as the executive lead. ***Tariff*** PA reminded the Board that the Tariff Engagement Document published in August had stated that there was the potential for a c £5.5m (12%) potential loss in 2015/16 based on Monitors' tariff proposals. A great deal of work has been done with Monitor to influence the tariff discussions, in conjunction with the SOA and national Clinical reference groups including three face to face meetings with Monitor and NHS England. The original loss was made up of a 5% loss related to a reduction the overall national quantum of funding for orthopaedics, and a 7% loss linked to our specialist casemix. The Trust and the SOA have been successful in addressing the casemix issue. Monitor have acknowledged some of our concerns, and due to the short timescale available to make changes, they have reverted back to 2014/15 relativities at a HRG level. This avoids the 7% loss of casemix. Monitor have not made any overall changes to the quantum issue, but again have acknowledged our concerns. They also agreed they will commission an independent review of the orthopaedic tariff in advance of 2016/2017. For 2015/16, there will also be a smoothing adjustment associated with transition to the new quantum, so the Trust expects to only incur 1/5th of the total hit on the quantum change in the next financial year. A very positive aspect of this work was a great deal of joint work with the Consultant team Overall the predicted loss has been reduced from c 12% to c1-2% in 2015/2016 and the Board congratulated Paul and his team for this progress. ***Long Waiters*** JL provided an update as follows:	

	The ROH now has commissioners agreement to participate in the national scheme and a funded waiting list initiative Previous reference has been made to the backlog in long waiters and the negotiations with commissioners about clearing it. These negotiations have emphasised the impact on patients of long waits particularly those with the most complex needs. At a late stage the NHS England area team and commissioners agreed that the ROH could join the national scheme for c 210 patients in October and November; the ROH will receive c£1.4m and will have a target exemption while the backlog is being cleared. c 179 patients have been cleared to date and we are on track to clear the targeted backlog. The biggest challenge is spinal deformity because of the scarcity PICU resources and pressures on the BCH. Additional relationships are being developed with other trusts with PICU facilities. The potential to convene a clinical risk senate is being considered for January 2015. We are also helping neighbouring acute trusts from Walsall, Gwent and Hereford clear their backlogs. Capacity and demand planning tools have been purchased and will go live on November 10th. These should help optimise consultant workloads and support the achievement of the 18 week target. Governors have raised previously the importance of maintaining the patient experience while additional activity has been taking place. Private facilities are being used to support some of this work; it is currently being used only for NHS work pending the completion of the review of the private ward to ensure that it can be run profitably although it was noted that private demand is limited. Tim Pile volunteered to help develop the private ward business model.	

	The Board congratulated Jonathan and his team for this progress which had also been strongly supported by the Council. ***100000 Genome Project*** This project seeks to map the genomes of 100 000 people by 2017. The CEO reported on further progress on the Genome project and described a proposal for the ROH to participate in Wave 2 which the Board supported; it approved this proposal in principle and delegated the Chair and CEO the authority to complete it and submit it. It was also agreed that the draft proposal would be circulated to Board members. **Resolved:** That the above update be noted.	
10/14/143	**<u>Quarter 2 Declaration – July to September 2014</u>** The CEO introduced the Quarter 2 declaration and invited a discussion as follows : • This is a regular responsibility of the Board and forms part of a report to Monitor •It was agreed that recent administrative issues regarding NED appointments would be referred to in the Q2 declaration and the CEO intends to have an informal conversation with Monitor about these. **Resolved:** The Trust Board hereby approves the draft Quarter 2 Declaration and delegates to the Chair and CEO the authority to finalise it based on the above amendment and submit it to Monitor	
10/14/144	**<u>Approval of amendments to the Constitution/ Standing Orders</u>** The Chairman stated that the CEO had received a notice of a motion as required by the Standing Orders and it had been passed it to her by the CEO as follows: *I hereby give notice of a motion under Standing Order 3.5 as required by Standing Order 3.14, namely:*	

	That the Standing Orders of the Board of Directors be amended in such manner as will be detailed in the relevant Trust Board paper (including appendices) to be provided for the Board meeting later this month. *Thank you.* *Frances Kirkham* *Non-executive director* She reminded Members of the Board that the Trust Board had approved in principle various revisions to the standing orders of both the Council of Governors and Trust Board at its September 2014 meeting, as well as a number of more minor amendments to the rest of the Constitution. These changes were also approved in principle by the Council of Governors at their September 2014 meeting and these changes are reflected in the amended Constitution provided as Appendix 1. Since the meetings of the Council and Trust Board in September there have been further corrections relating to minor format and wording matters; Frances Kirkham, Non-Executive Director has provided oversight to this activity. These further corrections have also been reflected in the amended Constitution provided as Appendix 1 The Council of Governors approved the version provided as Appendix 1 in their meeting today (on October 29th 2014) with the expectation that there would be no further changes prior to approval by the Trust Board. Mills and Reeve, solicitors to the Trust, have advised that the changes referred to above must be approved by the Council of Governors and the Board of Directors but will not require the approval of members at an Annual Members Meeting since they are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust. Under the Health and Social Care Act 2012, Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act. Mills and Reeve have been responsible for final review of the amended constitution prior to the September meeting of the Board and Council and have assumed responsibility for	

	assuring the Trust of such compliance. **Resolved:** That the Trust Board hereby approves in principle the further amended Constitution provided at Appendix 1, including the revised Standing Orders, with the expectation of final approval at its November meeting and adoption immediately after that date. This was agreed by all present.	
10/14/145	**Any Other Business** **Dr Leon Vries** Dr Leon Vries sadly died recently. The CEO and Chair have written formally to pass their condolences on to Leon's family; staff close to him attended his funeral and a book of condolences is available.	
Date and Time of Next Trust Board Meeting 26 November 2014 8.30 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

SHORT PUBLIC TRUST BOARD MEETING
TO BE HELD
ON
WEDNESDAY 29 OCTOBER,
11.00AM IN THE BOARD ROOM

AGENDA

ITEM	TITLE	NOTES	BOARD ACTION	PAPER
10/14/135	**Apologies & Welcomes**		To Note	
10/14/136	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
10/14/137	**Minutes of Public Board Meeting held on the 24th September 2014** Chairman		For Approval	Enc. 1
10/14/138	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
10/14/139	**Procedural Matters** Chairman			
10/14/140	**Appointment of Vice Chairman** Chairman		For Approval	Enc. 3
10/14/141	**Trust Board Committees** Company Secretary		For Approval	Enc. 4
10/14/142	**Chairman & NED update including update on CQC inspection** Chairman & NEDs		For Information	
	Performance Management / Assurance Reports			
10/14/143	**Quarter 2 Declaration – July to September 2014** Chief Executive		For Approval	Enc.5
	Strategy			

10/14/144	**Approval of amendments to the Constitution/ Standing Orders including the following Notice** Dear Jo **Notice of motion to propose the amendment of Trust Board Standing Orders** I hereby give notice of a motion under Standing Order 3.5 as required by Standing Order 3.14, namely: *That the Standing Orders of the Board of Directors be amended in such manner as will be detailed in the relevant Trust Board paper (including appendices) to be provided for the Board meeting later this month.* Thank you. Frances Kirkham Non-executive director **Company Secretary**		For Approval	Enc.6
10/14/145	**Any Other Business**			
	Date of Next Meeting: Wednesday 26 November 2014 at 8.30 a.m			

Confidential Matters

To resolve:

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

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.14 Variation and amendment of Standing Orders

The Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.16 has been given; and
- no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
- at least two-thirds of the Board members are present; and
- the variation proposed does not contravene the requirements of Monitor.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

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Enclosure 1

Minutes of the Trust Board Meeting
held in public on September 24th 2014 in the Boardroom

Present:
Trust Board
Dame Yve Buckland, Chairman
Mrs Jo Chambers, Chief Executive
Mr Jonathan Lofthouse, Director of Operations
Mr Paul Athey, Director of Finance
Mr Rod Anthony Non-Executive Director
Mr Tim Pile Non-Executive Director
Ms Elizabeth Chignell, Non-Executive Director
Mrs Frances Kirkham, Non-Executive Director

In attendance:
Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Julian Denney, (Interim Company Secretary)
Mr Roger Tillman Deputy Medical Director
Phil Begg Director of Strategy and Transformation (Designate)
Ed Davis Director of Research
Ms Lisa Pim Deputy Director of Nursing & Governance

Apologies:
Mrs Helen Shoker, Director of Nursing & Governance
Mr Andrew Pearson, Medical Director
Professor Tauny Southwood, Non-Executive Director

Agenda No.	Agenda Item	ACTION
09/14/115	**Apologies and welcomes** Apologies were received from Helen Shoker, Andrew Pearson and Tauny Southwood The Chairman welcomed Jonathan Lofthouse to the Board and congratulated him on his appointment as Director of Operations. She also thanked Amanda Markall who had been the previous Director of Operations and passed on the Board's best wishes for the future She also welcomed Phil Begg Director of Strategy and Transformation who will be taking up appointment at the Trust in November , Ed Davis Director of Research and Ms Lisa Pim Deputy Director of Nursing & Governance The Chairman noted that it was intended to recruit another NED with a clinical background.	

<table>
<tr><td>09/14/116</td><td><u>Declarations of Interest</u>
Jonathan Lofthouse declared an interest stating that he was the sole owner and director of the consultancy company Healthy Delivery Limited. Through this limited company he currently has his partner as one of his company's employees working within the KMPG UK Health Audit division as a clinical advisor to both KPMG and Monitor.</td><td></td></tr>
<tr><td>09/14/117</td><td><u>Patient Case – an illustration of the work we do</u>

•It was agreed to defer the patient case to the next full public meeting.</td><td></td></tr>
<tr><td>09/14/118</td><td><u>Minutes of the Trust Board meeting held on 30th July 2014</u>

It was noted that the spelling of Elizabeth Chignell's surname would be corrected.

Resolved:
That with the above correction the minutes of the above meeting be and are hereby approved as a true record.</td><td></td></tr>
<tr><td>09/14/119</td><td><u>Trust Board Action Points</u>
The action notes were updated (see separate sheet):

<table>
<tr><td>Action</td><td>Comment</td></tr>
<tr><td>03/14/44 Corporate Performance Report

(26.03.14)</td><td></td></tr>
<tr><td>05/14/78</td><td>Being handled at Oct 1 Board workshop – take off</td></tr>
<tr><td>05/14/83</td><td></td></tr>
<tr><td>05/14/88</td><td></td></tr>
<tr><td>07/14/93</td><td>Will be brought back to the next full public Board meeting</td></tr>
<tr><td>07/14/98</td><td></td></tr>
<tr><td>07/14/100</td><td></td></tr>
<tr><td>07/14/102</td><td>Being handled at Oct 1 Board workshop – take off</td></tr>
<tr><td>07/14/103</td><td>Completed : AC confirmed that when calculating the FFT results using the approach used in the commercial sectors,</td></tr>
</table></td><td></td></tr>
</table>

		90% of staff recommend the Trust as a place to receive care and treatment and 64% of staff would recommend the Trust as a place to work	
	07/14/106	Completed – feedback given later in the meeting today	
	07/14/107A	Completed	
	07/14/107B		
	07/14/107C	Completed. Paper prepared for the Governors meeting taking place today. Agendas and minutes are being sent to the Governors.	
	07/14/108	In progress – completion expected end October	
09/14/120	**Procedural Matters** Mr Rod Anthony left the room for this item. ***Ratification of Appointment of Rod Anthony as Non-Executive Director and Chair of the Audit Committee*** The Chairman reported that, due to a misunderstanding on the Trust's part, the meeting of the Council of Governors of 23rd May 2014 at which the appointment of Rod Anthony as a non-executive director was approved was not quorate and that the Council was taking steps to rectify this position at its meeting a few hours after this Board meeting. She also noted that the meeting of the Audit Committee of July 8th 2014 at which Rod Anthony and Elizabeth Chignell were present was as a consequence also not quorate. The Trust considers that all business conducted at the Audit Committee of July 8th 2014 was conducted properly and in good faith. However in order that there can be no doubt about the validity of business transacted and the legal effect of decisions taken at the above committee meeting , the Board on behalf of the Audit Committee hereby: (a) ratifies retakes and approves the decisions taken at, and the business of, the above committee meeting. (b) re-adopts and approves the minutes of the above committee meeting as subsequently adopted and approved, and	

	(c) agrees that, to the maximum extent possible in law, the decisions taken at and business of the above meeting shall be treated as having taken effect at the date of the said meeting (d) ratifies the appointment of Mr Rod Anthony as Chair of the Audit Committee subject to the Council of Governors retaking and approving the decisions taken at its meeting of 23rd May 2014 at which the appointment of Rod Anthony as a non-executive director was approved ***Public Notice of Meetings*** The Interim Company Secretary reported that, notwithstanding advance publication on the Trust's website and elsewhere of the public meetings of the Board of Directors of the Trust, the Trust had been in breach of paragraph 3.2 (5) of Annex 8 in that notice of such meetings have not been displayed in advance at the Trust headquarters since the Trust became an NHS foundation trust. Given the advance publicity which was provided for all such meetings, the Interim Company Secretary reported that the Trust is not aware that the interests of any person have been adversely affected by the failure of the Trust to provide notice of the said meetings at the Trust Offices. He further reported that the Trust believes that business at the said meetings was conducted in good faith and properly. However in order that there can be no doubt about the legal effect of decisions taken at the said meetings, the Board of Directors hereby: (a) retakes and approves the decisions taken at each of the said meetings (b) re-adopts and approves the minutes of the said meetings as subsequently adopted and approved (c) and agrees that, to the maximum extent possible in law, the decisions shall be treated as having taken effect at the date of the said meetings	
09/14/121	**<u>Chairman and NEDs' update</u>** Dame Yve Buckland, Chairman updated the Board as follows: ***Paediatrics ward*** • She had been delighted to participate in the opening of the new Children's Ward. This had been an excellent day for the Trust's younger patients and the staff and had helped raise the profile of the organisation as a whole ***Walkabouts to the wards and theatres*** •The Chairman had spent a lot of time on Wards 2, 3 and 1.	

	Patient feedback was overwhelmingly very good. •There had been one complainant, a carer of a patient who wanted to go home more quickly. • She was now capturing helpful suggestions more formally to be passed to the Directors of Nursing and Operations for consideration and implementation. ***Chairman and NED objectives appraisals*** •The Chairman is working through these with the NEDS and has agreed her own objectives with Alan Last ***FTN Conference*** •The CEO and Chairman are already attending together with some other executive directors. Elizabeth Chignell offered to attend and this was agreed and the CEO said that she would add her to the list. ***Clinical audit meetings*** •NEDs wished to know the dates of clinical audit meetings - . Roger Tillman agreed to ask Jane Jones to let all NEDs know the dates of the meetings. **Resolved:** That the Chairman and NEDS update be noted.	**JC** **RT**
09/14/122	**<u>Chief Executive's Report</u>** Jo Chambers introduced her report and made a number of supplementary points as follows: **CQC Visit**– the CEO noted that the CQC had produced a final version of their inspection report which would be presented to the Quality Summit on Monday 29 September. This would be attended by representatives from the Trust and other organisations such as Commissioners and NHS England. NEDs were welcome to attend. The Trust had written to the CQC regarding some matters of factual accuracy. **Top 100 places to work** – the CEO was delighted that the Trust had been included in this list produced by the HSJ **Genomics Clinical Centre Application** - The CEO reported that the Trust had been invited to collaborate in a West Midlands proposal to participate in the UK's 100,000 Genomics Programme and this was an exciting opportunity for the Trust. The Trust's lead for the project will be Mr Ed Davis, Director of Research and Development. This is a good opportunity for the	

Trust to actively engage in a wider set of research activities and be part of a nationally important project. Bids were currently being assessed and it was thought there would be 3 – 5 centres in the UK.

ROH Charity – the CEO has had a further meeting with the Chairman of Trustees of the ROH Orthopaedic Charity, Mr John Wheatley who is keen to explore opportunities to work in partnership with the Trust to support the objects of the charity. She has been invited to the next meeting of the trustees in mid-November to talk about the Trust's new strategic plan and in particular its ambitions in relation to developing an integrated research, evaluation, education and innovation capability, and the ROH as a knowledge leader workstream.

EMT – In addition to the items noted in the CEO report, the Director of Finance reported on the following highlights from the meeting last week in which the EMT:

- Reviewed and supported a paper on next steps in embedding values driven behaviours
- Reviewed EMT held risks and escalated the tariff risk from amber to red and closed a risk around management of complex patients.
- Approved the budget setting and business planning timetable
- Approved a Stage 1 business case for a new referral management system: this is an early win for the IT strategy
- The CD for Spinal Services presented the spinal strategy; it was agreed to set up a working group to look at short term pressures (Long term issues needed to be addressed as part of the tariff question).
- Prepared a high level model for medical workforce which recommends the introduction of an on call registrar rota and a number of non-medical posts to cover some work currently covered by locums

Policy Documents-The CEO drew the Board's attention to two policy documents exploring:

- oSustainability in the NHS in the long term
- oThe Better Care Fund

There are substantial concerns re deficits across the FT sector and there are widespread concerns re RTT.

The Board considered that the Trust should consider scenario planning drawing on the FTN work to model the impact of different polices having regard to any restrictions that may be in place at this stage in the electoral cycle .

Resolved:

	That the CEO's report be noted.	
09/14/123	**<u>Director of Research Report</u>** Ed Davis thanked the Board for the invitation to present and for the important role research had been given in the Trust strategy. He gave a presentation – appended **Alison please append this** ***The Chairman invited comments as follows:*** ***The Trust's attractiveness as a research centre*** • The CEO commented on the opportunity to collaborate with the wider system e.g. via the Genomics project. Some of our studies have very small volumes but may be the only or leading site in the country. Ed Davis considered the Trust well placed to attract high research interest given the high volume of mainstream patients plus the Trust's position as the national leader for a number of specialist conditions. ***Measuring Success*** •Regarding how success is measured Ed Davis commented that measuring clinical impact is difficult for everyone: NIHR use the number of patients accrued to studies as a surrogate for clinical impact. •NIHR were changing their approach to measurement to place a greater emphasis on research quality and patient impact – with more emphasis on patient stories. •The patient story approach, while less formal was important in raising the perception of the Trust as a world leader in terms of the difference it makes for patients - for example the ROH can offer a number of treatment opportunities that other centres cannot e.g. drug treatment for osteoarthritis. The Trust needed to celebrate research successes more ***Broadening the research talent base*** •The Board considered it important to involve a broader based number of clinicians in research – a small number of key people at the moment are doing a lot of this work in their own time and this may not be sustainable. Research needs to be considered core business. It is essential for the executive team to support research becoming mainstream e.g. in the discussion of job plans; the strategy supports this approach •Work is being done to nurture young doctors who wish to do research and see the ROH as the centre of choice for orthopaedic research •The Trust should continue to encourage nurses and AHP to lead research	

	Other matters •The employment of full time grant writer has been very helpful is supporting grant applications •We will seek accreditation of the tissue bank at ROH to ensure we get full NIHR credit The Board passed on its thanks on to Ed Davis and the rest of the team: they had made a very great contribution to developing the profile of research at the Trust **Resolved:** That the Director of Research's report be noted	
09/14/124	**<u>Corporate Performance report</u> <u>including report on action to improve referral to treatment times</u>** ***RTT – report on actions to reduce the number of long waiters*** Johnathan Lofthouse presented his report and highlighted the following points: •Commissioners have rejected an earlier application by the ROH for financial and other support to clear the backlog ; this position has been confirmed following two further applications to them •The ROH is in a vulnerable position regarding the number of patients in backlog pathways both from the perspective of patients and the Trust's reputation. •A letter has been received from the CEOs of NHS England, Monitor and the TDA reaffirming national standards and appearing to permit 18 week failure in order to reduce back log, provided this failure is temporary •Paediatric spinal deformity is the most critical area and we only have facilities to treat one patient a week typically at the BCH •We are working with our clinicians to understand the status of all of our patients and how to respond appropriately if capacity becomes free including looking outside of the immediate area for PICU beds ***Points made in discussion:*** The Board considers that, regarding the RTT backlog: •For adult patients the Trust should reallocate some theatre sessions to those clinicians with serious backlogs. This may also free up some clinicians to support the Transformation agenda •For paediatric patients the Trust should seek PICU beds from	**JL**

	any realistic source; managing the consultant timetable will still be difficult even if these are found •The Board supports the Director for Operations in pressing the Commissioners to have a Clinical Senate debate where there are clear clinical risks for particular patients Paul Athey presented the remainder of the CPR highlighting the following points: •There is one red rated area around the 62 day wait for cancer patients. This is a single patient breach – a secondary referral from the Royal Liverpool for specialist care. This has been reviewed in detail – it is considered that the care given by the ROH was very appropriate •Financial performance for August was good but there are some strong financial pressures around locum and similar costs and theatre staffing (which we are working to alleviate via recruitment locally and internationally and for which there is a national shortage) •Average LOS is a key issue: we are focussing on understanding this better •Cancelled operations – the Trust is assessing if our benchmarks set at the right level – there have been considerable inroads to date. Avoidable cancellations have fallen considerably. •Falls – the persistent red rating may be associated with increased reporting of falls and some of the activity may also be linked to enhanced recovery and earlier mobilisation. Work is being done on patient education to reduce the risk of falls. The Chairman has received feedback regarding the design of the bathrooms being sub optimal – is possible that charitable funds. Could be used to reduce the risk of falls. Only one fall this year was associated with major harm. **Resolved:** That the Corporate Performance report be noted.	
09/14/125	**<u>The Patient Quality Report</u>** Lisa Pim introduced her report and highlighted the following : •SSI infections rates – very positive progress has been made to reduce these •One patient attempted suicide – he was transferred to the QE Hospital and has been discharged with no ill effects. A review indicated that the patient's care was appropriate and that his mental health issues had been considered adequately. •Work is being to explore the possibility of automating the WHO checklist and tighten up the procedures for its completion	

	Resolved: That the Patient Quality report be noted.	
09/14/126	**<u>Safe Staffing</u>** Lisa Pim introduced her report noting that the Trust responded to ensure patient safety regarding the incidents described in the report The Chair invited a discussion as follows : • An assessment will be made regarding how the level of incidents compares with other providers **Resolved:** That the Safe Staffing report be noted.	**HS/LP**
09/14/127	**<u>Board Assurance framework (BAF)</u>** Lisa Pim presented the BAF and the Chair invited a discussion as follows: • The tariff risk has been escalated and will be discussed later on this agenda •The strategic risks will be considered at the forthcoming Board workshop **Resolved:** That the Board Assurance Framework be noted.	
09/14/128	**<u>Update on Five Year Strategic Plan including update on the tariff</u>** ***Tariff reductions going forward*** The Director of Finance updated the Board on the current position: •There have been concerns raised with Monitor regarding the impact of the tariff ; we have reinforced these concerns via the Orthopaedic Alliance •There has been a more positive recent meeting with Monitor supported by colleagues from Robert Jones and Agnes Hunt NHS Foundation Trust and the Orthopaedic Alliance. Monitor have agreed to work towards a solution and accept that that their initial proposals had scope for further adjustment and welcomed the ROH and colleagues' contribution to this activity. •Monitor have suggested a number of approaches to transition between the current tariff and their recent proposals. •There is still considerable uncertainty regarding the likely end point of these discussions.	

	•The formal consultation output is due to be released on the 23rd of October **Key points raised in discussion:** • The Board supported the Director of Finance in seeking to find a satisfactory outcome to these negotiations. ***Transformation Agenda :*** Jo Chambers drew the Board's attention to the following supplementary points to her report which were endorsed by Tim Pile: •We continue to make progress on the Transformation programme including confirming Phil Begg as a substantive appointee and engaging Karen Yates as interim programme director in the meantime •Tim Pile has had constructive meetings with Karen Yates in scoping the programme including ensuring the inclusion of cross cutting themes; this will be used to update the model in the Board papers. •Phil Begg has been liaising with Karen Yates to steer the development of the programme even before he starts his contract with the ROH in November •The Trust must proceed at pace seeking quick wins as well as refining the structures and processes. **Resolved:** That the Board note the Strategy Update.	
09/14/129	**<u>Constitution/ Review of Standing Orders</u>** The Chairman introduced this item and noted that following the revision of the main body of the constitution in July, it was necessary to update the Standing Orders. In parallel the terms of reference of Board committees were being updated (and in the case of the new Transformation Committee drafted) and the membership of each committee was being reviewed. An update of this work would be given in October. The Interim Company Secretary presented his report which explained the reasons for a further update to the Constitution particularly around the need to update the Council of Governors' and Board of Directors' Standing Orders, which formed Annexes 7 and 8 respectively and highlighted the more important changes that were proposed. He noted that the Chairman, CEO, DoF and Chair of Audit had reviewed the latest proposed revisions in detail already. Frances Kirkham had also reviewed the proposed changes	

	and her suggestions will be considered in the final draft. He further noted that Mills and Reeve, solicitors to the Trust have advised that the amendments to the constitution to giving effect to the changes referred to in his the report paper must be approved by both the Council of Governors and the Board of Directors but do not also require the approval of members at an Annual General Meeting as they do not mean are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust Under the National Health Service Act 2006, ("the 2006 Act") Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act. Mills and Reeve have reviewed the draft revised constitution attached at Appendix 2 to the Interim Company Secretary's report and in their view the revised constitution complies with the 2006 Act and the requirements of Monitor. It was noted that the process for approving the revised constitution would be as follows: 1.Any further changes agreed at today's meeting would be incorporated in the final draft of the revised constitution which would be amended and re-circulated. 2.Council members would also be considering the proposed changes and any further changes proposed by them would be included in a final draft of the revised constitution. 3.The Council of Governors would be asked to approve the amended constitution at the meeting of the Council on October 29th 2014 4. The Board of Directors would be asked to approve the amended constitution at the meeting of the Board on October 29th 2014. **Resolved:** That the amendments to the revised Constitution be and are hereby approved in principle with the expectation that a final amended constitution would finally be approved by both the Council of Governors and the Board of Directors on 29th October 2014 and adopted on that date.	

09/14/130	**Audit Committee** Rod Anthony, Chair of the Audit Committee gave a verbal update as follows: • There has not been a Committee meeting since the last meeting •Deloitte have been appointed as external auditors •The Director of Operations will provide a further update around assurances from reporting systems and will be reporting to the Committee in November ; this has been subject to audit by Baker Tilly •The Director of Finance reported that in addition there have been audits undertaken regarding reference costs and the quality impact of CIPs; there are also a number of general financial audits planned for the next month **Resolved:** That the Board : •Note the update of the Audit Committee	
09/14/131	**Clinical Governance Committee** No report this Board meeting	
09/14/132	**Charitable Funds committee** Frances Kirkham gave a verbal update noting progress in raising the profile of the Charity and the availability of funds to support bids. **Resolved:** That the Board : •Note the update from the Chair of the Charitable Funds Committee.	
09/14/133	**Council of Governors** The Chairman gave a verbal update regarding the work of the Council of Governors. •Work is ongoing to strengthen governance , improve governor training and to look at different approaches to governor involvement **Resolved:** That the Board : •Note the Chairman's update regarding the work of the Council	

	of Governors.	
09/14/134	**<u>Any Other Business</u>** • Whistle blowing – the Trust continues to ensure that staff are encouraged to come forward where appropriate • Patient Access - the Trust is considering the whether anything can be do to improve patient access to the building • Publicity- The Board agreed to ensure that photographs updated for new members of the Board and that Tim Pile would be noted as the whistle blowing contact on the public photographs • Smoking on site - concerns to be referred to the Director of Operations and the Estates Committee	
<u>Date and Time of Next Trust Board Meeting</u> 29 October 2014 11.00-12.00 - short public Board meeting in the Board room. Note that it is important that at least two thirds of the Members of the Board are present at the next meeting for formal approval of changes to the Standing Orders. This will be followed by lunch, a private NEDs meeting and a Board workshop in the afternoon.		
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

Enclosure 2

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 24th September 2014

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
03/14/44 Corporate Performance Report (26.03.14)	FK asked that a report on paediatrics be given to a future meeting.	AM	Done	√	Completed but kept on register as a reminder re Strategy Development
05/14/88	Create Action Plan to address issues identified by the CGC	TS/AP/HS	September 24 2014		
07/14/93	The Board requested that a further discussion be held about the pre-operative pathway.	AM	November 26 2014		
07/14/98	The personal databases issue should be added to the risk register. The Medical Director agreed to resend his letter with a return copy to be returned signed by the individual clinician	AP	August 15 2014		
07/14/100	Additional metrics relevant to patient concerns (e.g. waiting times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.	HS	September 24 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
07/14/107	It was agreed that Tauny S should meet up with the key individuals carrying out the Research Stocktake.	TS	End August 2014		
07/14/108	It was noted that a number of suggestions had been made for further amendments to the Constitution and that the standing orders of both the Council of Governors and the Board of Directors were also being reviewed and that these potential additional changes would need to be considered as part of a further revision to the Constitution after the amended Constitution had been approved and adopted by the Board. Such further amendments to the Constitution would need to be approved by the Council of Governors and Board before the further amended Constitution could be adopted.	JD	End October 2014		
09/14/121	FTN Conference: Elizabeth Chignell offered to attend and this was agreed and the CEO said that she would add her	JC	Oct 1st 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	to the list.				
09/14/121	NEDs wished to know the dates of clinical audit meetings - . Roger Tillman agreed to ask Jane Jones to let all NEDs know the dates of the meetings.	RT	Oct 1st 2014		
09/14/124	The Board considers that, regarding the RTT backlog: •For adult patients the Trust should reallocate some theatre sessions to those clinicians with serious backlogs. This may also free up some clinicians to support the Transformation agenda •For paediatric patients the Trust should seek PICU beds from any realistic source; managing the consultant timetable will still be difficult even if these are found •The Board supports the Director for Operations in pressing the Commissioners to have a Clinical Senate debate where there are clear clinical risks for particular patients	JL	Dec 1st 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
09/14/126	Regarding Safe Staffing an assessment will be made regarding how the level of incidents compares with other providers	**HS/LP**	1st Nov 2014		

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 29th October 2014 **ENCLOSURE NUMBER:3**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Appointment of the Vice Chairman of the Trust Board**

The Vice Chairman of the Trust Board is the Non-Executive Director who takes on the Chairman's duties in their capacity as Chairman of the Council of Governors or Chairman of the Board if the Chairman is absent for any reason and is appointed by both the Council of Governors and the Trust Board.

Tim Pile has acted in the role of Vice Chairman on an informal basis and the purpose of this paper is to confirm his appointment formally.

IMPLICATIONS

RECOMMENDATION

The Board is asked to approve the appointment of Tim Pile as Vice Chairman.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 29 October 2014 **ENCLOSURE NUMBER: 4**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Trust Board Committees**

This paper proposes various changes in relation to the Trust Board's Committees in line with the latest revision to the Constitution, the Foundation Trust Code of Governance and the Trust's Strategy

IMPLICATIONS

The rationale for these proposals is explained in more detail in Appendix 1. In summary it is proposed to:

1. Replace the existing Nominations and Remuneration Committee with two separate Committees in line with usual practice and creating the flexibility to have a separate Chair for each
2. Abolish the Investment Committee whose functions are considered to be best met by ad hoc working groups , the Transformation Programme or individual executive director's responsibilities
3. Create a new Transformation Committee to oversee the work of the Transformation Programme – this activity is work in progress and draft TOR are included for the Board's review
4. Update the terms of reference of the Audit Committee in line with current guidance in the FT Code of Governance
5. Update the terms of reference of the Clinical Governance Committee to ensure that all members are members of the Board as required by the Constitution and NHS Act 2006 and to clarify requirements for quoracy

RECOMMENDATIONS

The Board is asked to:

1. Approve the replacement of the existing Nominations and Remuneration Committee with a Nominations Committee with terms of reference in Appendix 2a and a Remuneration Committee with terms of reference in Appendix 2b
2. Approve the abolition of the Investment Committee
3. Approve the creation of a new Transformation Committee and review the draft terms of reference in Appendix 2c
4. Approve the revised terms of reference of the Audit Committee as detailed in Appendix 2d
5. Approve the revised terms of reference of the Clinical Governance Committee as detailed in Appendix 2e
6. Approve or confirm the appointment of Chairmen and Committee members as listed in Appendix 1

Appendix 1

1. Background

The existing Board Committees have terms of reference which were last revised in 2013 and it is good practice for there to be a review of these terms annually particularly if there are significant changes in strategy or governance. In 2014 there were a number of changes affecting the Trust in this category for example:

- A revised Constitution , revised Standing Orders and update to the Code of Governance for Foundation Trusts provided by Monitor
- A new five year strategy for the Trust , including the recommendation that Transformation Activities be overseen by a Board Committee
- Changes in Board membership including a new Chairman, a new CEO and a new Chair of the Audit Committee.

In developing the proposals key individuals have been consulted within the Trust including the Chairman, CEO, Director of Finance and the Chairs of the Committees affected. Consideration has also been given the Foundation Trust Code of Governance and practice in other Foundation Trusts.

This paper makes reference to the Charitable Funds Committee separately because it is not a committee of the Board, but a committee of the ROH in its role as corporate trustee. Those serving on the CFC are acting as “agents” of the ROH and may and do include non-Board members.

The remainder of this paper summarises the rationale for each of the changes.

2. Nominations and Remuneration Committee

The existing Committee combines the functions traditionally associated with two separate Committees. While this has the merit of simplicity it has the disadvantage of merging two different groups which are traditionally chaired by different individuals:

- The Nomination Committee is typically chaired by the Chairman of the Trust. It is important the Chairman maintains a close oversight of the composition of the Board as a whole, including consideration of the optimal balance of skills and experience among both executive and non-executive directors and this is facilitated by their role on the Council of Governors and its own nominations and remuneration committee.
- The Remuneration Committee has a more specialist role which is usually chaired by one of the other non-executive directors.

It is recommended that the existing committee be split and three options were considered:

a. A combined Nominations Committee covering both executive and non-executive directors
b. Two Nominations Committees- one each for executive and non-executive directors
c. A Nominations Committee for executive directors only (the recommended option)

In both option (a) and (b) Governors are required to be members of two committees - the Council of Governors' Nominations and Remuneration committee and:

a. The combined Nominations Committee in Option (a)
b. The Nominations Committee for non-executive directors in Option (b)

Option (c) is recommended as it avoids the need for Governors to be members of two committees.

It should be noted Section B.2.1, B2.3 and B2.6 of the FT Code of Governance envisage that either Option (a) or (b) will be implemented. However these provisions are listed within the 'comply or explain' section of the Code and a variation from the NHS Foundation Trust Code of Governance is permitted provided the Trust can illustrate how its actual practices are consistent with the principle to which the particular provision relates (see paragraphs in italics below), and it is considered that the TOR of both the proposed Trust Board Nominations Committee for Executive Directors and the Council of Governors Nominations and Remuneration Committee for Non-Executive Directors satisfy these principles.

Extract from FT Code of Governance - B.2 Appointments to the board

Main principle
B.2.a There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence.

Supporting principles
B.2.b The search for candidates for the board of directors should be conducted, and appointments made, on merit, against objective criteria and with due regard for the benefits of diversity on the board and the requirements of the trust.
B.2.c The board of directors and the council of governors should also satisfy themselves that plans are in place for orderly

succession for appointments to the board, so as to maintain an appropriate balance of skills and experience within the NHS foundation trust and on the board.

3. Investment Committee –

The current objective of the Investment Committee is "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". While this function is important it is considered that is essentially the responsibility of the sponsoring executive director to provide such assurance. In those cases where non-executive director input is felt desirable before a Board meeting it should be possible to do this by an informal arrangement.

It is therefore recommended that the Investment Committee be abolished with immediate effect.

4. Transformation Committee

It is proposed that the Trust should establish a Transformation Committee as a Committee of the Board which will (with external advice as appropriate) be responsible for providing assurance to the Board with regards to progress on the delivery of the Trusts Transformation programme.

The Transformation Committee will use the Programme Management structure to ensure that plans are rigorous, with formal processes in place for reviewing the overall transformation strategy and responding to underperformance in the delivery of individual initiatives.

The Transformation Committee will receive monthly reports regarding progress and key risks from a number of Programme Boards (relating directly to the Trusts Strategic Plan) and will ensure that supporting strategies are appropriately aligned and mutually reinforcing.

5. Audit Committee

The main revisions to the Terms of Reference are as follows:

- More explicit references to the responsibility to report to the Council of Governors in certain circumstances as recommended by the FT Code of Governance
- Membership and quoracy has been changed to reflect standard practice that the Audit Committee membership should be NEDs only
- The frequency of meetings has been reduced to at least 5 per year rather than 6; in effect, one per quarter with an extra one at year end to review the accounts. This change was discussed previously but not reflected in the 2013 revision.

The FT Code of Governance recommends that the Council of Governors should be consulted on any changes to the Audit Committee TOR and they endorsed the above changes at their September meeting.

6. Clinical Governance Committee

The Clinical Governance Committee membership included a mixture of Directors and non-Directors. Paragraph 15 Schedule 7 NHS Act 2006 states that the constitution must provide for all the powers of the corporation to be exercisable by the board of directors on its behalf and also that the constitution may provide for any of those powers to be delegated to a committee of directors or to an executive director. In other words Board Committees must include Board members only. The CGC TOR has been adjusted to reflect this requirement.

The CGC TOR states that the Chairman is "A non-executive Director with a clinical background." To allow the Committee to meet if the current Chair is absent this has been altered to read" In the absence of the Chair, on an occasional basis, a Chair will be chosen by the NEDs present from those NEDs present. On these occasions the Chair need not have a clinical background but should consider deferring any agenda item where the presence of a Chair with a clinical background is essential." Board members will be aware that is intended to recruit a further NED with a clinical background who can chair the Committee in the absence of the current chairman and in addition the date on which the Committee is held is being reviewed to maximise the likelihood of full attendance.

7. Committee Chairmen and Membership

It is proposed that the Chairmen and membership of the Board's Committees should be as follows:

	Audit	Remuneration	Nominations	CGC	Transformation
YB		Member	Chairman		Member
TP	Member	Member	Member		Chairman
FK	Member	Member	Member	Member	
EC		Chairman	Member	Member	Member
TS		Member	Member	Chairman	
RA	Chairman	Member	Member		Member
New NED		Member	Member	Member	Member
CE			Member	Member	Member
MD				Member	Member
DN				Member	Member
DF					Member
DO					Member

The initials CE, MD, DN, DF.DO, in the above table refer to the holders of the following Executive Director positions:

CEO
Medical Director
Director of Nursing and Governance
Director of Finance
Director of Operations

“New NED” in the above table refers to an additional Non-Executive Director which it intended that the Trust shall appoint in due course, subject to approval of the Council of Governors.

As stated previously, the Charitable Funds Committee is not a Committee of the Board. However, in considering the responsibilities of Directors it should be noted that all voting members of the Trust Board are members of the CFC and the Chairman of the Committee is Frances Kirkham.

Appendix 2a

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Nominations Committee (Executive Directors)
Draft Revision August 2014

1 Constitution

The Trust Constitution provides that:

The Trust will establish a nominations committee as a subcommittee of the Board which will (with external advice as appropriate) be responsible for the identification and nomination of executive directors. The equivalent function for non-executive directors will be carried out by the Members Council (Council of Governors) nominations and remuneration committee.
The nominations committee will give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the board of directors to meet them liaising closely with the Members Council (Council of Governors) nominations and remuneration committee. The chairman or an independent non-executive director will chair the nominations committee.

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,

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

As described in Section 1

6 Duties

6.1 To 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 To give full consideration to and make plans for succession planning for the Chief Executive and other Executive 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.
6.3 To evaluate the balance of skills, knowledge and experience of the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for the appointment of executive directors and the chief executive.
6.4 To be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise and making recommendations to the chairman, the other non-executive directors and, except in the case of the appointment of a chief executive, the chief executive. This responsibility also includes any responsibility to ensure that the Board as a whole ratifies executive director appointments if the Board as a whole deems this to be necessary.
6.5 To be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.
6.6 To establish a process to identify suitable candidates to fill executive director vacancies as they arise, ensuring that appointments to the board of directors are based on merit and objective criteria as well as meeting the “fit and proper” persons test described in the Provider Licence. This will include considering the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

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7 Permanency

The Committee is permanent

8 Membership

Chair

A non-executive Director – the Chairman or Senior Independent Director

Other members

All Non-Executive Directors
CEO (in the case of matters relating to the CEO themselves, the CEO shall withdraw from the Committee)

9 Quorum

At least 3 NEDs must be present including the Committee Chairman.

10 Secretariat

Company Secretary.

11 In attendance, by invitation

Director of Finance
Director of Workforce and organisation Development

12 Internal Executive Lead

CEO

13 Frequency of meetings

Not less than once a year; more frequently in the event of executive director vacancies.

14 Review of terms of reference

This should be undertaken annually.

15 Date of adoption

Predecessor Nominations and Remuneration Committee: October 30th 2013
Nominations Committee: October 29th 2014

16 Date of review

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Remuneration Committee Terms of Reference

1 Constitution

The Constitution of the Trust provides that:

The board of directors will establish a remuneration committee composed of non-executive directors which will include at least three independent non-executive directors. The remuneration committee will make available its terms of reference, explaining its role and the authority delegated to it by the board of directors.
The remuneration committee will have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee will also recommend and monitor the level and structure of remuneration for senior management.

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,

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

As described in Section 1

6 Duties

6.1 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 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.
6.1.5 To ensure the publication, in annual reports, of the total remuneration from NHS sources of the chief executive and executive directors.

7 Permanency

The Committee is permanent

8 Membership

Chair
A Non-executive Director

Other members
All other Non-Executive Directors

9 Quorum

At least 3 NEDs must be present including the Committee Chairman.

10 Secretariat

Company Secretary.

11 In attendance, by invitation

CEO
Director of Finance
Director of Workforce and organisation Development (who will also act as the Committee's expert advisor on HR matters)
(No Executive Director may take part in discussions affecting their own remuneration and terms of office)

12 Internal Executive Lead

CEO

13 Frequency of meetings

Not less than 1 meeting per annum

14 Review of terms of reference

This should be undertaken annually.

15 Date of adoption

Predecessor Nominations and Remuneration Committee: October 30th 2013
Remuneration Committee: October 29th 2014

16 Date of review

Appendix 2c

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Transformation Committee
Draft Terms of Reference - October 2014

2 Constitution

The Trust Constitution provides that the Board of Directors may establish such other committees as required to discharge the Trust's responsibilities (in addition to those named in the Standing Orders/ Constitution itself)

In October 2014 it was agreed that the Trust will establish a Transformation Committee as a Committee of the Board which will (with external advice as appropriate) be responsible for providing assurance to the Board with regards to progress on the delivery of the Trusts Transformation programme.

The Transformation Committee will use the Programme Management structure to ensure that plans are rigorous, with formal processes in place for reviewing the overall transformation strategy and responding to underperformance in the delivery of individual initiatives.

The Transformation Committee will receive monthly reports regarding progress and key risks from a number of Programme Boards (relating directly to the Trusts Strategic Plan) and will ensure that supporting strategies are appropriately aligned and mutually reinforcing.

The Transformation Committee will be chaired by a non-executive director of the Trust Board.

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 Programme Boards with appropriate membership to drive forward key transformation programmes.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

As described in Section 1

6 Duties

6.1 To assure the Board with regards to progress in the delivery of the Trusts Strategic Plan

6.2 To maintain oversight of the key risks to delivery of the Trusts Strategy and formally feed back to the Trust Board where appropriate

6.3 To regularly review and track the progress of key deliverables within the Trusts Strategic Plan – via routine monitoring reports presented by the seven Programme Boards

6.4 To ensure that plans are innovative, rigorous, realistic and credible; and to ensure that anticipated benefits are realised

6.5 To maintain on behalf of the Trust Board the overview of the full programme of work

6.6 To sign off the Project Brief of future key projects to ensure alignment to the overall strategy

6.7 To receive Change Forms for consideration where projects are moving significantly away from their original scope or timeline (potentially impacting on other parts of the Programme)

6.8 To support the Programme Boards in understanding the impact of delays and underperformance in individual initiatives on the wider programme; to ensure that risks are mitigated; interdependencies are managed and to help identify solutions where appropriate

6.9 To oversee the establishment and remit of the seven Programme Boards, headed by, accountable, Programme Leads

6.10 To review and ensure that supporting strategies (such as organisational development and leadership development are aligned and mutually reinforcing of the overall Strategic Plan

.

7 Permanency

The Committee is permanent but the requirement for its existence will be reviewed if the Transformation Programme, as conceived in October 2014, is agreed by the Trust Board to be substantially complete.

8 Membership

Chair

A non-executive Director – the Senior Independent Director. In the absence of the Senior Independent Director another non-executive director may chair the Committee provided this is agreed in advance by either the Senior Independent Director or the Chairman of the Trust Board

Other members

CEO
Director of Finance
Director of Nursing and Governance
Director of Operations
Medical Director

Trust Chairman
3 additional non-executive Directors

9 Quorum

At least three Executive Directors must be present plus the Committee Chairman.

10 Secretariat

Company Secretary

11 In attendance, by invitation

Regular attendance

Transformation Programme Manager
Transformation Programme Board Leads (x7)
Director of Workforce and Organisation Development
Director of Strategy &Transformation

12 Internal Executive Lead

Director of Strategy & Transformation

13 Frequency of meetings

Monthly

14 Review of terms of reference

This should be undertaken annually.

15 Date of adoption

29 October 2014:

16 Date of review

November 2015

Appendix 2d

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

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 and Council of Governors (for specific matters)

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:

6.1 Internal control and risk management

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.

6.2 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

To the extent that recommendations are not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendations were not adopted.

In support of the above the Audit Committee will make a report to the Council of Governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the Council of Governors to consider whether or not to re-appoint them.
The Audit Committee will approve the remuneration and terms of engagement of the external auditor. Consideration should be given to assessing the auditors work and fees on an annual basis, and there should be a market testing exercise at least once every 5 years.
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.

6.6.8 To report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

7 Permanency

The Committee is permanent

8 Membership

Chair
A suitably qualified non-executive Director

Other members
At least two other NEDs

9 Quorum

The Chair and one other NED.

10 Secretariat

PA to Director of Finance

11 In attendance, by invitation

Regular attendance
Director of Finance
Internal Auditors
External Auditors
Occasional attendance
Chief Executive
Chairman

12 Internal Executive Lead
Director of Finance

13 Frequency of meetings
Not less than 5 times per annum

14 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
.

15 Review of terms of reference

This should be undertaken annually.

16 Date of adoption

17 Date of review October 29th 2014

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

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. In the absence of the Chair, on an occasional basis, a Chair will be chosen by the NEDs present from those NEDs present. On these occasions the Chair need not have a clinical background but should consider deferring any agenda item where the presence of a Chair with a clinical background is essential.

Other members (voting)
At least two other NEDs
Medical Director
Chief Executive
Director of Nursing, Strategy and Governance
.

9 Quorum
At least 2 NEDs and one from Medical Director or Director of Nursing

10 Secretariat
Company Secretary

11 In attendance, by invitation
Deputy Medical Director
Deputy Director of Nursing
Executive Committee chairs or members invited to attend

12 Internal Executive Lead
Director of Nursing, and Governance

13 Frequency of meetings
At least 8 meetings per annum

14 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

15 Review of terms of reference
This should be undertaken annually.

Date of adoption October 30th 2013
Date of review October 29th 2014

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 29 October 2014 **ENCLOSURE NUMBER: 5**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Jo Chambers, Chief Executive**
AUTHOR(S)	**Jo Chambers, Julian Denney**
TITLE	**Governance Declaration – Quarter 2 2014/15**

SUMMARY

To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 2 2014/15 to Monitor.

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 Continuity of Services risk rating of at least 3 over the next 12 months.

For Governance that:
"The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

Report To	Trust Board
Report Of	Jo Chambers, Chief Executive
Report Presented By	Jo Chambers, Chief Executive
Purpose of the Report	To provide assurance and recommendations to the Trust Board in relation to the Governance Declaration for Quarter 2 2014/15 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 Risk Assessment Framework. The Q2 submission is due on the 31st October 2014.
2.00	**Detail** The reporting requirements summarised above are addressed and evidenced as follows. 1. Financial information The evidence to assure the Board of the Trust's financial performance for the 3 months from the 1st July 2014 to 30th September 2014 is contained in the Trust's Corporate Performance Report. The Trust is within the 85-115% capital expenditure threshold for Quarter 2 and as such is not required to make a declaration with regards to the 2014/15 capital plan at this quarter end. 2. Service Performance Targets The table of Monitor requirements and evidence is Appendix One of this report. The Trust has been able to sustain the delivery of all waiting time targets throughout the quarter. All other targets have been met. The Trust is planning to breach the RTT standard in Q3 in line with the national initiative to reduce long waits. This is agreed and funded nationally with a contract variation in place and agreement to not levy the usual contractual fines for breaches. The Trust plans to return to compliance in December. This position is agreed with Monitor and Commissioners. 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 Trust has appointed a new Director of Operations who is in post and a Director of Strategy and Transformation who will take up appointment in November 2014. The latter post is a reconfiguration of posts within the executive team reflecting the need to strengthen the Trust's change capability over the next few years. • There were no completed elections in this quarter but elections have been called in the following constituencies: • Birmingham & Solihull (2 seats)

- Rest of England & Wales (1 seat)
- Staff: Non-clinical (1 seat)

Results will be published on 10th November 2014

- 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.
- The Clinical Governance Committee has met once during the quarter and reviewed the relevant assurances that risks to compliance are being managed. The Committee has initiated a process of strengthening the way in which is receives assurance from various advisory groups including:
    - Reviewing all terms of reference to ensure they reflect current priorities and minimize duplication
    - Meeting advisory groups' chairs to confirm programmes of work including when they will attend the CGC to provide an in depth account of their areas of responsibility.
- The Board has held a Governance workshop which included inputs from the external review of Governance, the Trust 5 year strategy, consideration of the findings from the CQC inspection and an internal self-assessment of quality governance. The outputs of the workshop included revised strategic risks which the executive team are currently using to update their risk management plans , and a series of areas for action which will be further discussed at the October 29th Board workshop .
- The Audit Committee met once during the period in respect to this declaration and can offer the following assurance:
    - External Audit have provided updates on work on a Charitable Funds Audit, 2013/14 FT Performance & Sector Developments and have presented an annual plan on the outcome of their work to the Council of Governors.
    - The committee discussed the broader aspects of whistleblowing including the need for the Trust to develop an open learning culture, whereby all staff feel comfortable raising concerns directly, rather than through a formal procedure.
    - The Committee have recommended that the Trust nominate a lead NED for procurement
    - The Committee had reviewed certain strategic risks including those relating to potential tariff changes and a risk workshop was considered
    - Internal Audit have completed one piece of work on the Assurance Framework with regard to the key risks and where they fall against objectives and one piece of work on Reference Costing which concluded that substantial assurance could be taken in relation to the costing process
    - There has been positive engagement with Executives on key risk areas- for example the Committee received an update on management progress with implementation actions arising from the recommendations made by Internal Audit following their review of the 18 week control processes.

Appendix 1

The Trust provides financial information reflected in the CPR as assurance and performance and quality information as set out in the CPR and Patient Safety Report as assurance. In Quarter 2 there was a Quality Summit which followed the CQC inspection in Quarter 1. CQC have now published their formal report; the Trust accept the overall rating and has an action plan to address them which has already been implemented in part. In Quarter 2 an election was called but not completed as described above.	The Trust can confirm that there are no exception reports to be provided in quarter 2 with regard to: • Continuity of services • Financial Governance • Governance

Targets and indicators with thresholds for 2014/15

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring	Source	Comments
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	CPR	Achieved
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	CPR	Achieved
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	CPR	Achieved
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	CPR	Achieved
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	CPR	Achieved
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	CPR	Achieved
Cancer 2 week (all cancers)	93%	1.0	CPR	Achieved
C.Diff due to lapses in care	0	1.0	CPR	Achieved
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception		No
CQC compliance action outstanding (as at time of submission)	N/A			Yes *
CQC enforcement action within last 12 months (as at time of submission)	N/A			No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A			No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A			No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A			No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A			No

*Compliance actions have been identified as part of the CQC review published on 17th October 2014. A plan is in place to deliver the actions.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 29th October 2014 **ENCLOSURE NUMBER: 6**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Approval of amendments to the Constitution/ Standing Orders including notice of a motion to amend the Standing Orders received from Frances Kirkham**

For formal approval and adoption of further proposed amendments to the Constitution reflected in Appendix 1 which update the Council of Governors' and Board of Directors' Standing Orders as well as making a number of more minor changes to the rest of the Constitution.

IMPLICATIONS

The Trust Board approved in principle various revisions to the standing orders of both the Council of Governors and Trust Board at its September 2014 meeting, as well as a number of more minor amendments to the rest of the Constitution. These changes were also approved in principle by the Council of Governors at their September 2014 meeting and these changes are reflected in the amended Constitution provided as Appendix 1.

Mills and Reeve, solicitors to the Trust, advise that the changes referred to above must be approved by the Council of Governors and the Board of Directors but will not require the approval of members at an Annual Members Meeting since they are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust. Under the Health and Social Care Act 2012, Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act. Mills and Reeve have been responsible for final review of the amended constitution prior to the September meeting of the Board and Council and have assumed responsibility for assuring the Trust of such compliance.

Since the meetings of the Council and Trust Board in September there have been further corrections relating to minor format and wording matters; Frances Kirkham, Non-Executive Director, has provided oversight to this activity.

APPROVAL PROCESS

The Trust's current Constitution provides that:

45.1 The trust may make amendments of its constitution only if –

45.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

45.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

It further provides in relation to the Trust Board that the Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.16 *(this should refer to 3.5)* has been given; and
- no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
- at least two-thirds of the Board members are present; and
- the variation proposed does not contravene the requirements of Monitor.

A notice of a motion proposed by Frances Kirkham, Non-Executive Director has been given to Jo Chambers, CEO, in accordance with the above provisions.

RECOMMENDATIONS

The Board is asked to approve the amended constitution (including the amended standing orders) provided as Appendix 1 and to adopt the amended constitution from 29 October 2014.

CONSTITUTION OF THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

(Updated as per the Health and Social Care Act 2012)

www.roh.nhs.uk

29 October 2014

Constitution of The Royal Orthopaedic Hospital NHS Foundation Trust

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Paragraph

1. **Interpretation and definitions**

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph 11 of the constitution

constitution means this constitution and all annexes to it.

Monitor is the body corporate known as Monitor, as provided by Section 61of the 2012 Act.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. **Name**

The name of the foundation trust is The Royal Orthopaedic Hospital NHS Foundation Trust (the Trust).

3. **Principal purpose**

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income

available in order to better to carry on its principal purpose.

4. **Powers**

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. **Membership and constituencies**

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency

5.1.2 the staff constituency

6. **Application for membership**

An individual who is eligible to become a member of the Trust may do so on application to the trust.

7. **Public Constituency**

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. **Staff Constituency**

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

10 Restriction on membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9 – Further Provisions.

11. **Annual Members' Meeting**

The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

12. **Council of Governors – composition**

12.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13. **Council of Governors – election of governors**

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the Trust's Authorisation are attached at Annex 5.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 45 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

13.5 In order to assist prospective governors in deciding whether to nominate themselves for election the Trust shall publish a description of the requirements of the role, which shall be reviewed by the Council of Governors from time to time.

14. **Council of Governors - tenure**

14.1 An elected governor may hold office for a period of up to 3 years.

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.3 An elected governor shall be eligible for re-election at the end of his term.

14.4 An appointed governor may hold office for a period of up to 3 years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.6 An appointed governor shall be eligible for re-appointment at the end of his term.

15. Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

15.4 Annex 6 makes provision for the removal of Governors.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

17.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26) or, in his absence, the Vice Chairman (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors unless they have a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

19 Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the Trust has failed or is failing—

19.1.1 to act in accordance with its constitution, or

19.1.2 to act in accordance with provision made by or under

Chapter 5 of the 2006 Act.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22 Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

23. Board of Directors – composition

23.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 up to 7 other non-executive directors; and

23.2.3 up to 7 executive directors.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer

23.5 One of the executive directors shall be the finance director

23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the executive directors is to be a registered nurse or a registered midwife.

24. Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors – qualification for appointment as a non-executive director.

A person may be appointed as a non-executive director only if –

25.1 he is a member of a Public Constituency, or

25.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university , and

25.3 he is not disqualified by virtue of paragraph 29 below.

26. Board of Directors – appointment and removal of chairman and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the Trust and the other non-executive directors.

26.2 Removal of the chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

27. Board of Directors – appointment of vice chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a vice chairman.

28. Board of Directors - appointment and removal of the Chief Executive and other executive directors

28.1 The non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chairman, the Chief Executive and the

other non-executive directors shall appoint or remove the other executive directors.

29. **Board of Directors – disqualification**

The following may not become or continue as a member of the Board of Directors:

29.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

29.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

30. **Board of Directors – meetings**

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

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. **Board of Directors – standing orders**

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8.

32. **Board of Directors - conflicts of interest of directors**

32.1 The duties that a director of the Trust has by virtue of being a director include in particular –

32.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

32.1.2 A duty not to accept a benefit from a third party by reason

of being a director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2 The matter has been authorised in accordance with the constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than –

32.4.1 The trust, or

32.4.2 A person acting on its behalf.

32.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered –

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the directors appointed for the purpose under the constitution.

32.10 A matter shall have been authorised for the purposes of paragraph 32.2.2 above if:

32.10.1 The Board of Directors, in accordance with the requirements set out in this paragraph 32.10, authorise any matter or situation proposed to them by any director which would, if not authorised, involve a director (an "Interested Director") breaching his duty under paragraph 32.1.1 above to avoid Conflicts;

32.10.2 The matter in question shall have been proposed by any director for consideration in the same way that any other matter may be proposed to the Board of Directors under the provisions of this Constitution;

32.10.3 Any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interested Director; and

32.10.4 The matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

33. Board of Directors – remuneration and terms of office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

33.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34. Registers

The Trust shall have:

34.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of governors;

34.4 a register of directors; and

34.5 a register of interests of the directors.

35 Admission to and removal from the registers

35.1 Any person entitled to be a Member who, as appropriate, applies or is entitled to become a Member, shall have their name and the constituency or class to which they belong added to the register of Members.

35.2 The register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted (which may be the Secretary), their date of becoming a member of the Council of Governors, the anticipated length of their term and the date of their ceasing to be a member of the Council of Governors.

35.3 The Register of Directors shall list the names of Directors, their capacity on the Board of Directors and an address through which they may be contacted (which may be the Secretary)

36 Registers – inspection and copies

36.1 The Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37 Transition

37.1 With effect from the end of the 30th July 2014 (Effective Date) the following provisions of this paragraph 37 shall take effect:

37.1.1 Public members who on the Effective Date live in an electoral area comprised in a Birmingham public

constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of Annex 1 shall become members of the Birmingham and Solihull public constituency as described in Part B of Annex 1;

37.1.2 Public members who on the Effective Date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become members of the Rest of England public constituency as described in Part B of Annex 1;

37.1.3 Public governors who on the Effective Date live in an electoral area comprised in a Birmingham public constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of Annex 1 shall become governors in the Birmingham and Solihull public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.4 Public governors who on the Effective Date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become governors in the Rest of England public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.5 If the number of governors for any public constituency following implementation of the preceding provisions of this paragraph would exceed the number of governors allowed for that constituency, then the governors in that constituency shall draw lots to determine which of their number shall retire

38. **Documents available for public inspection**

38.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current constitution,

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The Trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40. Audit committee

The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the Trust's auditor.

41.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. Annual report, forward plans and non-NHS work

42.1 The Trust shall prepare an Annual Report and send it to Monitor.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

42.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about –

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must –

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the directors of the Trust of its determination.

42.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the governors and members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the annual accounts;

43.1.2 any report of the auditor on them;

43.1.3 the annual report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Instruments

44.1 The Trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The Trust may make amendments of its constitution only if –

45.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

45.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2 Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

45.4 Amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and significant transactions

46.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

46.2 The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

PART A (until the Effective Date – see paragraph 37)

There are five public constituencies reflecting the populations the Trust serves:

- South Birmingham
- Heart of Birmingham
- Eastern and Northern Birmingham
- Other West Midlands
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

South Birmingham Public Constituency:

Bartley Green
Billesley
Bournville
Brandwood
Edgbaston
Hall Green
Harborne
King's Norton
Longbridge
Moseley
Northfield
Quinton
Selly Oak
Weoley

Heart of Birmingham

Aston
Bordesley Green
Handsworth Wood
East Handsworth
Ladywood
Lozells
Nechells

Small Heath
Soho
Sparkbrook
Sparkhill
Springfield

Eastern and Northern Birmingham

Northern Birmingham:
Kingstanding
Perry Barr
Oscott
Sutton Four Oaks
Sutton New Hall
Sutton Vesey

Eastern Birmingham:
Acocks Green
Erdington
Hodge Hill
Kingsbury
Shard End
Sheldon
Stockland Green
Washwood Heath
Yardley.

Other West Midlands - comprising the metropolitan boroughs of:

Coventry
Dudley
Sandwell
Solihull
Walsall
Wolverhampton

Rest of England and Wales

Initially the Trust will utilise the details of patients from the Patient Administration System as information to support membership recruitment within the Public Constituency in addition to other recruitment efforts.

The Trust intends to develop membership numbers in the Public Constituency over time; however the minimum number of members in the public constituency described above is to be 100 persons split across the 5 constituencies as follows:

Public Constituency	Minimum Number
South Birmingham	41
Heart of Birmingham	9
Eastern and Northern Birmingham	13
Other West Midlands	31
Rest of England and Wales	6
Total	100

PART B (with effect from the Effective Date– see paragraph 37)

Two public constituencies reflecting the populations the Trust serves:

- **Birmingham and Solihull**
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

Birmingham and Solihull

The electoral areas listed in Part A of this Annex for the three former Birmingham constituencies plus Solihull.

Rest of England and Wales

The electoral areas in England and Wales not comprised in the Birmingham and Solihull constituency. The minimum number of members for each Public Constituency is as follows:

Public Constituency	**Minimum Number**
Birmingham and Solihull	67
Rest of England and Wales	33
Total	100

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

All Staff eligible for membership as described in paragraph 0 of the constitution will automatically become members of the Staff Membership Constituency upon Authorisation. Staff will have the right to opt out of automatic membership if they so wish.

There will be two classes of Staff Membership which will be determined based on Whitley Staff Groups:

- Clinical–comprising Medical, Nursing, Allied Health Professionals and Scientists

- Non-Clinical – comprising all staff not included in the clinical class.

There will be a minimum of 25% of total staff within each class, as specified below:

Staff Membership Class	Number of Staff in Post	Minimum Number in Constituency
Clinical	**468**	**117**
Non-Clinical	**339**	**85**

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust will not have a Patient Constituency; patients of the Trust may become members within the Public Constituency providing they fulfil the membership criteria.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 12.2 and 12.3)

PART A (until the Effective Date)

The Council of Governors is to comprise:

Elected Members

13 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
South Birmingham	5
Heart of Birmingham	1
Eastern and Northern Birmingham	2
Other West Midlands	4
Rest of England and Wales	1
Total	**13**

3 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	1
Total	**3**

In order to take into account the changing nature of the local health economy at the commissioning level, the Trust intends to retain the flexibility to increase the staff Members of Council and the Nominated Members of Council. Any increases in Staff Members of Council will require an increase in Public Members of Council in order to ensure that the relative proportion of Staff members to other Constituencies remain constant.

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
South Birmingham PCT	1
Heart of Birmingham (Teaching) PCT	1
Birmingham City Council	1
University of Birmingham	1
University of Central England	1
Patient Support Group Representative	1
Birmingham Council of Faiths Representative	1
Local Member of Parliament Representative	1
Bournville Village Trust	1
Total	**9**

PART B (with effect from the Effective Date – see paragraph 37

Elected Members

9 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
Birmingham and Solihull	5
Rest of England and Wales	4
Total	9

4 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	2
Total	**4**

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
Birmingham City Council	1
Birmingham City University	1
Local Member of Parliament Representative	1
University of Birmingham	1
Bournville Village Trust	1
Total	**5**

ANNEX 5 –THE MODEL ELECTION RULES

(Paragraph13)

Part 1-Interpretation

1. Interpretation

Part 2-Timetable for election

2. Timetable
3. Computation of time

Part 3-Returning officer

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4-Stages Common to Contested and Uncontested Elections

8. Notice of election
9. Nomination of candidates
10. Candidate's consent and particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination papers
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination papers
17. Withdrawal of candidates
18. Method of election

Part 5–Contested elections

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting documents
25. Ballot paper envelope and covering envelope

The poll

Procedure for receipt of envelopes

Part 6 – Counting the votes

Part 7–Final proceedings in contested and uncontested elections

Part 8–Disposal of documents

Part 9–Death of a candidate during a contested election

Part 10 – Election expenses and publicity

Expenses

Publicity

Part 11 – Questioning elections and irregularities

Part 12 – Miscellaneous

Part 1 - Interpretation

1. Interpretation

(1) In these rules, unless the context otherwise requires:

"the Trust"	Means the Royal Orthopaedic Hospital NHS Foundation Trust;
"election"	Means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;
"Monitor"	Means the Independent Regulator for NHS foundation trusts; and
"the2006Act"	Means the National Health Service Act 2006.

(2) Other expressions used in these rules and in Schedule 7 of the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

(1) The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

(1) In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday; or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

(1) Subject to rule 64, the returning officer for an election is to be appointed by the Trust.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

(1) Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

(1) The Trust is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules; and

(b) such remuneration and other expenses as the Trust may determine.

7. Duty of co-operation

(1) The Trust is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

(1) The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(c) the details of any nomination committee that has been established by the Trust;

(d) the address and times at which nomination papers may be obtained;

(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer;

(f) the date and time by which any notice of withdrawal must be received by the returning officer;

(g) the contact details of the returning officer; and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

(1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer:

(a) is to supply any member of the Trust with a nomination paper; and

(b) is to prepare a nomination paper for signature at the request of any member of the Trust,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

(1) The nomination paper must state the candidate's:

(a) full name;

(b) contact address in full; and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

(1) The nomination paper must state:

(a) any financial interest that the candidate has in the Trust; and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

(1) The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

(1) The nomination paper must be signed and dated by the candidate, indicating that:

(a) they wish to stand as a candidate;

(b) their declaration of interests as required under rule 11, is true and correct; and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

(1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand;

(b) decides that the nomination paper is invalid;

(c) receives satisfactory proof that the candidate has died; or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election;

(b) that the paper does not contain the candidate's particulars, as

required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;

(d) that the paper does not include a declaration of eligibility as required by rule 12; or

(e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

(1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing; and

(b) the declared interests of each candidate standing, as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the Trust as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

(1) The Trust is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the Trust is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

(1) A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

(1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the Trust.

Part 5 – Contested elections

19. Poll to be taken by ballot

(1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper

(1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify:

(a) the name of the Trust;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) instructions on how to vote;

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and

(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter is the person to whom the ballot paper was addressed;

(b) that the voter has not marked or returned any other voting paper in the election; and

(c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter;

(b) the address of the voter;

(c) the voter's signature; and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(1) The Trust is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll

(1) The returning officer is to publish a notice of the poll stating:

(a) the name of the Trust;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency;

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post;

(f) the address for return of the ballot papers, and the date and time of the close of the poll;

(g) the address and final dates for applications for replacement ballot papers; and

(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer

(1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the Trust named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope;

(b) a declaration of identity (if required);

(c) information about each candidate standing for election, pursuant to rule 59 of these rules; and

(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

(3) The returning officer shall have the right to edit or not publish any election statement if it exceeds the permitted number of words or because it contains statements which he reasonably believes are factually inaccurate, offensive or libellous.

25. Ballot paper envelope and covering envelope

(1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and

(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed declaration of identity if required; and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote

(1) An individual who becomes a member of the Trust on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

(1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers

(1) If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and

(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers

(1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she:

(a) is satisfied as to the voter's identity;

(b) has no reason to doubt that the voter did not receive the original ballot paper; and

(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper

(1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration; and

(b) of the particulars of that member's qualification to vote as a member of the public or patient constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for:

(a) the name of the voter;

(b) the address of the voter;

(c) the voter's signature; and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents

(1) Where the returning officer receives a:

(a) covering envelope; or

(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper

(1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) put the declaration of identity if required in a separate packet; and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”;

(b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it to the ballot paper;

(c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (public and patient constituency)

(1) Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to:

(a) mark the declaration of identity “disqualified”;

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the declaration of identity in a separate packet.

35. Sealing of packets

(1) As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;

(b) the declarations of identity if required;

(c) the list of spoilt ballot papers;

(d) the list of lost ballot papers;

(e) the list of eligible voters; and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

36. Interpretation of Part 6

(1) In Part 6 of these rules:

"continuing candidate"	Means any candidate not deemed to be elected, and not excluded;
"count"	Means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;
"deemed to be elected"	Means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;
"mark"	Means a figure, an identifiable written word, or a mark such as "X";
"non- transferable vote"	Means a ballot paper– (a) on which no second or subsequent preference is recorded for a continuing candidate, or (b) which is excluded by the returning officer under rule44(4)below;
"preference"	As used in the following contexts has the meaning assigned below– (a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference, (b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and (c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on;
"quota"	Means the number calculated in accordance with rule 41 below;

“surplus”	Means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both)exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value)of all transferable papers from the candidate who has the surplus;
“stage of the count”	means– (a) the determination of the first preference vote of each candidate, (b) the transfer of a surplus of a candidate deemed to be elected, or (c) the exclusion of one or more candidates at any given time;
“transferable paper”	Means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;
“transferred vote”	means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred; and
“transfer value”	Means the value of a transferred vote calculated in accordance with paragraph(4) or (7) of rule 42 below.

37. Arrangements for counting of the votes

(1) The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count

(1) The returning officer is to:

(a) count and record the number of ballot papers that have been returned; and

(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

39. Rejected ballot papers

(1) Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;
(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate;
(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or
(d) which is unmarked or rejected because of uncertainty,

Shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and soon, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

40. First stage

(1) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

41. The quota

(1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 44 has been

complied with.

42. Transfer of votes

(1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those papers for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1) (a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall beat a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those papers for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5) (a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at:

(a) a transfer value calculated as set out in paragraph (4)(b) above; or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

43. Supplementary provisions on transfer

(1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule 42 above:

(a) record the total value of the votes transferred to each candidate;

(b) add that value to the previous total of votes recorded for each candidate and record the new total;

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and

(d) compare

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule 42 or 44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be ,all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule 42 or 44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non- transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

44. Exclusion of candidates

(1) If:

(a) all transferable papers which under the provisions of rule 42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred; and
(b) subject to rule 45 below, one or more vacancies remain to be filled,

The returning officer shall exclude from the election at that stage the candidate with the lowest vote (or, where paragraph (12) below applies, the candidates with the lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels so that they are grouped as:

(a) ballot papers on which a next available preference is given; and

(b) ballot papers on which no such preference is given (thereby including

ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule 43 above, transfer each sub-parcel of ballot papers referred to in paragraph(2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule 45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and soon until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes; or

(ii) the total transfer value of votes transferred to each candidate;

(b) add that total to the previous total of votes recorded for each candidate and record the new total;

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total; and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule 42 and rule 43.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

45. Filling of last vacancies

(1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall there upon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of anyone continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall there upon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

46. Order of election of candidates

(1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which the respective surpluses were transferred, or would have been transferred but for rule 42 (10) above.

(2) A candidate credited with a number of votes equal to, and not greater

than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

47. Declaration of result for contested elections

(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the North Staffordshire Combined Healthcare NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust; or
(ii) in any other case, to the chairman of the Trust; and

(c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make a list including:

(a) the number of first preference votes for each candidate whether elected or not;

(b) any transfer of votes;

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place;

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 39(1), available on request.

48. Declaration of result for uncontested elections

(1) In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the Trust; and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

49. Sealing up of documents relating to the poll

(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers;

(b) the ballot papers endorsed with “rejected in part”;

(c) the rejected ballot papers; and

(d) the statement of rejected ballot papers.

(2) The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;

(b) the declarations of identity;

(c) the list of spoilt ballot papers;

(d) the list of lost ballot papers;

(e) the list of eligible voters; and

(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the Trust to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

50. Delivery of documents

(1) Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, the returning officer is to forward them to the chairman of the Trust.

51. Forwarding of documents received after close of the poll

(1) Where:

(a) any voting documents are received by the returning officer after the close of the poll; or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or

(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the Trust.

52. Retention and public inspection of documents

(1)The Trust is to retain the documents relating to an election that are forwarded to the chairman by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the Trust shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the Trust, and the Trust is to provide it, and may impose a reasonable charge for doing so.

53. Application for inspection of certain documents relating to an election

(1) The Trust may not allow the inspection of, or the opening of any sealed packet containing:

(a) any rejected ballot papers, including ballot papers rejected in part;

(b) any disqualified documents, or the list of disqualified documents,

(c) any counted ballot papers;

(d) any declarations of identity; or

(e) the list of eligible voters,

By any person without the consent of the regulator.

(2) A person may apply to the regulator to inspect any of the documents listed in (1), and there regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;

(b) time;

(c) place and mode of inspection;

(d) production or opening,

and the Trust must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1):

(a) in giving its consent, the regulator;

(b) and in making the documents available for inspection, the Trust,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given; and

(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

54. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to the returning officer's

satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died; and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and

(ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49(1)(a).

Part 10 – Election expenses and publicity

Election expenses

55. Election expenses

(1) Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

56. Expenses and payments by candidates

(1) A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

57. Election expenses incurred by other persons

(1) No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise; or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58. Publicity about election by the Trust

(1) The Trust may:

(a) compile and distribute such information about the candidates; and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the Trust about the candidates, including information compiled by the Trust under rule 59, must be:

(a) objective, balanced and fair;

(b) (as far as the information provided by the candidates so allows)equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election; and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the Trust proposes to hold a meeting to enable the candidates to speak, the Trust must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the Trust must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59. Information about candidates for inclusion with voting documents

(1) The Trust must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of

these rules.

(2) The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words (if supplied by the candidate); and

(b) a photograph of the candidate (if supplied by the candidate).

60. Meaning of "for the purposes of an election"

(1) In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

61. Application to question an election

(1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote; or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and

(b) be in such a form as the regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(7) The regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.

(8) The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the Trust, the applicant and the members of the constituency (or class with in a constituency) including all the candidates for the election to which the application relates.

(9) The regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

62. Secrecy

(1) The following persons:

(a) the returning officer; and

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the Trust who has or has not been given a ballot paper or who has or has not voted;
(ii) the unique identifier on any ballot paper; and
(iii) the candidate(s)for who many member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63. Prohibition of disclosure of vote

(1) No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification

(1) A person may not be appointed as a returning officer, or as staff of the

returning officer pursuant to these rules, if that person is:

(a) a member of the Trust;

(b) an employee of the Trust;

(c) a director of the Trust; or

(d) employed by or on behalf of a person who has been nominated for election.

65. Delay in postal service through industrial action or unforeseen event

(1) If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24; or

(b) the return of the ballot papers and declarations of identity,

The returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the regulator.

66. Effect of administrative or clerical errors on election

(1) Elections shall not be invalidated by any administrative or clerical error on the part of the Trust or any acts or omissions of the returning officer acting in good faith on the basis of such error.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 22)

1. The Council of Governors will meet quarterly.

2. Any Member of Council judged by the Council of Governors to have acted in a manner which brings the Trust into disrepute will not be permitted to continue as a Member of Council.

3. NOT USED

4. The number of full terms of office for Elected Members of Council will be 3.

5. Under Paragraph 26.2 of the Constitution, 75% of all the Members of Council have to be in support in order to remove the Chairman or Non-Executive Directors

6. The following may not become or continue as a member of the Council of Governors:

   6.1 They are a Director of the Trust, or a Governor, Member of Council or Director of another NHS Body, or of an independent/private sector health care provider whose activities compete with those of the Trust. These restrictions do not apply to Appointed Partnership Members of Council;

   6.2 they are under sixteen years of age;

   6.3 being a member of a public constituency, they were or were entitled to be a member of one of the classes of the staff constituency at any point during the preceding two years;

   6.4 being a member of one of the public constituencies, they refuse to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

   6.5 they are currently on the sex offenders register.

   6.6 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, expiry of a fixed term contract, disability, ill health or age from any paid employment with a health service body. In other cases of dismissal, such as capability, an individual may be permitted to become a Member of Council, at the discretion of the Trust, and subject to full disclosure of the relevant circumstances and facts concerning that dismissal;

   6.7 they are a person whose tenure of office as the Chairman or as a

member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non- attendance at meetings, or for non-disclosure of a pecuniary interest;

6.8 they have had their name removed, by a direction under section 46 of the 1977 NHS Act from any list prepared under Part II of that Act or have otherwise been disqualified or suspended from any healthcare profession, and have not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable);

6.9 they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

6.10 they are an elected Member of Council and they cease to be a member of the constituency or class by which they were elected. This may include, but is not restricted to, the reasons for ceasing to be a member identified in Annex 9;

6.11 they are a Member of Council appointed by a partnership organisation and they cease to be sponsored by their partnership organisation;

6.12 they are a member of the Patient and Public Involvement Forum relating to this Foundation Trust or anybody succeeding it in this role;

6.13 they fail to or indicate that they are unwilling to act in the best interests of the Trust and in accordance with The Seven Principles of Public Life laid out by the Committee on Standards in Public Life in its First Report as amended from time to time;

6.14 they fail to agree (or, having agreed, fail) to abide by the values of the Trust set out in Annex 10.

7. A member of the Council of Governors shall immediately cease to be so if:

7.1 they resign in writing to the secretary;

7.2 they fail to attend at least half of the meetings of the Council of Governors in any financial year, unless the majority of the Council of Governors are satisfied that;

7.2.1 their absences were due to reasonable causes, and

7.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as the majority of Members of the Council of Governors consider reasonable.

7.2.3 if any of the provisions in paragraph 6 above apply.

7.2.4 without good reason they fail to undertake any training which the Council of Governors requires all members of the Council of Governors to undertake.

8. Members of the Council of Governors from elected staff who are subject to on-going formal disciplinary action in respect of their employment or engagement with the Trust, will be suspended from their membership of the Council of Governors pending the outcome of disciplinary action.

9. A Member of the Council of Governors may be removed from the Council of Governors by a resolution approved by not less than two-thirds of the remaining members of the Council of Governors present and voting at a general meeting of the Council of Governors on the grounds that:

9.1 they have committed a serious breach of the Trust Principles set out in Annex 10, or

9.2 they have acted in a manner detrimental to the interests of the Trust, and

9.3 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a member of the Council of Governors.

10. Where a vacancy arises from any reason (other than expiry of term of office) amongst the appointed member of the Council of Governors the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

11. Vacancies amongst the elected members of the Council of Governors will be dealt with under paragraph 9 of Annex 9.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 18)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Standing Orders
Council of Governors

CONTENTS

1. INTRODUCTION

1.1 Statutory Framework

1.1.1 The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act").

1.1.2 The principal places of business of the Trust is:

- The Royal Orthopaedic Hospital, Bristol Road South, Northfield, Birmingham B31 2AP.

1.1.3 NHS Foundation Trusts are governed by, the 2006 Act as amended by the 2012 Act, their constitutions and their NHS provider licences issued by Monitor (Regulatory Framework).

1.1.4 The functions of the Trust are conferred by the Regulatory Framework. As a body corporate it has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.1.5 The Regulatory Framework requires the Council of Governors to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Company Secretary).

2.2 Any expression to which a meaning is given in the 2006 Act (as amended by the Health and Social Care Act 2012 Act) or in the Regulations or Orders made under the 2006 Act shall have the same meaning in the interpretation and in addition:

"**TRUST**" means the Royal Orthopaedic Hospital NHS Foundation Trust.

"**COUNCIL OF GOVERNORS**" means the Council of Governors of the Trust as defined in the Constitution.

"**BOARD OF DIRECTORS**" means the Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.

"**CHAIRMAN OF THE BOARD**" or "Chairman of the Trust" is the person appointed by the Council of Governors to lead the Board of Directors and

to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions “the Chairman of the Board” and “the Chairman of the Trust” shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is so otherwise unavailable.

“**CHIEF EXECUTIVE**” means the chief executive officer of the Trust.

“**COMMITTEE**” means a committee of the Council of Governors

“**CONSTITUTION**” means the constitution of the Trust.

“**COMMITTEE MEMBERS**” means the Chairman and the Members of Council or Directors formally appointed by the Council of Governors or Board of Directors to sit on or to chair specific committees.

“**EXECUTIVE DIRECTOR**” means a Member of the Board of Directors who holds an executive office of the Trust.

“**FT CODE OF GOVERNANCE**” means the NHS Foundation Trust Code of Governance issued by Monitor from time to time.

“**LEAD GOVERNOR**” means a Member of the Council elected by the Council of Governors to hold that office for a term determined by the Council of Governors who may also be removed from office by a resolution of the Council of Governors.

“**MEMBER OF THE COUNCIL**” means a Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the Chairman).

“**MONITOR**” means the body corporate known AS Monitor, as provided by Section 61 of the 2012 Act.

“**NON-EXECUTIVE DIRECTOR**” means a member of the Board of Directors who does not hold an executive office with the Trust.

“**OFFICER**” means employee of the Trust or any other person holding a paid appointment or office with the Trust.

“**SOs**” means these Standing Orders.

“**SCHEME OF DELEGATION**” means the schedule of matters reserved to the Board of Directors and the Delegation of Powers, as approved by the Board of Directors and reviewed from time to time.

“**SECRETARY TO THE TRUST**” means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board Governors and the Chairman and monitor the Trust’s compliance with the Regulatory Framework and these standing orders.

"**VICE CHAIRMAN**" means the Non-Executive Director appointed from amongst the Non-Executive Directors as Vice Chairman by the Council of Governors to take on the Chairman's duties in his capacity as chairman of the Council of Governors if the Chairman is absent for any reason.

"**CLEAR DAYS**" means in any period the duration of which is determined by a starting and finishing event, all complete days in that period excluding the day when the event referred to as starting the period occurs (for example sending out an Agenda) and the day on which the event referred to as ending the period occurs (for example the date of the meeting). For the avoidance of doubt clear days include weekends and public holidays. As an example an Agenda sent out on a Friday for a meeting on a Wednesday represents four clear days: Friday and Wednesday are excluded so that Saturday, Sunday, Monday and Tuesday are the four clear days.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council of Governors

3.1.1 In accordance with the Constitution of the Foundation Trust, the composition of the Council of Governors after the Effective Date shall be:

- 9 Public representatives
- 4 Staff representatives
- 5 nominated representatives comprising
- 1 University of Birmingham representative
- 1 Birmingham City University representative
- 1 Birmingham City Council representative
- 1 Member of Parliament representative
- 1 representative of Bournville Village Trust

3.2 Role of the Chairman

3.2.1 The Chairman is not a member of the Council of Governors. However under the Regulatory Framework, he/she presides at meetings of the Council of Governors and has a casting vote.

3.2.2 Where the Chairman of the Trust has died or has ceased to hold office, or where he/she has been unable to perform his/her duties as Chairman owing to illness or any other cause, the Vice Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his/her duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include references to the Vice Chairman.

3.3 Role and Responsibilities of the Council of Governors

3.3.1 The role and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust Constitution, are:

- To appoint or remove the Chairman and other Non-Executive Directors of the Foundation Trust at a members' general meeting (except for the initial Chairman and Non-Executive Directors)
- To approve (by a majority of members of the Council of Governors) the appointment by the Non-Executive Directors of the Chief Executive (except for the initial Chief Executive)
- To appoint or remove the auditor at a general meeting of the Council of Governors.
- To be consulted by the Trust's Board of Directors on forward plans and to have the Council of Governors' views taken into account
- To be presented with at a general meeting of the Council of Governors, the Annual Report and Accounts and the report of the Trust's auditor

3.3.2 The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its Directors. The Council of Governors does not have the right to veto decisions made by the Board of Directors.

3.3.3 The Council of Governors, and individual Members of Council, are not empowered to speak on behalf of the Trust, and must seek the advice and views of the Chairman concerning any contact from the media or any invitation to speak publicly about the Trust or their role within it.

4. MEETINGS OF THE COUNCIL

4.1 Admission of the Public

4.1.1 The public shall be afforded facilities to attend all formal meetings of the Council of Governors except where the Council resolves:

(a) That members of the public be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; and/or

(b) That in the interests of the public order the meeting adjourn for a period to be specified in such resolution to enable the Council to complete business without the presence of the public.

4.1.2 Nothing in these Standing Orders shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of

proceedings as they take place, without the prior agreement of the Council.

4.2 Calling Meetings

4.2.1 Ordinary meetings of the Council shall be held at such times and places as the Council may determine and there shall be not less than 3 or more than 4 formal meetings in any year except in exceptional circumstances.

4.2.2 The Chairman of the Foundation Trust may call a meeting of the Council at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of Members of the Council, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at Trust's Headquarters, such one third or more Members of the Council may forthwith call a meeting.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his/her behalf shall be delivered to every Member of the Council, or sent by post to the usual place of residence of such Member of the Council, so as to be available to him at least three Clear Days before the meeting.

4.3.2 Want of service of the notice on any Member of the Council shall not affect the validity of a meeting.

4.3.3 In the case of a meeting called by Members of the Council in default of the Chairman, the notice shall be signed by those Members of the Council and no business shall be transacted at the meeting other than specified in the notice.

4.3.4 Agendas will be sent to Members of the Council before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three Clear Days before the meeting, save in emergency. Failure to despatch the agenda and supporting papers within the above timescales shall not affect the validity of a meeting unless the consequences of such failure were to reduce attendance at the meeting below a level at which the meeting was quorate.

4.3.5 Before each meeting of the Council a public notice of the time and place of the meeting shall be displayed at the Trust's offices and on the Trust's website and the public part of the agenda shall be displayed on the Trust's website at least three Clear Days before

the meeting, save in the case of emergencies.

4.4 **Setting the agenda**

4.4.1 The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2 A Member of the Council desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5 **Petitions**

4.5.1 Where a petition has been received by the Trust, the Chairman of the Council shall include the petition as an item for the agenda of the next Council meeting.

4.6 **Chairman of Meeting**

4.6.1 At any meeting of the Council, the Chairman of the Trust, if present, shall preside, unless he/she has a conflict of interest. If the Chairman is absent from the meeting or has a conflict of interest the Vice Chairman, if he/she is present, shall preside, unless he/she also has a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

4.7 **Notices of Motion**

4.7.1 A Member of the Council desiring to move or amend a motion shall send a written notice thereof at least 10 Clear Days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting,

without notice on any business mentioned on the agenda.

4.8 Withdrawal of Motion or Amendments

4.8.1 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.9 Motion to Rescind a Resolution

4.9.1 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Member of the Council who gives it and also the signature of four other Council Members. When any such motion has been disposed of by the Council, it shall not be competent for any member other that the Chairman to propose a motion to the same effect within six months, however the Chairman may do so if he/she considers it appropriate.

4.10 Motions

4.10.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.10.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Council to move:

- An amendment to the motion
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business(*)
- The appointment of an adhoc committee to deal with a specific item of business
- That the motion be now put.(*)
- A motion resolving to exclude the public under SO4.1.1.

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Member of the Council who has not previously taken part in debate and who is eligible to vote.

No amendment to the motion shall be admitted, if in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.11 Chairman's Ruling

4.11.1 Statements of Members of the Council made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters

shall be final.

4.12 **Voting**

4.12.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Members of the Council present and voting on the question and, in the case of number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

4.12.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Council present so request.

4.12.3 If at least one-third of the Members of the Council present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Council present voted or abstained.

4.12.4 If a Member of the Council so requests, his/her vote shall be recorded by name upon any vote (other than paper ballot).

4.12.5 In no circumstances may an absent Member of the Council vote by proxy. A Member of the Council may only vote if present at the time of the vote on which the question is to be decided. A Member of the Council is considered to be present at a meeting in the circumstances outlined in Standing Orders 4.13 below.

4.13 Any Governor or member of a committee of the council of Governors may participate in a meeting of the council of Governors or such Committee by conference, telephone, computer or video link whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence, in person at such meeting and in the event of a vote count toward that vote..

4.14 **Minutes**

4.14.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

4.14.3 Minutes shall be circulated in accordance with the members' wishes.

4.15 Suspension of Standing Orders

4.15.1 Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, including one public Member of Council and that a majority of those present vote in favour of suspension.

4.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Members of the Council.

4.15.4 No formal business may be transacted while Standing Orders are suspended.

4.16 Variation and Amendment of Standing Orders

4.16.1 These Standing Orders shall be amended only if the variation proposed does not contravene the Regulatory Framework any statutory provisions, guidance or best practice advice issued by Monitor and is approved in accordance with paragraph 45 of the Trust's Constitution.

4.17 Record of Attendance

4.17.1 The names of the Chairman and Members of the Council present at the meeting shall be recorded in the minutes.

4.18 Quorum

4.18.1 No business shall be transacted at a meeting unless at least six Members of Council are present of which at least two are public Members of Council.

4.18.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned at the discretion of the Chairman and the Trust Secretary shall give or shall procure the giving of notice to all Members of the Council of the date, time and place of the adjourned meeting. Notwithstanding Standing Order 4.18.1 above, upon convening, those present shall constitute a quorum.

4.18.3 If a Member of the Council has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest (see

Standing Order 6, 7 or 8) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. COMMITTEES

5.1 Subject to the Regulatory Framework, the Council may appoint committees of the Council to assist the Council in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly of the Chairman and Members of the Council of Governors.

5.2 A committee appointed under this regulation may, subject to any restriction imposed by the Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chairman" is to be read as a reference to the Chairman of the Committee as the context permits, and the term "Member of the Council" is to be read as a reference to a member of the committee also as the context permits.

5.4 Subject to Standing Order 5.5, each sub-committee shall have such terms of reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance for Governors issued by Monitor. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Council may not delegate any decision-making or executive powers to any committee or sub-committee.

5.6 The Council shall approve the appointments to each of the committees which it has formally constituted.

5.7 The committees and sub-committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

5.8 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

5.9 A Governor or a member of a committee shall not disclose any matter reported to the Council or otherwise dealt with by the committee notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

5.10 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of members of the Council of Governors attending the meeting.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 The Regulatory Framework requires Council Members to declare interests which are relevant and material to the Council of which they are a Member. All existing Council Members should declare such interests. Any Council Members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as "relevant and material" are defined in the Trust's Constitution as follows:

any pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors.

6.1.3 At the time Council members' interests are declared, they should be recorded in the Council minutes. Any changes in interests should be declared at the next Council meeting following the change occurring.

6.1.4 Council members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.1.5 During the course of a Council Meeting, if a conflict of interest is established, the Member of the Council concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.1.6 There is no requirement for the interests of Council members' spouses or partners to be declared. However Standing Order 7, which is based on the regulations, requires that the interests of Members of the Council's spouses, if living together, in contracts should be declared. Therefore the interests of Council Members'

spouses and cohabiting partners should also be regarded as relevant.

6.1.7 If Council members have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.2 **Register of Interests**

6.2.1 The Company Secretary to the Trust will ensure that a Register of Interests is established to record formally declarations of interests of Council Members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by Council Members, as defined in Standing Order 6.1.2.

6.2.2 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared will be incorporated.

6.2.3 The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.2.4 In establishing, maintaining, updating and publicising the Register, the Trust shall comply with the Regulatory Framework.

7. DISABILITY OF CHAIRMAN AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chairman or another Member of the Council has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council may exclude the Chairman (or Member of the Council) from a meeting of the Council while any contract, proposed contract or other matter in which he/she has pecuniary interest, is under consideration.

7.3 For the purpose of this Standing Order the Chairman or Member of the Council shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she, is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.4 The Chairman or a member of the Council shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in a company, body or person with which he/she is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Member of the Council in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Member of Council:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

7.6 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Council and applies to a Member of the Council of any such committee or sub-committee as it applies to a Member of the Council.

8. STANDARDS OF BUSINESS CONDUCT POLICY

Members of Council should comply with the Trust Constitution, the NHS principles of conduct, the NHS Foundation Trust Code of Governance, published by Monitor, the requirements of the Regulatory Framework, and any guidance for Governors issued by Monitor.

8.1 Interest of Members of Council in Contracts

8.1.1 If it comes to the knowledge of a Member of Council that a contract in which he/she has any pecuniary interest not being a contract to which he/she is a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Company Secretary of the Trust of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.1.2 A Member of Council should also declare to the Company Secretary of the Trust any other employment or business or other relationship of his/hers, or of cohabitating spouse, which might reasonably be predicted could conflict with the interests of the Corporation.

8.2 Canvassing of and recommendations by Members of the Council in Relation to Appointments

8.2.1 Canvassing of Members of Council of the Trust or of any Committee of the Council of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment.

8.2.2 A Member of the Council shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Member of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.2.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.3 Relatives of Members of the Council or Officers

8.3.1 Candidates for any staff appointment under the Trust, shall when making application, disclose in writing to the Trust whether they are related to any Member of the Board of Directors or Council of Governors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.3.2 The Chairman and every Member of the Council and officer of the Trust shall disclose to the Chief Executive any relationship between him/herself and a candidate of whose candidature that Member of the Council or Officer is aware.

8.3.3 On appointment, Members of the Council (and prior to acceptance of an appointment in the case of officer members) should disclose to the Council whether they are related to any other Member of the Council or holder of any office in the Trust.

8.3.4 Where the relationship to a Member of the Council of the Trust is disclosed, the Standing Order headed Disability of Chairman and Members of the Board in proceedings on account of pecuniary interest (SO 7) shall apply.

9. MISCELLANEOUS

9.1 Interface between the Board of Directors and the Council of Governors

9.1.1 The Board of Directors will co-operate with the Council of Governors in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:

(i) The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to Monitor.

(ii) The Directors are to present to the Council of Governors at a general meeting the annual accounts, any report of the Auditor on them, and the annual report. This requirement may be satisfied by at least one Executive Director being present at the relevant meeting to discharge these responsibilities

9.2 Standing Orders to be given to Members of the Council

9.2.1 It is the duty of the Secretary to the Trust to ensure that existing Members of the Council and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

9.3 Review of Standing Orders

9.3.1 Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 31)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Board of Directors

STANDING ORDERS

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, and subject to the Constitution at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Company Secretary to the Board of Directors, or in their absence the Chief Executive or Director of Finance

1.2 Any expression to which a meaning is given in the 2006 Act or in the Regulations and Orders made under the Act shall have the same meaning in these Standing Orders and Standing Financial Instructions, unless the context otherwise requires and in addition:

1.2.1 "**the 2006 Act**" is the National Health Service Act 2006 as amended by the 2012 Act.

1.2.2 "**the 2012 Act**" is the Health and Social Care Act 2012.

1.2.3 "**Accounting Officer**" means the person who from time to time discharges the Functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust it shall be the Chief Executive.

1.2.4 "**Board of Directors**" means the Board of Directors as constituted in accordance with the Constitution.

1.2.5 "**Chairman of the Board of Directors**" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions "the Chairman of the Board" and "the Chairman of the Trust" shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable. The Chairman is also the Chairman of the Council of Governors.

1.2.6 "**Chief Executive**" means the Chief Executive Officer of the Trust.

1.2.7 "**Clear Days**" means in any period the duration of which is determined by a starting and finishing event, all complete days in that period excluding the day when the event referred to as starting the period occurs (for example sending out an Agenda) and the day on which the event referred to as ending the period occurs (for example the date of the meeting). For the avoidance of doubt clear days include weekends and public holidays. As an example an Agenda sent out on a Friday for a meeting on a Wednesday represents four clear days: Friday and Wednesday are excluded so that Saturday, Sunday, Monday and Tuesday are the four clear days.

1.2.8 “**Clinical Governance** Committee" means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Trust has responsibility.

1.2.9 "**Committee**" means a formal committee or sub-committee created and appointed by the Board of Directors.

1.2.10 "**Committee members**" means members formally appointed by the Board of Directors to sit on or to chair specific committees.

1.2.11 “**Constitution**” means this constitution and all annexes to it.

1.2.12 " **Council of Governors**" means the Council of Governors of the Trust as constituted in accordance with Annex 4 of the Constitution.

1.2.13 "**Director of Finance**" means the chief financial officer of the Trust appointed to discharge the usual functions of its chief financial officer..

1.2.14 "**Executive Director**” means a member of the Board of Directors who holds an executive office of the Trust.

1.2.15 “**FT Code of Governance**” means the NHS Foundation Trust Code of Governance issued by Monitor from time to time.

1.2.16 “**Funds** held on trust” shall mean those funds which the Trust holds on incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under the Regulatory Framework. Such funds may or may not be charitable.

1.2.17 "**Member**" means Executive Director or Non-Executive Director of the Board of Directors as the context permits.

1.2.18 “**Monitor**” means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

1.2.19 “**Nominated Officer**" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.20 "**Non-Executive Director**" means a member of the Board of Directors who does not hold an executive office with the Trust and is appointed by the Council of Governors.

1.2.21 "**Staff**" means any employee of the Trust who is not a Director, or any other person who is the equivalent of an employee at the Trust and who in the discretion of senior management should be treated as an employee.

1.2.22 “**Regulatory Framework**” means the 2006 Act, the Trust’s NHS provider licence and the Trust’s constitution.

1.2.23 "**SFIs**" means Standing Financial Instructions approved by the Board of Directors and reviewed by it from time to time..

1.2.24 "**SOs**" means Standing Orders.

1.2.25 “**Scheme of Delegation**” means the schedule of matters reserved to the Board of Directors and the Delegation of Powers, as approved by the Board of Directors and reviewed from time to time.

1.2.26 "**Trust**" means the Royal Orthopaedic Hospital NHS Foundation Trust.

1.2.27 "**Trust Secretary**" means a person appointed by the Trust in accordance with the Constitution to be the Trust Secretary to act independently of the Board of Directors and the Council of Governors to provide advice relating to the governance of the Trust and monitor the Trust's compliance with the Regulatory Framework.

1.2.28 “**Vice Chairman**" means the Non-Executive Director appointed by the Council of Governors in general meeting from the Non- Executive Directors as Vice Chairman to take on the Chairman's duties in his capacity as Chairman if the Chairman is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

(1) The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the 2006 Act.

(2) The principal place of business of the Trust is Royal Orthopaedic Hospital NHS Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

(3) NHS Foundation Trusts are governed by the 2006 Act, their constitutions and their NHS provider licences issued by Monitor (the Regulatory Framework).

(4) The functions of the Trust are conferred by the Regulatory Framework.

(5) As a body corporate, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients property held by the Trust on behalf of patients

(6) The Regulatory Framework requires the Trust to adopt Standing Orders for the regulation of its proceedings and business.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

(8) The Scheme of Delegation and the Standing Financial Instructions provide a comprehensive business framework for the administration of the Trust's affairs and need to be read in conjunction with the Constitution. All Directors and Nominated Officers should be aware of the existence of these documents and where necessary familiar with the detailed provisions contained in them.

1.2 Monitor and the NHS Framework

(1) In addition to the statutory requirements, Monitor's provider licence requires the Trust to comply with best practice in the NHS.

(2) The Regulatory Framework requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board of Directors, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The framework also requires the establishment of audit and remuneration and nominations committees with formally agreed terms of reference.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers – Scheme of Delegation

The Trust has powers to delegate and make arrangements for delegation. Under SO5 (Arrangements for the Exercise of Trust Functions by Delegation) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Board of Directors of any of its functions by a committee of the Board of Directors or sub-committee appointed by virtue of SO 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit. Delegated Powers are covered in the Scheme of Delegation.

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERS AND TENURE

2.1 Composition of the Membership of the Board of Directors and principles for the appointment of members and role of the Nominations and Remuneration Committees

(1) In accordance with the Trust's constitution, the composition of the Board of Directors shall be:

(i) A non-executive Chairman who is also the Chairman of the Council of Governors;

(ii) Up to 7 Non-Executive Directors;

(iii) Up to 7 Executive Directors;

such that at least half the Board of Directors, (excluding the Chairman), shall be Non-Executive Directors.

(2) The Board will determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. Such factors will include whether the Director:

(i) has been an employee of the NHS Trust within the last five years;

(ii) has had within the last three years, a material business relationship with the Trust either directly, or as a partner shareholder, director or senior employee of a body that has such a relationship with the Trust;

(iii) has received or is receiving additional remuneration from the Trust apart from a director's fee, participates in the Trust's performance-related pay scheme, or is a member of the Trust's pension scheme;

(iv) has close family ties with any of the Trust's advisers, directors or senior employees;

(v) holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;

(vi) has served on the board of the Trust for more than six years from the date of their first appointment.

(3) One of the Executive Directors shall be:

(i) the Chief Executive (whose appointment is to be approved by the Council of Governors except the initial Chief Executive);

(ii) the Director of Finance;

(iii) a Medical Practitioner

(iv) a Registered Nurse

(4) In consultation with the Council of Governors, the Board will appoint one of the Non-Executive Directors who is deemed by the Board of Directors to be independent by reference to FT Code of Governance to be the Senior Independent Director. The term of office of the Senior Independent Director shall be specified by the Board of Directors on appointing him or her but shall not exceed the remainder of his or her term as a Non-Executive Director.

(5) The Senior Independent Director shall perform the role set out in the FT Code for senior independent directors and in SO10(2), and otherwise as summarised in a role description agreed between the Board of Directors and the Council of Governors which shall as a minimum include:

(i) providing a sounding board for the Chairman and serving as an intermediary for other Directors where necessary;

(ii) leading the Non-Executive Directors in the evaluation of the Chairman as part of process agreed with the Council of Governors;

(iii) Being available to governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Director of Finance has failed to resolve or for which such contact is inappropriate; and

(iv) Attending sufficient meetings with Governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of Governors.

The role description of the Senior Independent Director will be updated from time to time to reflect any changes to the role of Senior Independent Governor in the FT Code from time to time.

2.2 Appointment, re-appointment and removal of the Chairman and Non-Executive Directors

As provided by paragraph 26 of the Constitution, the Council of Governors at a general meeting of the Council of Governors shall appoint, re-appoint or remove the Chairman of the Trust and the other Non-Executive Directors.

2.3 Remuneration and terms of office of the Chairman and Non-Executive Directors

(1) The Chairman and the Non-Executive Directors are to be appointed by the Council of Governors at a general meeting at which the Council of Governors shall decide (taking into account the views of the Council of Governors' Nominations and Remuneration Committee);

(i) the period of office;

(ii) the remuneration and allowances; and

(iii) the other terms and conditions of office of the Chairman and other Non-Executive Directors.

2.4 Appointment and removal of Chief Executive and other Executive Directors

(1) As provided by paragraph 29 of the Constitution, the Non-Executive Directors shall appoint or remove the Chief Executive, save that the appointment of the Chief Executive (other than the initial Chief Executive) shall require the approval of a majority of the Governors present and voting at a general meeting of the Council of Governors.

(2) The Nominations Committee of the Board of Directors shall appoint or remove the other Executive Directors

2.5 Remuneration and terms of office of the Chief Executive and the Executive Directors

(1) The Remuneration Committee of the Board shall decide:

(i) The period of office;
(ii) The remuneration and allowances; and
(iii) The other terms and conditions of office of the Chief Executive and other Executive Directors.

(2) The Trust may reimburse Directors' travelling and other costs and

expenses incurred in carrying out their duties at rates determined by the Remuneration Committee of the Board above. These are to be disclosed in the annual report.

2.6 Appointment and Powers of Vice Chairman

(1) Subject to Standing Order 2.6(2) below, the Chairman and members of the Trust may appoint one of their number who is not also an Executive Director, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman. The Chairman and members may there upon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.6 (1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where he/she have been unable to perform his her duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case maybe; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

2.7 ROLE OF THE BOARD

2.7.1 Role of Members

(1) The Board is collectively responsible for the performance of the Trust. The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public.

(2) The Board of Directors will:

(i) provide entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

(ii) be responsible for ensuring compliance by the Trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

(iii) develop and articulate a clear “vision” for the Trust which will

be a formally agreed statement of the organisation's purpose and intended outcomes which can be used as a basis for the organisation's overall strategy, planning and other decisions.

(iv) set the Trust's strategic aims at least annually taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.

(v) as a whole be responsible for ensuring the quality and safety of health care services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies.

(vi) ensure that the Trust functions effectively, efficiently and economically.

(vii) set the Trust's vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met

(3) All Directors:

(i) will take decisions objectively in the best interests of the Trust and avoid conflicts of interest.

(ii) have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.

(iii) have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

(4) Non-Executive Directors will scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They will satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. They are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing executive directors, and in succession

planning.

2.7.2 Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and the Standing Financial Instructions and the Scheme of Delegation.

2.7.3 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she shall be the Accounting Officer for the Trust and shall be responsible to Monitor under the NHS Foundation Trust Accounting Officer Memorandum.

2.7.4 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7.5 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

2.7.6 Chairman

(1) The Chairman shall be responsible for the operation of the Board of Directors and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with their terms of appointment and with these Standing Orders.

(2) The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the debate and ultimate resolutions.

(3) The Chairman will also be the Chairman of the Council of Governors.

2.8 Corporate Approach to Trust Business

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.9 Schedule of Matters Reserved to the Board of Directors and Scheme of Delegation

The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall be read in conjunction with these Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Board Members

The Chairman will ensure that the designation of Lead roles or appointments of Board members as set out in any statutory or other guidance binding on the Trust will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may determine.

(2) The Chairman of the Trust may call a meeting of the Board of Directors at any time.

(3) One third or more members of the Board of Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forth with call a meeting.

(4) Ordinary meetings of the Board of Directors shall be held in public.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three Clear Days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any one member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

(5) Before each public meeting of the Board of Directors a notice of the time and place of the meeting shall be displayed at the Trust's principal offices and on the Trust's website; and the public part of the agenda shall be displayed on the Trust's website at least three Clear Days before the meeting.

3.3 Agenda and Supporting Papers

The Agenda and supporting papers, will be sent to Members no later than three Clear Days before the meeting, save in emergency. Failure to despatch the agenda and supporting papers within the above timescales shall not affect the validity of a meeting unless the consequences of such failure were to reduce attendance at the meeting below a level at which the meeting was quorate.

3.4 Petitions

Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board of Directors wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

(2) The notice shall be delivered at least 10 Clear Days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 ‘Motions: Procedure at and during a meeting’, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

(i) Who may propose

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

(ii) Contents of motions

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board of Directors;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

(iii) Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(iv) Rights of reply to motions

(a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their

amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

(v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

(vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business (*);
- that the question should be now put (*);
- the appointment of an 'adhoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion resolving to exclude the public, including the press.

(*) In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Board of Directors it shall not be competent for any director other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or

recommendations of a Committee or the Chief Executive

3.9 Chairman of meeting

(1) At any meeting of the Board of Directors the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (if the Board of Directors has appointed one), if present, shall preside.

(2) If the Chairman and Vice-Chairman are absent, such member (who is not also an Executive Director of the Trust) as the members present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions)and their interpretation of the Standing Orders and Standing Financial Instructions ,at the meeting, shall be final.

3.11 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Members (including at least one Member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(2) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(3) If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, at the discretion of the Chairman the meeting shall stand adjourned and the Trust Secretary shall give or shall procure the giving of notice to all Members of the date, time and place of the adjourned meeting. Notwithstanding Standing Order 3.11(1) above, upon convening, those present shall constitute a quorum.

(4) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

(1) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.13 - Variation and Amendment of Standing Orders, every

question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote.

(2) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(3) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(4) If a member so requests, their vote shall be recorded by name.

(5) In no circumstances may an absent member vote by proxy. A Member may only vote if present at the time of the vote on which the question is to be decided. A Member is considered to be present at a meeting in the circumstances outlined in SO 3.16 below.

(6) A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

(7) A manager attending the Board of Directors meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or rules relating to the quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board of Directors are present (including at least one member who is an Executive Director of the Trust and one Non-Executive who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the decision to suspend Standing Orders shall be recorded in the Board's minutes.

(2) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

(3) Formal business can only be transacted while standing orders have been suspended with the written agreement of the Audit Committee.

(4) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall be amended only if the variation proposed does not contravene the Regulatory Framework any guidance or best practice advice issued by Monitor and is approved in accordance with paragraph 45 of the Trust's Constitution

3.15 Record of Attendance

(1) The names of the Chairman and Directors present at the meeting shall be recorded.

3.16 Participation in Meetings

(1) Any Director or Member of a Committee of the Board of Directors may participate in a meeting of the Board of Directors or such committee by telephone, computer or video link whereby all persons participating in the meeting can hear each other participate in the meeting in this manner shall be deemed to constitute presence, to count towards a quorum and in the event of a vote count toward that vote.

(2) All decisions taken in good faith at a meeting of the Board of Directors or at any Committee of the Board shall be valid and shall not be invalidated even if it is discovered subsequently that there was a defect in the calling of the meeting, or by any vacancy of its membership or defect in a Director's appointment.

3.17 Minutes

(1) The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

(2) No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

3.18 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all public meetings of the Trust, but shall be required to withdraw upon the Board of Directors deciding as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'-Guidance should be sought from the NHS Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

The Chairman (or Vice -Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board of Directors to complete its business without the presence of the public'.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed' Items Taken in Private 'outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **(Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon a resolution of the Board of the Trust.

3.19 Observers at Board of Directors meetings

The Board of Directors will decide what arrangements and terms and

conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board of Directors' meetings and may change, alter or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

(1) Subject to the Regulatory Framework, the Board of Directors may appoint committees consisting of Directors.

(2) The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committees as the context permits, and the term “member” is to be read as a reference to a member of other committees also as the context permits. (There is no requirement to hold meetings of committees established by the Board of Directors in public.)

4.3 Confidentiality

4.3.1 A Member of a Committee shall not disclose a matter dealt with, by, or brought before, the Committee without its permission until the Committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

4.3.2 A Director or a Member of a Committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or Committee shall resolve that it is confidential.

4.4 Terms of Reference

Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

4.6 Approval of Appointments to Committees

The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Regulatory Framework, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the relevant legislation.

4.8 Committees established by the Board of Directors

4.8.1 The committees and sub-committees established by the Board of Directors are:

(i) Remuneration Committee;

(ii) Nominations Committee;

(iiii) Clinical Governance Committee; and

(iv) Audit Committee.

4.8.2 The constitution and terms of reference of Committees referred to in SO 4.8.1 shall be as set out in terms of reference to be agreed by the Board of Directors.

4.8.3 Other Committees

The Board of Directors may also establish such other committees as required to discharge the Trust's responsibilities

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 The Board of Directors may make arrangements for the exercise, on

behalf of the Board of Directors, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board of Directors has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board of Directors for noting.

5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by other committees or sub-committees, which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees, or sub-committees and their specific executive powers shall be approved by the Board of Directors.

5.4 Delegation to Nominated Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board of Directors. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance to provide information and advise the Board of Directors in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board of Directors as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall be read in conjunction with these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non- compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the Royal Orthopaedic Hospital NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for the Royal Orthopaedic Hospital NHS Foundation Trust staff

- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND STAFF UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to the Board of Directors

The Regulatory Framework requires members of the Board of Directors to declare interests which are relevant and material to the Board of Directors of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment. All interests should be "re-declared" at least annually

7.1.2 Interests which are relevant and material

(1) Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance and best practice advice issued by Monitor:

(i) Directorships, or equivalent held in private companies, public limited companies, (with the exception of those of dormant companies), NHS organisations, government departments, local authorities, charities or voluntary organisations. This includes positions of authority which are comparable to a director in a company, such as a trustee of a charity or voluntary organisation and partnerships (including membership of LLPs).

(ii) Subject to SO 7.3.(1) (iv) any pecuniary interest in a contract within the meaning of SO 7.3 (1) (iii) other than those pecuniary interests that are not regarded as such under SO7.3(1)(iv) (Exception to Pecuniary Interests).

(iii) Direct ownership or part-ownership of private companies, public limited companies, partnerships (including membership of LLPs) or sole trader businesses in the field of health and

social care, for example pharmaceuticals, medical devices, and some consultancy or IT. For the avoidance of doubt interests held via pooled investments such as investment trusts, unit trusts and pension funds managed by an independent manager should be excluded under this heading.

(iv) Direct ownership or part-ownership of private companies, public limited companies, partnerships (including membership of LLPs) or sole trader businesses likely to do business with the Trust. For the avoidance of doubt interests held via pooled investments such as investment trusts, unit trusts and pension funds managed by an independent manager should be excluded under this heading.

(v) Any employment, volunteer position or fee generating relationship with an organisation in the field of health or social care.

(vi) Research funding/ grants that may be received by an individual or their employer or organisation of which they are a director to fund work that they are directly involved or which any private or public company, business or consultancy which is owned in whole or part by them is directly involved in.

(2) If any member of the Board of Directors comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member should have declared their interest under 7.1.2 (1) (ii) but if they have not already done so, they should do so by giving notice in writing of such fact to the Trust as soon as practicable. In addition they should alert the Chairman of any such interest at the beginning of every Board meeting at which such contract is likely to be material to any Board discussion, notwithstanding that such interest has already been declared and recorded on the Register of Director's interests.

7.1.3 **Advice on Interests**

(1) If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Board of Directors or with the Trust's Company Secretary.

(2) Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

7.1.4 Recording of Interests in Board minutes

(1) At the time Board members' interests are declared, they should be recorded in the Board minutes.

(2) Any changes in interests should be declared at the next Board of Directors meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of declared interests in Annual Report

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of interest which arise during the course of a meeting

During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

(1) The Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Board members. The Register shall include the names of each Director, whether he has declared any interests and, if so, the interests declared and details of the business of the organisations declared.

(2) These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

(3) The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Members in proceedings on account of Pecuniary Interest

(1) Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) “Pecuniary interest” subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

(a) they, or a nominee of theirs, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(b) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

(a) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or

(b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract, or

(c) those securities of any company in which they (or any person connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one percent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph(c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the Board of Directors

(1) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contractor other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question

with respect to it.

(2) The Board of Directors may exclude the Chairman or a member of the Board from a meeting of the Board of Directors while any contract, proposed contractor other matter in which they have a pecuniary interest is under consideration.

(3) Any remuneration, compensation or allowance payable to the Chairman or a Member in their capacity as Chairman or member of the Board of Directors as agreed by the Remuneration and Appointments Committee shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(4) This Standing Order applies to a committee or sub-committee as it applies to the Board.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and Guidance

Directors must comply with the Trust's Constitution, the requirements of the Regulatory Framework and any guidance and best practice advice issued by Monitor or any policies issued by the Trust.

7.4.2 Interests of Staff

(i) Any member of Staff of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the member of Staff shall declare their interest by giving notice in writing of such fact to the Company Secretary or Chief Executive as soon as practicable.

(ii) Any member of Staff should also declare to the Company Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. This could include any significant opportunity for personal gain, financial or otherwise associated with the member of Staff's status as an member of Staff of the Trust and access to the Trust's resources, for example relating to IP, wider know how, brand and reputation.

(iii) The Trust will require interests, employment or relationships of members of Staff so declared to be entered in a register of interests of Staff. All declarations across the Trust should be "re-declared" at least annually. Trust management shall have discretion regarding which members of Staff or which staff groups are required to add an entry in the register of interests of Staff. For example management may decide that it is not a proportionate approach to risk management to require junior staff with no budgetary responsibility

to add their entry to the register of interests of Staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

(i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust

7.4.4 Relationships of Directors or Officers

(i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Director or Officer of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(ii) The Chairman and every Executive and Non-Executive Director of the Trust shall disclose to the Board of Directors any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

(iii) On appointment, Non-Executive Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed "Disability of Chairman and members in proceedings on account of pecuniary interest" (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Company Secretary or a nominated manager by them in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 Register of Sealing

The Company Secretary shall keep a register in which they, or another manager of the Authority authorised by them, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

(1). The Board of Directors will co-operate with the Council of Governors in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:

(i) The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to Monitor.

(ii) The Directors are to present to the Council of Governors at a general meeting the annual accounts, any reports of the Auditor on them, and the annual report. This requirement may be satisfied by at least one Executive Director being present at the relevant meeting to discharge these responsibilities

10. COMMUNICATION AND CONFLICT

(1) These Standing Orders describe the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasizes the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests

an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

(2) Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides. The Senior Independent Director or Chairman will encourage informal methods of communication on behalf of the Board of Directors including: discussions between Governors and the Chairman, the Chief Executive or a Director, through the office of the Chief Executive or any other person appointed to perform the duties of the Chief Executive to the Board.

(3) Formal communications are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively. Communications initiated by the Council of Governors, and intended for the Board of Directors, will be conducted as follows:-

(i) Specific requests by the Council of Governors will be made through the Chairman, to the Board of Directors;

(ii) Any Governor has the right to raise specific issues at a duly constituted meeting of the Council of Governors through the Chairman. In the event of disagreement, two thirds of the Governors present must approve the request. The Chairman will raise the matter with the Board of Directors and provide the response to the Council of Governors.

(iii) Joint informal meetings will take place between the Council of Governors and the Board of Directors as and when necessary.

(4) The following formal methods of communication will also be used:-

(i) Provision of formal reports or presentations by Executive Directors to a meeting of the Council of Governors.

(ii) Reporting the views of the Council of Governors to the Board of Directors through the Chairman or Vice Chairman.

(5) The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

(6) If through informal efforts the Chairman cannot achieve resolution of a disagreement or conflict, the Chairman will follow the dispute resolution procedure as described in Annex 9.

11 MISCELLANEOUS (see overlap with SFI No.21.3)

11.1 Standing Orders to be given to Board of Directors

It is the duty of the Company Secretary to the Trust to ensure that existing Board of Directors and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

11.2 Review of Standing Orders

Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph10.4)

1. Disqualification

1.1 A person may not become a member of the Trust if within the last five years they have been involved as a perpetrator in an incident of violence or abuse:

1.1.1 at any NHS hospitals or facilities;

1.1.2 against any NHS employees or other persons who exercise functions for the purposes of the NHS;

1.1.3 against registered volunteers;

1.1.4 against patients or the public on NHS premises.

2. Expulsion from membership of the Trust

2.1 A Member shall cease to be a Member if:

2.1.1 they resign by notice to the Company Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this Constitution;

2.1.4 they cease to be entitled under this Constitution to be a member of any of the Public Constituencies or of any of the classes of the Staff Constituency;

2.1.5 if after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a Member.

2.2 A Member may be expelled by a resolution approved by not less than two- thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors. The following procedure is to be adopted:

2.2.1 Any Member may complain to the Company Secretary that another Member has acted in away detrimental to the interests of the Trust, or is otherwise disqualified as set out in paragraph 2 above.

2.2.2 The Chairman of the Council of Governors, assisted by the Company Secretary, will judge the manner in which the

complaint should be managed.

2.2.3 If appropriate, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that the point of view of the Members involved is heard and may either:

2.2.3.1 dismiss the complaint and taken no further action; or

2.2.3.2 arrange for the complaint to be considered at the next meeting of the Council of Governors.

2.2.4 Details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the next meeting of the Council of Governors.

2.2.5 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

2.2.6 If the Member complained of fails to attend the meeting without reasonable cause the meeting may proceed in their absence.

2.2.7 The Council of Governors will take a view on the complaint and may decide to expel the Member from membership of the Foundation Trust. To effect expulsion from membership, the Council of Governors will adopt a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

2.2.8 A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel that person has been carried.

A member who is expelled may apply for re-admission to membership. This application is to be made in writing to the Chairman, who will arrange for the application to be considered by the next meeting of the Council of Governors. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

3. Trust Secretary

3.1 The Trust may have a Trust Secretary, who shall be appointed and removed by the Chairman and Chief Executive acting jointly.

4. Indemnity

4.1 The Trust Secretary and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly and the Trust may also take out and maintain for their benefit insurance against such risks. Any costs arising in this way will be met by the Trust.

5. **Vacancies**

The validity of any act of the Trust is not affected by any vacancy among the Directors or the Members of Council or by any defect in the appointment of any Director or Member of Council.

6. **Directors**

6.1 If:

6.1.1 an Executive Director is temporarily unable to perform their duties due to illness or some other reason(the "Absent Director");and

6.1.2 the Board of Directors agree that it is inappropriate to terminate the Absent Director's term of office and appoint a replacement director; and

6.1.2 the Board of Directors agree that the duties of the Absent Director need to be carried out;

then the Chairman (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting director as an additional director to carry out the Absent Director's duties temporarily.

6.2 For the purposes of paragraph 6.1 of this Annex, the maximum number of directors that may be appointed under paragraph 23 of the Constitution shall be relaxed accordingly.

6.3 The Acting director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint them under this paragraph notifies them that they are no longer to act as an Acting director.

6.4 An Acting director shall be an Executive Director for the purposes of the 2006 Act. He/she shall be responsible for their own acts and defaults and he/she shall not be deemed to be the agent of the Absent Director.

7. **Vacant Executive Director Positions**

7.1 If:

7.1.1 an Executive Director post is vacant ("Vacant Position");and

7.1.2 the Board of Directors agree that the Vacant Position needs to be filled by an interim post holder pending appointment of a permanent post holder,

then the Chairman (if the Vacant Position is the Chief Executive) or the Chief Executive (in any other case) may appoint a director as an interim director ("Interim Director") to fill the Vacant Position pending appointment of a permanent post holder.

7.2 The Interim Director will vacate office on the appointment of a permanent post holder or, if earlier, the date on which the persons entitled to appoint them under this paragraph notifies them that they no longer wish them to act as an Interim Director.

7.3 An Interim Director shall be an Executive Director for the purposes of the 2006 Act including purposes such as counting toward the quorum and voting rights.

8. **Vacant Council of Governor positions**

8.1 When a vacancy arises for one or more elected Members of Council, the Council of Governors shall have the option:

8.1.1 to take from the list of members who stood for election at the most recent election of Members of Council for the class or constituency in question whichever member who was not elected as a Member of Council at the recent election but had secured the next most votes at that time. This procedure, which shall be an uncontested election for the purposes of the Model Rules for Elections as they apply to the Trust, shall be available to the Members of Council on 2 occasions within 12 months of the previous election. Members of Council appointed in this way shall hold office for a minimum of 6 months from their appointment but, subject thereto, shall hold office until the earlier of the conclusion of the next election of Members of Council and (except where the vacancy arose through expiry of a term of office) the date on which would have expired the term of office of that Member of Council whose cessation of office gave rise to the vacancy;

8.1.2 to hold the post vacant until the next scheduled annual election of Members of Council; or

8.1.3 proceed to call an election for the vacant post.

ANNEX 10 – TRUST PRINCIPLES

Trust values

The Trust's values aim to create a culture of excellent patient care by ensuring all at the Trust:

- Respect and listen to everyone
- Have compassion for all
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Be open, honest and challenge ourselves to deliver the best
- Learn, innovate and improve to continually develop orthopaedic care

Members of Council

As to qualities of Members of Council:

- Honesty and integrity
- Demonstrates the Trust Values and is able to act and take decisions in accordance with the Trusts Equality and Diversity Policy and the Equality Act 2010 in particular to have due regard for factors in relation to the following protected characteristics as specified in the Equality Act of patients and staff:
- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.
- Representation of broad public constituency
- Awareness of community diversity and a willingness to be trained in that context

The Council of Governors may from time to time amend or vary such statement of principles as it thinks fit.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD
ON
WEDNESDAY 26 NOVEMBER,
10.00AM IN THE BOARD ROOM

AGENDA

ITEM	TITLE	NOTES	BOARD ACTION	PAPER
11/14/146	**Apologies & Welcomes**		To Note	
11/14/147	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
11/14/148	**Patient Case – an illustration of the work we do** Director of Nursing and Governance			
11/14/149	**Minutes of Public Board Meeting held on the 29th October 2014** Chairman		For Approval	Enc. 1
11/14/150	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
11/14/151	**Chairman & NED update** **Including:** • Governor election results • NEDs objectives progress and sharing • Recruitment of additional NED • Attendance at Council meetings by NEDS • FTN events for NEDs • Minute of Appointment Committee meeting for the appointment of the Director of Operations • December Board development event – proposals and discussion • Ratification of Tender for building work Chairman & NEDs		For Information	

11/14/152	**Chief Executive's Report** **Including:** • AHSN genomics submission approval by CEO and Chair Chief Executive		For Information and Assurance	Enc. 3
11/14/153	**Medical Director's Update** Medical Director **Including:** • Update on research activities		For Information and Assurance	Enc. 4
	Performance Management / Assurance Reports			
11/14/154	**Corporate Performance Report including report on action to improve referral to treatment times** Director of Finance and Director of Operations		For Assurance	Enc. 5
11/14/155	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 6
11/14/156	**Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 7
11/14/157	**Board Assurance Framework** Director of Nursing & Governance		For Assurance	Enc. 8
11/14/158	**CQC Action Plan** Director of Nursing & Governance		For Assurance	Enc. 9
	Strategy			
11/14/159	**Update on Five Year Strategic Plan including update on the tariff** Chief Executive and Director of Finance		For Information	Enc. 10

11/14/160	**Approval of amendments to the Constitution/ Standing Orders including the following Notice** Dear Jo **Notice of motion to propose the amendment of Trust Board Standing Orders** We hereby give notice of a motion under Standing Order 3.5 as required by Standing Order 3.14, namely: *That the Standing Orders of the Board of Directors be amended in such manner as will be detailed in the relevant Trust Board paper (including appendices) to be provided for the Board meeting later this month.* Thank you. Frances Kirkham and Rod Anthony Non-executive directors **Company Secretary**		For final approval and adoption	Enc. 11
	Board Committees			
11/14/161	**Audit Committee**		For Assurance	Enc 12
11/14/162	**Clinical Governance Committee**		For Assurance	Enc 13
11/14/163	**Charitable Funds Committee**		For Assurance	Verbal
11/14/164	**Council of Governors** Chairman		For Information	Verbal
11/14/165	**Board Calendar 2015** Chairman			Enc 14
11/14/166	**Any Other Business**			
	Date of Next Meeting: Wednesday 4 February 2015 at a time to be advised. **There is also a private Board development event planned for Wednesday 7 January 2015.**			

Confidential Matters

To resolve:

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

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

Enclosure 1

Minutes of the Trust Board Meeting
held in public on October 29th 2014 in the Boardroom

Present:
Trust Board
Dame Yve Buckland, Chairman
Mrs Jo Chambers, Chief Executive
Mr Jonathan Lofthouse, Director of Operations
Mr Paul Athey, Director of Finance
Mr Rod Anthony Non-Executive Director
Mr Tim Pile Non-Executive Director
HH Frances Kirkham, Non-Executive Director
Mrs Helen Shoker, Director of Nursing & Governance
Mr Andrew Pearson, Medical Director
Professor Tauny Southwood, Non-Executive Director

In attendance:
Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Mr Julian Denney, (Interim Company Secretary)
Professor Phil Begg Director of Strategy and Transformation (Designate)
Mr Alan Last, Former Lead Governor
Ms Marion Betteridge, Public Governor
Ms Yvonne Scott, Public Governor
Mr Rob Talboys, Public Governor
Ms Karen Hughes, Staff Governor
Ms Marion Thompson, Appointed Governor

Apologies:
Ms Elizabeth Chignell, Non-Executive Director
Mr Roger Tillman Deputy Medical Director

Agenda No.	Agenda Item	ACTION
10/14/135	**Apologies and welcomes** Apologies were received from Elizabeth Chignell and Roger Tillman Luke Gibbin from Johnson and Johnson was welcomed as a member of the public	
10/14/136	**Declarations of Interest** Rod Anthony stated that he is acting as interim Director of Finance of the Big Lottery Fund for c 3months	

<table>
<tr><td></td><td>It was noted that following a suggestion from Frances Kirkham, a “bible” of key documents was available for inspection including the Constitution and the registers of interest.</td><td></td></tr>
<tr><td>10/14/137</td><td><u>Minutes of the Trust Board meeting held on 24th September 2014</u>
It was agreed that formal titles should be used in the list of those present , in attendance, and giving apologies

Resolved:
That with the above amendment the minutes of the above meeting be and are hereby approved as a true record.</td><td></td></tr>
<tr><td>10/14/138</td><td><u>Trust Board Action Points</u>
The action notes were updated (see separate sheet):

<table>
<tr><th>Action</th><th>Comment</th></tr>
<tr><td>03/14/44 Corporate Performance Report

(26.03.14)

FK asked that a report on paediatrics be given to a future meeting</td><td>Keep until November – then take off and build into Transformation Programme</td></tr>
<tr><td>05/14/88

Create Action Plan to address issues identified by the CGC</td><td>Still proceeding suggest review in November</td></tr>
<tr><td>07/14/93

The Board requested that a further discussion be held about the pre-operative pathway.</td><td>Will be brought back to the next full public Board meeting</td></tr>
<tr><td>07/14/98

The personal databases issue should be added to the risk register.

The Medical Director agreed</td><td>Completed</td></tr>
</table>
</td><td></td></tr>
</table>

to resend his letter with a return copy to be returned signed by the individual clinician	
07/14/100 Additional metrics relevant to patient concerns (e.g. waiting times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.	To be deferred to November
07/14/107B It was agreed that Tauny S should meet up with the key individuals carrying out the Research Stocktake.	Completed - close
07/14/108 It was noted that a number of suggestions had been made for further amendments to the Constitution	In progress – completion expected end October
09/14/121A FTN Conference: Elizabeth Chignell offered to attend and this was agreed and the CEO said that she would add her to the list.	Completed
09/14/121B NEDs wished to know the dates of clinical audit meetings - . Roger Tillman agreed to ask Jane Jones to let all NEDs know the dates	Completed

	of the meetings.		
	09/14/124 The Board considers that, regarding the RTT backlog: •For adult patients the Trust should reallocate some theatre sessions to those clinicians with serious backlogs. This may also free up some clinicians to support the Transformation agenda •For paediatric patients the Trust should seek PICU beds from any realistic source; managing the consultant timetable will still be difficult even if these are found •The Board supports the Director for Operations in pressing the Commissioners to have a Clinical Senate debate where there are clear clinical risks for particular patients	On the agenda today	
	09/14/126 Regarding Safe Staffing an assessment will be made regarding how the level of incidents compares with other providers	To be deferred to November	
10/14/139	**<u>Procedural Matters</u>** Frances Kirkham and Tauny Southwood left the room for this item The Chairman reported that the Trust had previously asked Frances Kirkham and Tauny Southwood to continue to serve		

as Non-Executive Directors after January 2014. Due to an oversight on the Trust's part the Council of Governors did not make a formal approval of their appointment for a second term when their current term of office expired: on 31st January 2014 in the case of Tauny Southwood and 10th February 2014 in the case of Frances Kirkham.

The Chairman further reported that both Tauny and Frances had nevertheless continued as if in office from that date to the current date and she thought that they had acted in complete good faith and had been doing an excellent job in an equivalent role to that of a Non-Executive Director.

Members of the Council had agreed that had they been aware that Tauny's and Frances' terms of office had come to an end, they would have appointed them as non-Executive Directors at a general meeting of the Council prior to the expiry of their terms of office and they have formally appointed them for a second term of office at their meeting this morning.

She noted that even if Tauny and Frances were excluded from the calculation of the Quorum of the Board since February 2014, all Board meetings since that time would have been quorate.

She also noted however that the Tauny and Frances were members of the following Committees:

	Remuneration& Nominations	CGC
FK	Member	Member
TS	Member	Chairman

Frances Kirkham was also Chairman and Tauny Southwood a member, of the Charitable Funds Committee which is not a committee of the Board, but a committee of the ROH in its role as corporate trustee.

The Trust considers that all business conducted at the above Committees was conducted properly and in good faith and hereby resolves to re-appoint Tauny and Frances to their respective roles on these committees (and in the case

	of the former Remuneration and Nominations Committee, its successor committees), to the maximum extent possible in law, as if they had been appointed prior to the expiry of the first term of office on 31st January 2014 in the case of Tauny Southwood and 10th February 2014 in the case of Frances Kirkham. However in order that there can be no doubt about the validity of business transacted and the legal effect of decisions taken at the above committee meetings between 1st February 2014 and the date of this Board meeting, the Board agrees that meetings of the following Committees will be convened immediately after this Board meeting to ratify the decisions taken during that period: Remuneration Committee Nominations Committee Clinical Governance Committee	
10/14/140	**<u>Appointment of Vice Chairman of the Trust Board</u>** Mr Tim Pile left the room for this item. The Chairman stated that Tim Pile has acted in the role of Vice Chairman on an informal basis and the purpose of the paper was to confirm his appointment formally. She also stated that Tim Pile has acted as Senior Independent Director. The appointment needs to be approved by both the Council of Governors and the Trust Board. **Resolved:** The Trust Board hereby approves the appointment of Tim Pile as Vice Chairman of the Trust Board and Senior Independent Director	
10/14/141	**<u>Trust Board Committees</u>** The interim Company Secretary explained the rationale for the paper which proposed various changes in relation to the Trust Board's Committees in line with the latest revision to the Constitution, the Foundation Trust Code of Governance and the Trust's Strategy and the requirement to update the terms of reference of Committees on a regular basis. He drew Board members attention to the names of proposed	

Chairmen and Committee members as listed in Appendix 1.

Points made in discussion:

The appointment of Chairmen and Committee members as listed in Appendix 1 was approved with the following changes:

- Frances Kirkham has not been a member of the Audit Committee in the past and will not be so in the future
- The new NED is appointed by the Board to join the Audit Committee as soon as practicable after their appointment to the Board and the Board delegates to the Chairman of the Audit Committee and the Chairman of the Trust the authority to agree this date with the new NED and Elizabeth Chignell.
- Elizabeth Chignell will continue to be a member of the Audit Committee until the new NED joins the Audit Committee
- The changes associated with the appointment of the new NED will be confirmed by the Board as soon as the date is known
- It was also agreed that all Committees should have the power to elect one of their members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman and their Terms of reference should be amended to reflect this.

The membership of the Board's Committees is therefore as follows:

	Aud	Rem	Noms	CGC	Trans
YB		M	C		M
TP	M	M	M		C
FK		M	M	M	
EC	M until new NED takes over	C	M	M	M
TS		M	M	C	
RA	C	M	M		M
New NED	M	M	M	M	M
CE			M	M	M
MD				M	M
DN				M	M
DF					M

DO					M	

It was also noted that the old job title for the Director of Nursing and Governance had been used in the CGC TOR and that this would be corrected in the final version

Resolved:

The Trust Board hereby:

1. Agrees that all Committees should have the power to elect one of their members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman and their Terms of reference in the appendices 2a to 2e below should be amended to reflect this and subject to this change hereby:

2. Approves the replacement of the existing Nominations and Remuneration Committee with a Nominations Committee with terms of reference in Appendix 2a and a Remuneration Committee with terms of reference in Appendix 2b
2.Approves the abolition of the Investment Committee
3.Approves the creation of a new Transformation Committee with terms of reference in Appendix 2c
4.Approves the revised terms of reference of the Audit Committee as detailed in Appendix 2d
5.Approves the revised terms of reference of the Clinical Governance Committee as detailed in Appendix 2e subject to the change in wording referred to above

and subject to the amendments in the "Points made in discussion" section and associated summary table above hereby approves the appointment of Chairmen and Committee members as listed in Appendix 1

10/14/142 **<u>Chairman and NEDs' update including update on CQC inspection</u>**

Dame Yve Buckland, Chairman invited the CEO to provide an update for the Board as follows:

Update on CQC inspection

- Overall the "Requires Improvement" recommendation is accepted. There were no substantive points raised that had not already been identified by the Trust.
- Some of the most significant areas for improvement have already been discussed at the Board for example long

	waits in Outpatients. Some early work will be done, buying and using scheduling tools to create some early improvements while recognising that this activity is part of a long term improvement journey •There were some safety issues in HDU which the Trust challenged – nonetheless steps have been taken to strengthen the provision of equipment in HDU and the Trust is confident that the CQC concerns have been addressed •The Trust is inviting CQC to come back in 6 months for a limited scope inspection focusing on the services giving greater concern. This inspection creates the opportunity for those services to be rerated. •The Trust intends to push for some of the ground breaking surgical work to be recognised as outstanding over the longer term. •A Board agreed action plan will be created and submitted to CQC (this will be circulated to Board members by email circulation). The action plan will be shared with Audit Committee ***Strategy*** •There are a number of streams of work carrying on. These include defining priorities in more detail and sequencing those priorities based on dependencies between one activity and another and mapping existing activities to programme workstreams. The afternoon Board workshop will focus on this activity. •Regarding governance of the programme a Committee of the Board chaired by Tim Pile will be set up to oversee the transformation. •Phil Begg has been appointed as director of strategy and transformation as the executive lead. ***Tariff*** PA reminded the Board that the Tariff Engagement Document published in August had stated that there was the potential for a c £5.5m (12%) potential loss in 2015/16 based on Monitors' tariff proposals. A great deal of work has been done with Monitor to influence the tariff discussions, in conjunction with the SOA and national Clinical reference groups including three face to face meetings with Monitor and NHS England. The original loss was made up of a 5% loss related to a reduction the overall national quantum of funding for	**HS**

orthopaedics, and a 7% loss linked to our specialist casemix.

The Trust and the SOA have been successful in addressing the casemix issue. Monitor have acknowledged some of our concerns, and due to the short timescale available to make changes, they have reverted back to 2014/15 relativities at a HRG level. This avoids the 7% loss of casemix.

Monitor have not made any overall changes to the quantum issue, but again have acknowledged our concerns. They also agreed they will commission an independent review of the orthopaedic tariff in advance of 2016/2017. For 2015/16, there will also be a smoothing adjustment associated with transition to the new quantum, so the Trust expects to only incur 1/5th of the total hit on the quantum change in the next financial year.

A very positive aspect of this work was a great deal of joint work with the Consultant team

Overall the predicted loss has been reduced from c 12% to c1-2% in 2015/2016 and the Board congratulated Paul and his team for this progress.

Long Waiters

JL provided an update as follows:

The ROH now has commissioners agreement to participate in the national scheme and a funded waiting list initiative

Previous reference has been made to the backlog in long waiters and the negotiations with commissioners about clearing it. These negotiations have emphasised the impact on patients of long waits particularly those with the most complex needs.

At a late stage the NHS England area team and commissioners agreed that the ROH could join the national scheme for c 210 patients in October and November; the ROH will receive c£1.4m and will have a target exemption while the backlog is being cleared. c 179 patients have been cleared to date and we are on track to clear the targeted backlog.

The biggest challenge is spinal deformity because of the scarcity PICU resources and pressures on the BCH. Additional relationships are being developed with other

	trusts with PICU facilities. The potential to convene a clinical risk senate is being considered for January 2015. We are also helping neighbouring acute trusts from Walsall, Gwent and Hereford clear their backlogs. Capacity and demand planning tools have been purchased and will go live on November 10th. These should help optimise consultant workloads and support the achievement of the 18 week target. Governors have raised previously the importance of maintaining the patient experience while additional activity has been taking place. Private facilities are being used to support some of this work; it is currently being used only for NHS work pending the completion of the review of the private ward to ensure that it can be run profitably although it was noted that private demand is limited. Tim Pile volunteered to help develop the private ward business model. The Board congratulated Jonathan and his team for this progress which had also been strongly supported by the Council. ***100000 Genome Project*** This project seeks to map the genomes of 100 000 people by 2017. The CEO reported on further progress on the Genome project and described a proposal for the ROH to participate in Wave 2 which the Board supported; it approved this proposal in principle and delegated the Chair and CEO the authority to complete it and submit it. It was also agreed that the draft proposal would be circulated to Board members. **Resolved:** That the above update be noted.	
10/14/143	**<u>Quarter 2 Declaration – July to September 2014</u>** The CEO introduced the Quarter 2 declaration and invited a	

	discussion as follows : • This is a regular responsibility of the Board and forms part of a report to Monitor •It was agreed that recent administrative issues regarding NED appointments would be referred to in the Q2 declaration and the CEO intends to have an informal conversation with Monitor about these. **Resolved:** The Trust Board hereby approves the draft Quarter 2 Declaration and delegates to the Chair and CEO the authority to finalise it based on the above amendment and submit it to Monitor	
10/14/144	**<u>Approval of amendments to the Constitution/ Standing Orders</u>** The Chairman stated that the CEO had received a notice of a motion as required by the Standing Orders and it had been passed it to her by the CEO as follows: *I hereby give notice of a motion under Standing Order 3.5 as required by Standing Order 3.14, namely:* *That the Standing Orders of the Board of Directors be amended in such manner as will be detailed in the relevant Trust Board paper (including appendices) to be provided for the Board meeting later this month.* *Thank you.* *Frances Kirkham* *Non-executive director* She reminded Members of the Board that the Trust Board had approved in principle various revisions to the standing orders of both the Council of Governors and Trust Board at its September 2014 meeting, as well as a number of more minor amendments to the rest of the Constitution. These changes were also approved in principle by the Council of Governors at their September 2014 meeting and these changes are reflected in the amended Constitution provided as Appendix 1. Since the meetings of the Council and Trust Board in September there have been further corrections relating to minor format and wording matters; Frances Kirkham, Non-Executive Director has provided oversight to this activity. These further corrections have also been reflected in the amended Constitution provided as Appendix 1	

	The Council of Governors approved the version provided as Appendix 1 in their meeting today (on October 29th 2014) with the expectation that there would be no further changes prior to approval by the Trust Board. Mills and Reeve, solicitors to the Trust, have advised that the changes referred to above must be approved by the Council of Governors and the Board of Directors but will not require the approval of members at an Annual Members Meeting since they are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust. Under the Health and Social Care Act 2012, Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act. Mills and Reeve have been responsible for final review of the amended constitution prior to the September meeting of the Board and Council and have assumed responsibility for assuring the Trust of such compliance. **Resolved:** That the Trust Board hereby approves in principle the further amended Constitution provided at Appendix 1, including the revised Standing Orders, with the expectation of final approval at its November meeting and adoption immediately after that date. This was agreed by all present.	
10/14/145	**Any Other Business** **Dr Leon Vries** Dr Leon Vries sadly died recently. The CEO and Chair have written formally to pass their condolences on to Leon's family; staff close to him attended his funeral and a book of condolences is available.	
Date and Time of Next Trust Board Meeting 26 November 2014 8.30 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

Enclosure 2

PUBLIC TRUST BOARD ACTION POINTS FROM A MEETING HELD ON 29th October 2014

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
03/14/44 Corporate Performance Report (26.03.14)	FK asked that a report on paediatrics be given to a future meeting.	JL	Done	√	Completed but kept on register as a reminder re Strategy Development. Agreed that this should be taken off after November and subsumed with the Transformation Programme.
05/14/88	Create Action Plan to address issues identified by the CGC	TS/AP/HS	November 26 2014		Outstanding.
07/14/93	The Board requested that a further discussion be held about the pre-operative pathway.	JL	November 26 2014		
07/14/100	Additional metrics relevant to patient concerns (e.g. waiting times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.	HS	November 26 2014	√	Listening event held this month in OPD, outcome of patient and visitor comments awaited. New Matron and Head of Outpatients in post and developing relevant metrics and mechanism of how to share data, with ROH and visitors. Note- CQC action plan addresses this action and will be followed up in this way.
07/14/108	It was noted that a number of suggestions had been made for further amendments to the Constitution and that the standing orders of both the Council of Governors and the Board of Directors were also being reviewed and that	JD	November 26 2014	√	Complete

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	these potential additional changes would need to be considered as part of a further revision to the Constitution after the amended Constitution had been approved and adopted by the Board. Such further amendments to the Constitution would need to be approved by the Council of Governors and Board before the further amended Constitution could be adopted.				
09/14/124	The Board considers that, regarding the RTT backlog: •For adult patients the Trust should reallocate some theatre sessions to those clinicians with serious backlogs. This may also free up some clinicians to support the Transformation agenda •For paediatric patients the Trust should seek PICU beds from any realistic source; managing the consultant timetable will still be difficult even if these are found	JL	Dec 1st 2014		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	•The Board supports the Director for Operations in pressing the Commissioners to have a Clinical Senate debate where there are clear clinical risks for particular patients				
09/14/126	Regarding Safe Staffing an assessment will be made regarding how the level of incidents compares with other providers	HS	November 26 2014	√	Provided within the Safe Staffing Report this month.
10/14/142	A Board agreed action plan will be created and submitted to CQC (this will be circulated to Board members by email circulation). The action plan will be shared with Audit Committee	HS	November 26 2014	√	Approved and submitted to CQC week ending 14.11.14. Trust Board standing agenda item until March 2015.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26 November 2014 **ENCLOSURE NUMBER: 3**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Chief Executive's Report**

SUMMARY

This report provides an update to Board members of key issues and activities since the last meeting.

IMPLICATIONS

To ensure Board members are aware of the context and policy framework in which the Trust is operating, and to highlight matters of interest.

RECOMMENDATIONS

The Board is asked to note the contents of the report and discuss items as appropriate.

To note the Chair and CEO approval of the submissions to the Genomics Project.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update the Board on national and local issues.
Recommendation	The Board is asked to note the contents of the report and discuss items as appropriate.

This report provides Board members with an overview of key issues in relation to the Trust.

1 100,000 Genome Project

At the last Board meeting, the Board supported in principle the Trust's participation in the West Midlands bid to become one of 3 – 5 national centres for the UK's 100,000 Genome Project, and to support the Trust being accelerated into Phase 2 of the project. The Board delegated authority to the submit information to the Chair and CEO.

Since the last meeting various requests have been made for information in support of the overall West Midlands business case, which is being evaluated currently and a decision is expected in early December.

The Trust has fully met all of the requests for information and submitted these with the approval of the Chair and CEO. It was interesting to discover that some of the cancers that the ROH deal with are so rare that they were not even registered on the national template and this is being addressed nationally; this clearly supports our position as a Trust with an important contribution to make in the field of rare diseases and cancers, which are the focal point of the project in the first instance.

I am pleased to report that the Trust has been moved from Phase 2 to Phase 3 of the West Midlands plan and therefore, if the bid is successful, the project will 'go live' at ROH by July 2015.

In my role as a Board member on the West Midlands Academic Health Science Network I am a member of the wider leadership team for the West Midlands collaboration.

The project will be led by the AHSN and hosted by University Hospitals Birmingham NHS Foundation Trust.

2 Strategic Development of Organisational Capability

- Professor Phil Begg has now taken up his role as Director of Strategy and Transformation.
- Sally Xerri-Brooks has been appointed to the Head of Communications role and will start with the Trust on 8 December 2014.
- Mr Matthew Revell, Consultant Surgeon, has been appointed as Chief Clinical Information Officer.
- Our work with the King's Fund has now commenced which is designed to help the Trust better design its clinical leadership approaches and support clinical leaders to enable the transformation set out in our strategy.
- Further work is underway to reconfigure executive team portfolios in support of delivering the strategy and a new operational structure is being developed to enable internal management arrangements to be streamlined.

3 Other External and Partnership Engagement

- I attended a Midlands and East Tripartite meeting where the national leaders of NHS England, Monitor and the Trust Development Agency presented their views on the service going forward and the challenges of sustaining services in the current economic climate. An overview of the national context is set out below.
- The Chairman and I hosted a meeting with our counterparts at University Hospitals Birmingham NHS Foundation Trust as part of developing relationships and considering areas of mutual benefit.
- All CEOs and Chief Officers from the Birmingham, Sandwell and Solihull Unit of Planning met to consider the future options and scenarios for the local health system over a 15 year timeline. The meeting was an all-day event facilitated by the Health Services Management Centre of the University of Birmingham. There was equal focus on how to develop effective working and leadership across organisations and the development of strategic health system thinking. Further work will be undertaken as a group and also within the Unit of Planning working groups to develop future scenarios.
- I attended the annual HSJ Summit on 11 and 12 November 2014. This is an opportunity for senior leaders in the NHS, private sector, patient and voluntary sector groups to consider the challenges and opportunities for the NHS moving forward into a most challenging period.
- I attended the Foundation Trust Network annual conference where all the national managerial and political leaders gave speeches or took part in question and answer sessions setting out their respective visions for the future. The NHS England Five Year Forward View document was a major part of the framework within which other discussions took place. The Secretary of State set out four 'pillars' for change:
    - A strong economic position to support funding of NHS and Social Care
    - Changing models of care
    - Embracing new technologies to support innovation
    - Culture change to secure real and lasting change.

The Shadow Secretary of State set out a clear ambition for 'whole person care, creating more integration of physical health, mental health and social care services, commissioned through Health and Well-Being Boards. He set out a 10 year plan, including repeal of the Health and Social Care Act.

4 National Policy and Context

4.1 The national Five Year Forward View document has been published by NHS England, which aims to provide a strategic framework within which the NHS will operate and develop in future years.

4.2 Simon Stevens, Chief Executive of NHS England, led the development of the document which has shared support with other statutory bodies, Monitor, the Trust Development Authority, the Care Quality Commission, Health Education England and Public Health England.

4.3 The document sets out the need for additional funding for the NHS even with some significant efficiency improvements delivered by the service. The document also sets out the need for different models of care to inform local discussions with partners about what best serves the interests of their populations. There is some alignment and acknowledgement of the 'Dalton Review' which is due to report soon on potential provider organisational forms.

4.4 There is greater focus on partnerships with patients and communities with particular emphasis on prevention of ill-health as a central strand of future sustainability. This strand targets lifestyle behaviours and considers the contributory factors such as deprivation, social and economic influences on avoidable illness.

4.5 NHS England identifies new models of care as a means to create sustainable delivery of effective care. Guiding principles include:

- A need to manage networks of care and not just organisations
- Necessary growth in out of hospital care
- Integration of mental and physical health services around the patient or service user
- Faster learning from local and international best practice
- Evaluation of the beneficial impacts on cost and patient benefit

4.6 Primary care will be strengthened and out of hospital care will be critical to effective transformation and the Forward View sets out several immediate measures to stabilise general practice, including:

- Stabilising core funding for the next two years
- Independent review of resource distribution for primary care
- Giving CCGs greater influence over wider NHS budgets to facilitate a shift in investment from acute to primary and community services
- New funding scheme such as the Challenge Fund to improve GP infrastructure and services, GP training, recruitment and retention schemes.

4.7 Seven new care delivery models will be prioritised and promoted by NHS England:

- Multispecialty Community Providers (MCPs) – extended GP practices and other community professionals
- Primary and Acute Care Systems (PACs) – vertically integrated organisations. Hospitals with GP surgeries, or Accountable Care Organisations, or MCPs taking over DGHs.
- Urgent and emergency care (UEC) networks – a reorganisation and simplification of existing urgent and emergency care pathways, such as linked hospitals
- Viable smaller hospitals – reviewing NHS payments regime for the impacts of scale, models of medical staffing, reference to Dalton Review incorporating three new organisational models of small hospital provision, e.g.:
    - 'hospital chains'
    - Outsourced specialist service provision, (i.e. Moorfield Eye Hospital)
    - Mini-PACs incorporating local acute, primary and community care
- Specialised care – stronger concentration of a particular care service (e.g. orthopaedic care in south west London). Specialist providers will be incentivised through prime contracting and delegated capitated budgets to develop geographic networks of services, integrating organisations and services around patients.
- Modern maternity services – a review of future models of maternity units to report by summer 2015; better alignment of tariff.
- Enhanced health in care homes – utilising the Better Care Fund, NHS England will work with local authority social services and care homes to develop more in-reach support to reduce avoidable admissions to hospital.

Significant work will be done to develop new local partnerships to facilitate the introduction and development of these new approaches. It will be important for the ROH to consider opportunities to support the evolution of the systems it serves and to be aware of potential risks if it is not engaged in the wider system and able to adapt its offering.

4.8 The national system leaders are committed to greater alignment and recognise the need for alignment of leadership, together with a workforce modernisation programme to ensure the availability of the right skills as well as improved recruitment and retention strategies.

Information is also seen as a key enabler and new technology 'road maps' will be published before April 2015, and a range of strategies will be developed to accelerate health innovation.

Additionally, a continued drive on efficiency and productivity is seen as essential through three approaches:

- Demand – more prevention and greater support for patients and carers

- Efficiency – accelerating efficiency programmes to increase the annual net efficiency gain from 0.8% per annum to 2% per annum until 2020.
- Funding – the Forward View discusses options for closing the £30bn gap.

4.9 These challenges and approaches will provide substantial challenge to all parts of the health and social care system and many providers are already facing significant financial challenges. The Forward View suggests that Foundation Trusts' surpluses and investment power could be used to support investment in new primary care models, or used to pump prime various new care models. The ROH has plans to invest its surpluses in much needed new information systems and organisational infrastructure to enable it to transform and therefore this potential national intervention would not be welcomed.

Tariff changes are also a cause for concern where the impact of price changes may create unintended consequences particularly for specialist work that is only undertaken in a few hospitals but where tariff is insufficient to meet costs, and commissioning budgets are in deficit but patients are still experiencing very long waits for access to specialist care.

Whilst the ROH is putting much effort into implementing its 5 year strategic plan, all efforts must be considered in the context of the changing national and economic picture. A key principle to adopt will be to take action that is of benefit to patients irrespective of potential longer-term changes in commissioning intentions, tariff or organisational form within the local health economy.

In hearing the national leaders and politicians speak at events over the last couple of weeks, it is clear that there is no 'one size fits all' solution and very much recognition that there are different types of health systems, different geographies, different population needs and different states of organisational health. The leadership challenge for all is substantial and will require a combination of sustainable change through transformation and culture change, greater collaboration across systems with improved collaborative leadership and efficiency savings at a level not achieved anywhere before. In return for improved operational performance, the new government is being asked to consider an additional £8bn as a contribution to the £30bn gap with the NHS closing the remainder through transformation and efficiency.

These are matters that the Board will want to review of the next few months and beyond the election and assimilate into our strategic plan refresh in the light of emerging information, tariff changes and developing local system plans.

In relation to the local Unit of Planning group, there is some focus on realising land sales or better utilising primary care estate to progress some of the ambition set out in the Forward View. Chief Officers have agreed there needs to be an estates strategy. There is general agreement that local plans align reasonably well to the national framework and more work is needed to develop strategic plans for maternity services, the urgent care system and specialist services.

5 National Performance Review

As reported previously, there is national ambition to reduce the number of patients waiting for treatment beyond the NHS Constitution commitment of 18 weeks from referral to treatment. Funds have been made available but limited progress is evident to date. All providers are encouraged to ensure that the investment brings about the required reduction in waits, and for acute providers with A & E departments, that improvement in delivery of agreed waiting standards are achieved.

The ROH is providing assistance to a number of other Trusts as well as treating additional long waiting patients on our own lists; an update will be provided to the Board when performance is considered.

6 Executive Management Team

EMT has met twice since the last Board meeting and a verbal update will be given of any key decisions taken.

7 Recommendation

The Board is asked to note the contents of the report and discuss items as appropriate.

To note the Chair and CEO approval of the submissions to the Genomics Project as delegated at the previous meeting.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26 November 2014 **ENCLOSURE NUMBER: 4**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Andrew Pearson**
SUBJECT:	**Medical Director's Report**

TITLE:

SUMMARY

This report provides an update to Board members of key issues and activities since the last meeting

IMPLICATIONS

To inform the Board of my main areas of activity and highlighting areas of concern

RECOMMENDATIONS

The Board is asked to note the contents of this report and to discuss items as felt appropriate

Report to:	Trust Board
Report of:	Medical Director
Purpose of Report:	To update the Board on issues and areas of concern
Recommendations:	The Board is asked to note the contents of the report and discuss as appropriate

Issues resolved since last report

1 Outcomes

There is continuing work occurring around the development of an integrated outcome measurement and reporting capability in the Trust. Since my last report we have appointed to the new post of Chief Clinical Informatics Officer (Matthew Revell). He is working closely with Tony Eardley, interim CIO and other clinical and non-clinical stakeholders to deliver on the strategy. There remain some obstacles to completing this work, but I am confident that these will be resolved.

2 Infection Rates

Monitoring of surgical site infection rates has been extended to 12 months for all arthroplasty patients (previously 30 days). We have already seen a reduction in SSI rates by 65% over the last two years

3 Personal Databases

A Caldicott Guardian concern has been the possible holding of patient sensitive information 'off-site' in a non encrypted and/or password protected format.

A questionnaire was sent to all doctors employed by the Trust requiring of them a statement that they either do not hold such data off-site or if they do that it is held in an encrypted format. The assumption however is that there should be no need to hold such information in personal databases off-site. The letter informed medics that in the event of a breach of the Data Protection Act if they were prosecuted by the Information Commissioner they would not be indemnified by the Trust. I have to date received replies from approximately 1/3rd of the medical body.

New Issues

1 Junior Doctor Forum

I have had a 'mid-term' meeting with the GP trainee doctors. This is an informal opportunity for them to raise issues they may have around their work.

Generally they are very happy with their placement here. They find their workload reasonable and interesting. They find their teaching relevant and appropriate and it is provided in a distraction free environment.

The issues they have raised are:

1. Very slow response time from switchboard when phoning from an internal number forcing them to call from a mobile to speed the response time
2. Lack of access to library facilities after 7pm and at weekends
3. Delays in getting blood results especially INR results causing errors and delays in treatment decisions with increased length of stay

Solution

1. Re-examine SLA with UHB for switchboard service
2. Library to explain why facilities are unavailable out of hours
3. Possibility of 'near' patient testing for INR

2 Medical Workforce

The medical workforce options analysis was reported to the Board in September 2014. The next steps are the appointment of a project lead to take this forwards. The Trust remains vulnerable to the shortage of appropriate and available junior doctors to ensure a compliant on-call out of hours rota and this has resulted in a heavy reliance on agency locum staff with significant cost and variability of quality. There is no likelihood that this will change in the foreseeable future and there will need to be a paradigm shift in the way that the Royal Orthopaedic Hospital provides a safe and affordable out of hours service going forwards, accepting that this may impact on the working patterns of junior doctors and consultants during daytime service. This will be a significant piece of work and will by necessity dovetail with the Nursing Workforce Review which is ongoing.

Solution

Appointment of an experienced project manager who can work with the Directors of Nursing, Workforce, Operations and Medical Director to see this work through to a workable and sustainable conclusion.

3. Medical Engagement & Leadership

This has been recognised as a crucially important issue and without it the 5 year strategy is unlikely to succeed. The Board has approved funds to engage the Kings Fund to work with the Trust over the coming months to help identify and develop those clinicians with leadership skills and interests.

The challenge is getting clinicians to fully understand the importance of committing to leadership roles that they sign up to. Often clinical commitments 'trump' management and leadership commitments, weakening the voice and influence that they might otherwise have.

I sense a move in the right direction amongst the clinicians, with some coming forwards to take up these important roles, but I remain concerned that the level of engagement is quite variable and at present is insufficient to fulfil the ambitions of the strategy.

Solution

I am hopeful that the Kings Fund work will encourage and help develop the future clinical leaders and drive engagement, but the Board should consider that the senior clinical leaders will need to be recruited from outside the Trust if we are unable to develop sufficient numbers of motivated clinicians from within.

4. Knowledge Leader – strand 7 of the 5 year strategy

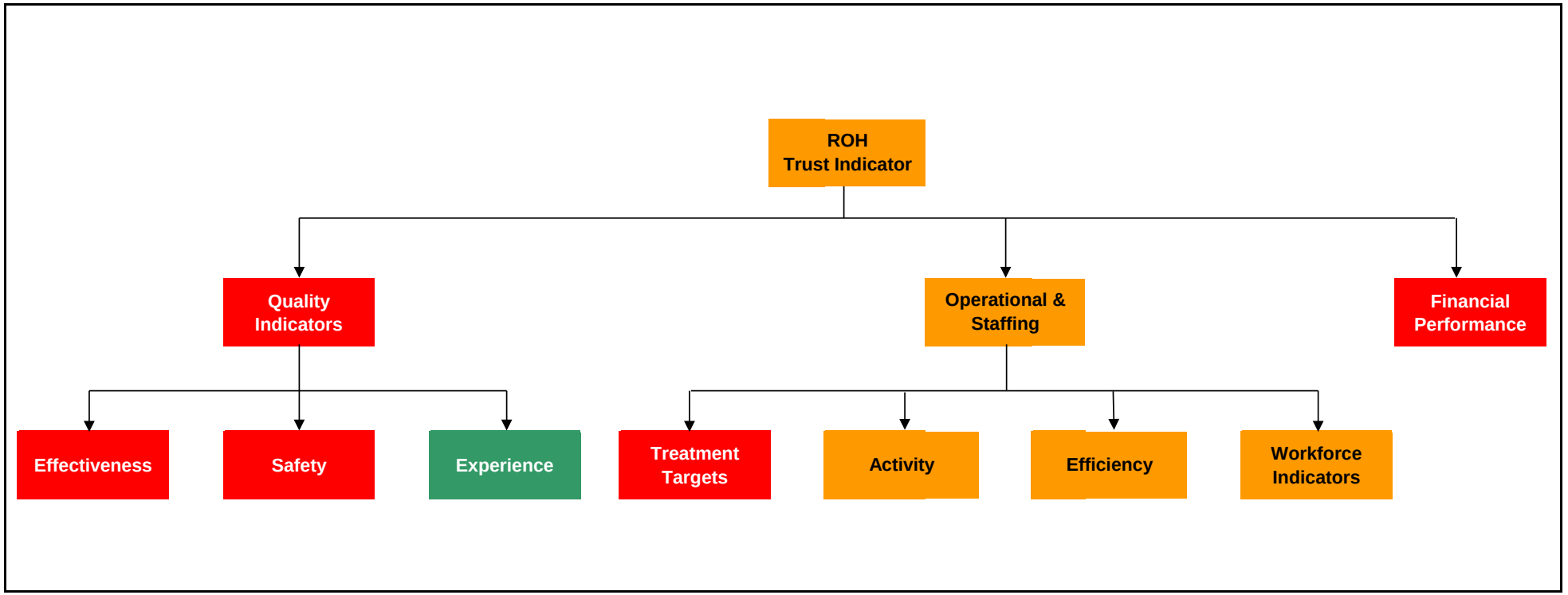
In order to fulfil the Trust strategy of becoming the 'Knowledge Leader' for Orthopaedics, strand 7, it is necessary for the organisation to have a co-ordinated research and innovation capability supported by a robust outcomes and clinical audit processes maintaining its renowned position for undergraduate and postgraduate teaching. At present the Trust partially delivers on some of these areas and this is a cause of frustration for clinicians and executive alike. We have to rectify the current position and to achieve this it is essential that the vision is shared with and understood by the staff of the organisation.

Denise McLellan is conducting a series of workshops to share the vision and to encourage discussion. The first workshop has already occurred and she tells me the feedback has been very encouraging.

Some of the vested interests in maintaining the status quo in the organisation are going to be challenging and will I believe consume a fair deal of energy and time in resolving. But there is an absolute determination from the Executive to address this.

The Board is asked to note the contents of this report and discuss as appropriate.

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending 31st October 2014



Quarterly Detailed Report
Executive Summary as at 31st October 2014

Headlines

- For the year to date the Trust made a surplus before impairments of £742k compared to a planned surplus of £931k.
- The overall backlog has reduced by 16, however, the admitted backlog has increased by 15 and is now amber rated.
- Non admitted RTT was breached in the period as expected due to backlog clearance activities in month.

Monitor Compliance Framework Targets	31st October 2014 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	92.68%	92.68%	1	6
Referral to treatment time - Admitted %	90%	91.63%	91.63%	0	6
Referral to treatment time - Incomplete Pathways %	92%	94.67%	94.67%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	79%	79%	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				

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

Key Trust Targets		31st October 2014 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	6	↑	3
	Complaints	<=12	11	↓	4
	CQUINS	100%	90%	→	11
	Total Unexpected Hospital Deaths	0	0	→	5
Efficiency & Workforce	Total Backlog Patients	<400	401	↑	6
	Incomplete 14 - 18 Week Waiters	<450	531	↑	6
	Total Admitted Patient Care Patients vs Plan	100%	99.1%	↓	7
	Unused Theatre Sessions	<44	50	↓	8
	Sickness	3.7%	4.8%	↓	9
Financial	Surplus	£931k	£742k	↓	10
	CIP	£950k	£1,070k	↑	10
	Agency Expenditure	£91k	£262k	↓	11
	Locum Doctor Expenditure	£46k	£188k	↓	11

Trust Summary

For the year to date the Trust made a surplus before impairments of £742k compared to a planned surplus of £931k. This represents an in month surplus of £180k in comparison to a planned surplus of £392k.

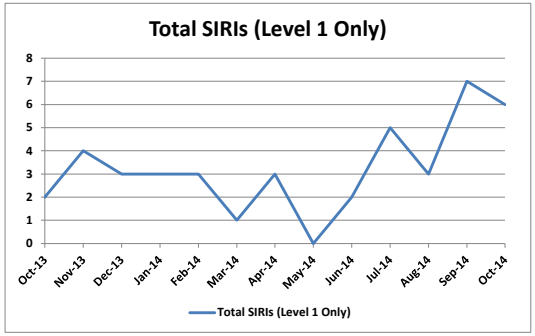
The Trust did not receive authority to respond to backlog clearance until 11th October and thus consequently is expected to deliver admitted RTT where an in month underachievement would have been preferable.

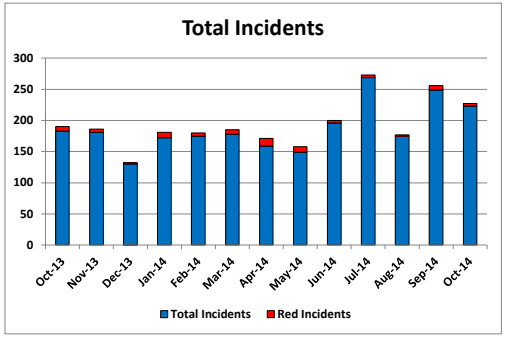
Quarterly Detailed Report
Safety Indicators as at October 2014

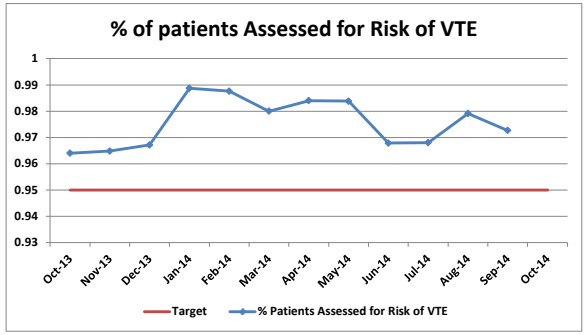
Headlines

- Patient falls have decreased from 13 to 12, although this remains red rated. Avoidable falls with harm have also decreased, from 2 down to 0.
- Total incidents have decreased, but are still green. Red incidents have decreased from 7 to 4.
- There were 6 SIRIs, in comparison to last month's 7, although this remains red rated.

	Monitor	National	CQC Standard		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	14/15 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	4	3	3	3	1	3	0	2	5	3	7	6	26
			4,16	SIRI per 1000 bed days	0.62	1.39	1.01	0.90	0.85	0.27	0.89	0.00	0.56	1.30	0.86	1.90	1.58	1.03
			4,16	Total Incidents	183	181	130	172	175	178	159	149	196	269	175	249	223	203
			4,16	Incidents per 1000 bed days	56.82	62.70	43.61	51.71	49.30	47.94	47.04	41.98	54.87	69.74	50.23	67.52	58.73	56.07
			4,16	Red Incidents	7	5	2	9	5	7	12	9	4	4	2	7	4	42
			9,16	Total Medicine Incidents Reported	21	16	8	11	18	18	19	17	12	22	17	12	16	115
			9,16	Medicine Incidents Reported per 1000 bed days	6.52	5.54	2.68	3.31	5.07	4.85	5.62	4.79	3.36	5.70	4.88	3.25	4.21	4.54
				Medicine Incidents with Harm	1	3	2	1	3	3	3	2	4	7	6	4	0	26
		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	96.40%	96.48%	96.71%	98.87%	98.76%	98.00%	98.40%	98.38%	96.78%	96.80%	97.91%	97.27%		97.57%
			9	Incidence of Hospital Related VTE	1	0	1	1	1	1	1	0	1	2	2	3	2	11
			4	Patient Falls - Inpatients	4	8	6	3	6	12	6	7	5	6	5	13	12	54
			4	Patient Falls per 1000 bed days	1.24	2.77	2.01	0.90	1.69	3.23	1.78	1.97	1.40	1.56	1.44	3.52	3.16	2.13
				Avoidable Patient Falls with Harm							0	0		2	2	2	0	6
			4,16	% Harm Free Care	97.00%	98.90%	97.50%	97.41%	100.00%	97.71%	89.90%	99.02%	96.91%	95.88%	98.25%	98.04%	97.96%	96.61%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

There were 6 SIRIs, in comparison to last month's 7.

Total incidents have decreased from 249 to 233.

There have been 4 red incidents in month, compared to 7 last month.

Medicine incidents have increased from 12 to 16, and have become red rated.

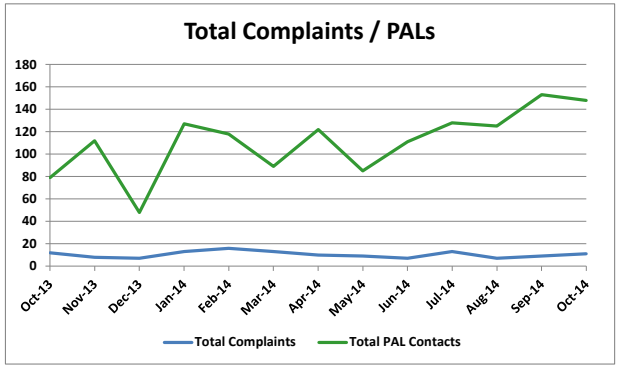
Additional information on all of the above is included in the Quality Report.

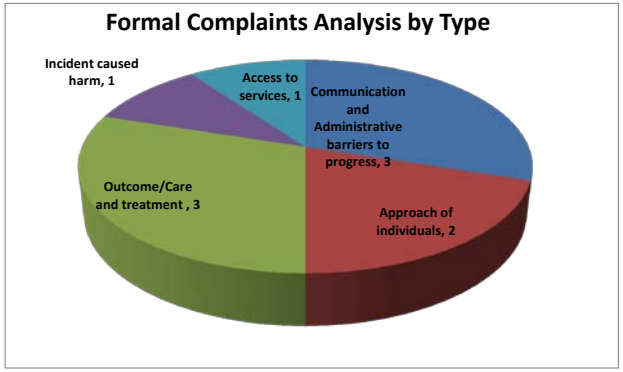
Quarterly Detailed Report
Experience Indicators as at October 2014

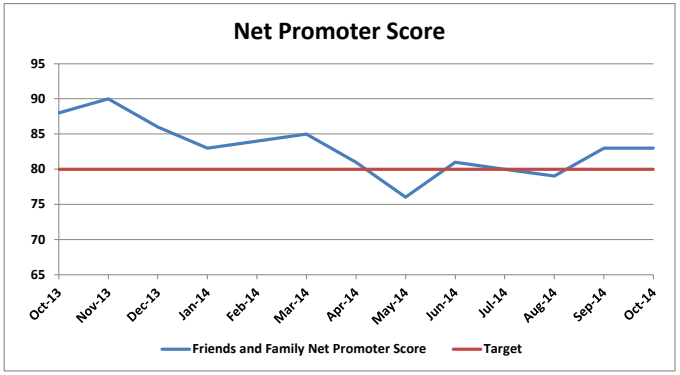
Headlines

- Complaints are up from 9 to 11.
- PALs contacts decreased from 153 to 148, and the percentage which were complaints dropped by almost 10%.
- The friends and family response rate has increased from 46.5% to 51.7%.

	Monitor	National	CQC Standard		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	14/15 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:34	1:16	1:63	1:37	1:27	1:42	1:46	1:48	1:60	1:31	1:73	1:31	1:42	**1:45**
			17	Total Complaints	12	8	7	13	16	13	10	9	7	13	7	9	11	**9**
			17	Complaints reverted to informal <48 hrs	0	1	0	0	0	0	0	0	0	0	0	1	1	**2**
			17	Formal	12	7	7	13	16	13	10	9	7	13	7	8	10	**64**
			17	Complaints per 1000 bed days	3.73	2.77	2.35	3.91	4.51	3.50	2.96	2.54	1.96	3.37	2.01	2.44	2.90	**2.61**
				Complaints Response Time (Average No of Days)	35	53	49	45	53	25		46	59	41	24		109	55.80
			17	Total PAL Contacts	79	112	48	127	118	89	122	85	111	128	125	153	148	**872**
			17	PALS Contacts per 1000 bed days	24.53	38.80	16.10	38.18	33.24	23.97	36.09	23.95	31.08	33.19	35.88	41.49	38.98	**34.43**
				Total PALS Concerns				65	65	56	80	59	49	88	73	84	68	501
			17	Total Compliments	409	124	440	481	439	552	455	436	423	409	511	276	465	**2975**
			17	Compliments per 1000 bed days	127.00	42.96	147.61	144.62	123.66	148.67	134.62	122.85	118.42	106.04	146.67	74.84	122.47	**117.46**
				Food - Real Time Patient Survey	90.60%	92.00%	96.60%	95.00%	93.00%	98.20%	97.20%	90.60%	97.70%	94.20%	95.00%	95.50%	98.30%	**95.50%**
			17	Friends and Family Net Promoter Score	88	90	86	83	84	85	81	76	81	80	79	83	83	**80**
				Friends and Family Response Rate	49.0%	51.0%	44.0%	40.0%	43.0%	46.0%	53.0%	39.0%	40.0%	53.0%	52.0%	46.5%	51.7%	**47.9%**







PALS
PALs contacts decreased from 153 to 148, and the percentage which were complaints dropped by almost 10%.

COMPLAINTS
The number of complaints received this month is 11, up from 9 last month.

COMPLIMENTS
The number of compliments received this month is 465, which is significantly higher than last month's 276, and more in line with average for the year.

Further information on experience is included in the Quality Report.

Quarterly Detailed Report
Effectiveness Indicators as at October 2014

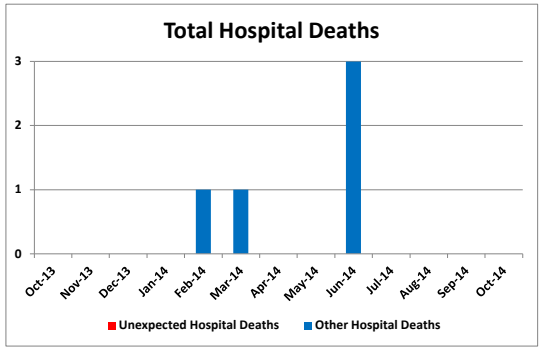
Headlines

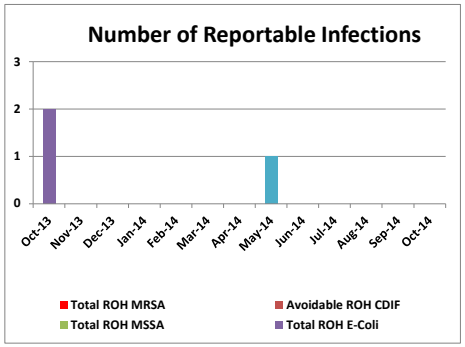
There were 2 Grade 3/4 avoidable pressure ulcers, and 1 grade 1/2.

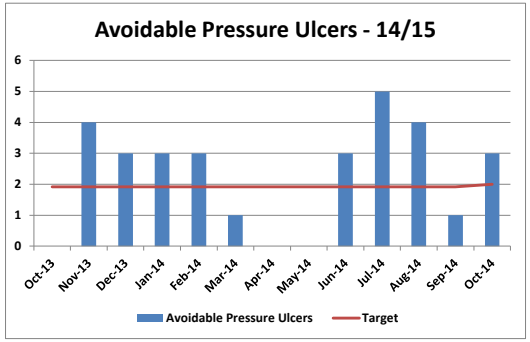
There continue to be no MRSA and avoidable Cdiff cases for 2014/15

There were no patient deaths in month

	Monitor	National	CQC Standard		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	14/15 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	0	0	0	1	1	0	0	3	0	0	0	0	3
			4,18	Hospital Deaths per 1000 bed days	0.00	0.00	0.00	0.00	0.28	0.27	0.00	0.00	0.84	0.00	0.00	0.00	0.00	0.12
			4,18	Unexpected Hospital Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0
				Other Hospital Deaths	0	0	0	0	1	1	0	0	3	0	0	0	0	3
			8	MRSA % Screened	132.00%	114.30%	100.10%	135.40%	102.00%	109.00%	115.00%	118.00%	126.00%	122.20%	107.00%	103.00%	125.00%	117%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
				Avoidable ROH CDIF								0	0	0	0	0	0	0
				Unavoidable ROH CDIF								1	0	0	0	0	0	1
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	2	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	HCAIs not attributable to ROH	0	0	0	0	0	0	0	0	0	0	0	1	0	1
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	2	1	0	0	0	0	0	0	1	0	0	2	3
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	0	2	2	3	3	1	0	0	3	4	4	1	1	13
			4	Avoidable Pressure Ulcers per 1000 bed days	0.00	1.39	1.01	0.90	0.85	0.27	0.00	0.00	0.84	1.30	1.15	0.27	0.79	0.63
				% Completion of WHO Checklist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.69%	96.88%	97.88%	96.23%	97.69%	95.92%	97.96%	98.69%







Effectiveness Commentary

There were 2 Grade 3/4 avoidable pressure ulcers, and 1 grade 1/2.

There were no reportable infections, or patient deaths this month.

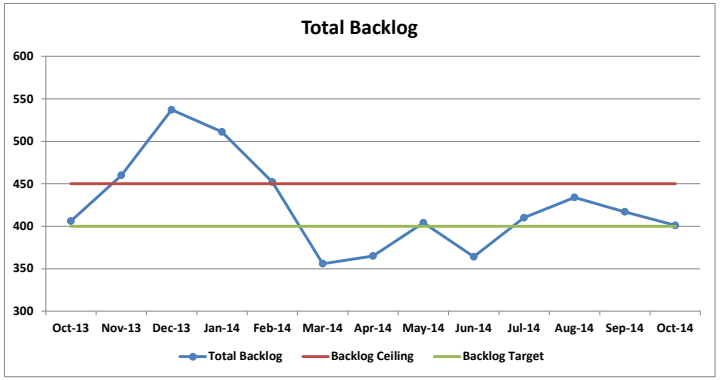
Further information on effectiveness is included in the Quality Report.

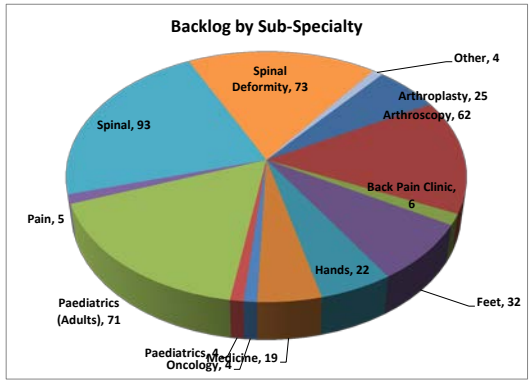
Quarterly Detailed Report
Treatment Targets as at October 2014

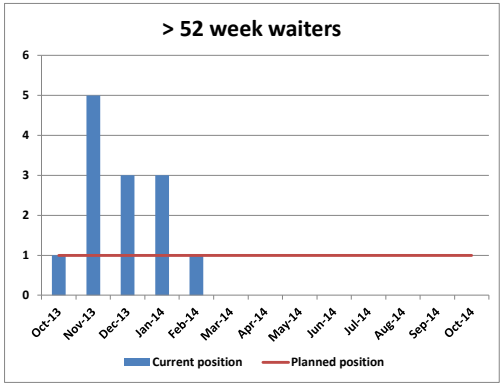
Headlines

- The overall backlog has reduced by 16, however, the admitted backlog has increased by 15 and is now amber rated.
- Non admitted RTT was breached in the period as expected due to backlog clearance activities in month, which will be excelerated in November.
- The 62 day cancer waits target has been missed in month.

	Monitor	National	CQC Standard		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	14/15 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	1	5	3	3	1	0	0	0	0	0	0	0	0	**0**
				Referral to treatment waits over 45 weeks	7	9	6	6	5	7	5	4	5	4	4	8	11	**6**
	M	N	4	Referral to treatment time - Non Admitted %	95.24%	95.13%	95.12%	95.13%	95.00%	95.01%	95.32%	95.48%	95.15%	95.75%	95.24%	95.05%	92.68%	**94.95%**
	M	N	4	Referral to treatment time - Admitted %	90.09%	88.12%	83.25%	83.65%	88.76%	88.37%	91.12%	92.51%	91.74%	93.21%	91.57%	91.96%	91.63%	**91.96%**
	M	N	4	Referral to treatment time - Incomplete Pathways %	94.00%	93.33%	87.49%	92.71%	93.21%	94.63%	94.75%	94.43%	95.10%	94.52%	94.09%	94.26%	94.67%	**94.55%**
			4	Non admitted Backlog - Pathways waiting >18 wks	160	167	259	260	199	152	156	211	174	173	168	168	137	**170**
			4	Admitted Backlog - Pathways waiting >18 wks	246	293	278	251	253	204	209	193	190	237	266	249	264	**230**
			4	Total Backlog - 18 week pathways waiting >18 wks	406	460	537	511	452	356	365	404	364	410	434	417	401	**399**
			4	Incomplete 14 -18 Week Waiters	565	640	721	721	520	475	379	574	547	536	471	594	531	519
				Non Admitted Median Wait (Weeks)	8.56	7.98	7.96	8.54	8.53	7.91	7.80	8.46	8.90	8.39	8.46	9.00	8.92	**8.56**
				Admitted Median Wait (Weeks)	10.24	10.07	11.06	11.23	10.67	9.95	9.20	9.29	9.49	9.54	9.69	10.64	10.06	**9.70**
				Incomplete Median Wait (Weeks)	6.04	6.61	7.09	7.10	6.02	5.62	5.90	6.65	5.71	5.81	6.24	6.30	5.63	**6.03**
	M	N	4	Cancer 2 week (all cancers)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	**100.00%**
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	91.60%	100.00%	**97.37%**
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.10%	100.00%	100%*	100.00%	**100.00%**
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	100.00%	85.70%	66.70%	81.80%	100.00%	100.00%	100.00%	100.00%	90.90%	93.1000%	85.70%	85.70%	78.60%	**89.66%**
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.43%	99.36%	99.37%	98.90%	99.82%	99.57%	99.15%	99.58%	99.15%	99.09%	99.58%	99.06%	99.33%	**99.29%**
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	1	0	0	0	0	0	0	0	0	0	1	**1**
			1,21	Data Quality on Ethnic Group - Inpatients	95.65%	95.70%	95.47%	96.19%	96.16%	96%	95.58%	95.50%	96.00%	95.75%	97.23%	96.72%	95.30%	**95.67%**







Treatment Targets Commentary

The Trust did not receive authority to respond to backlog cleance until 11th October and thus consequently delivered admitted patient performance where an in month underachievement would have been preferable.The overall backlog has reduced by 16, however, the admitted backlog has increased by 15 and is now amber rated.

The Trust started to receive additional referral volumes during October from Walsall Healthcare.

All other fields were much broad tolerence.

Quarterly Detailed Report
Activity Targets as at October 2014

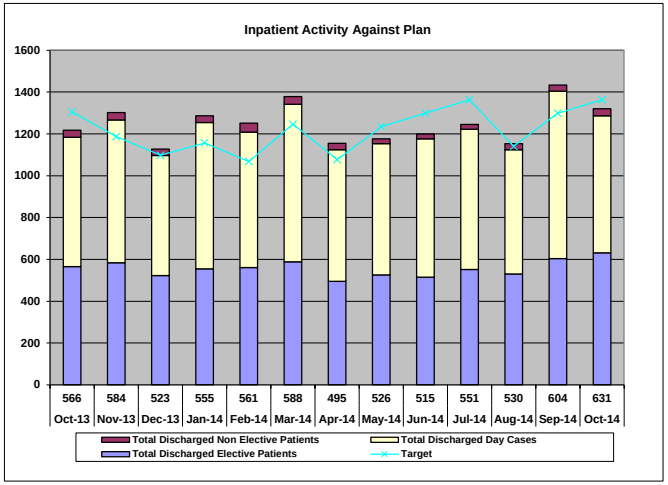
Headlines

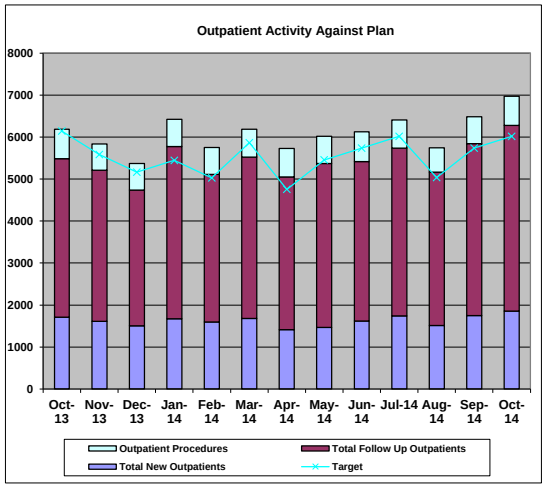
Day Case and non-elective activity is below plan in month, although DC activity overall for the year to date has still been met.

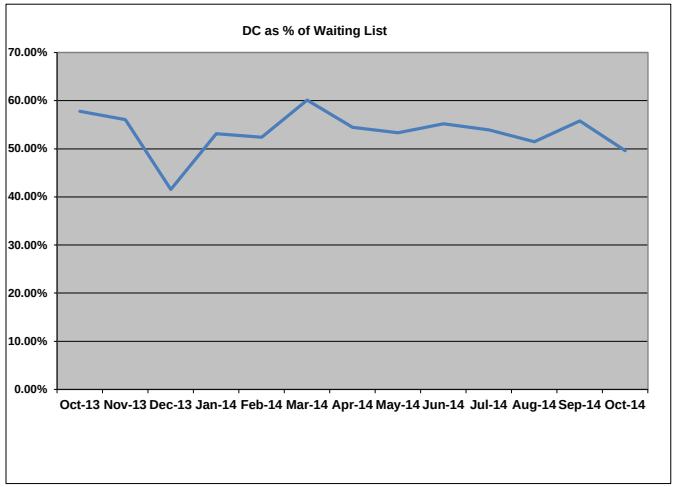
Elective acti Elective and non-elective activity is below plan, but amber rated instead of last month's red rating.

Outpatient activity remains strong.

							Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	14/15 Full Year Position
							1217	1302	1127	1287	1251	1379	1155	1177	1199	1246	1154	1434	1320	
	TargetID	Data Lead	Monitor	National	CQC Standard															
Activity	381	HI			4	Total Discharged Elective Patients	566	584	523	555	561	588	495	526	515	551	530	604	631	3852
	382	HI			4	Total Discharged Non Elective Patients	33	35	31	32	43	38	31	23	22	23	30	30	34	193
	383	HI			4	Total Discharged Day Cases	618	683	573	700	647	753	629	628	662	672	594	800	655	4640
	384	HI			4	Total New Outpatients	1709	1614	1503	1672	1593	1682	1415	1467	1618	1742	1513	1746	1857	11358
	385	HI			4	Total Follow Up Outpatients	3778	3600	3237	4101	3519	3840	3636	3902	3802	3993	3648	4101	4418	27500
	386	HI			4	Outpatient Procedures	697	618	627	652	643	663	675	646	707	671	585	634	697	4615
	460	HI				DC as a % of WL	57.76%	56.08%	41.58%	53.15%	52.39%	60.10%	54.46%	53.36%	55.21%	53.93%	51.47%	55.79%	49.62%	53.43%
		HI			4	Elective as % Against Plan	85.1%	96.6%	93.5%	94.2%	103.1%	92.6%	98.4%	91.2%	84.8%	86.5%	99.4%	99.5%	99.1%	93.9%
		HI			4	Non Elective as % Against Plan	78.1%	91.2%	87.3%	85.5%	124.5%	94.3%	110.7%	71.9%	64.7%	63.9%	100.0%	88.2%	94.4%	83.9%
		HI			4	Day Cases as % Against Plan	103.3%	125.6%	113.9%	132.0%	132.2%	131.9%	115.2%	100.3%	100.6%	97.4%	102.8%	121.6%	94.9%	104.4%
		HI			4	% New Outpatients Against Plan	109.7%	114.0%	114.8%	121.1%	125.0%	113.1%	107.9%	97.5%	102.3%	105.0%	108.9%	110.4%	111.9%	106.3%
		HI			4	% Follow Up Outpatients Against Plan	97.8%	102.5%	99.6%	119.7%	111.3%	104.1%	124.8%	116.8%	108.2%	108.4%	118.3%	116.7%	119.9%	115.9%
		HI			4	% Outpatient Procedures Against Plan	96.7%	94.3%	103.4%	102.0%	109.0%	96.3%	127.0%	106.0%	110.3%	99.9%	104.0%	99.0%	103.7%	106.6%







Activity Commentary

The Trust lost a higher than planned number of theatre sessions during the month of October due inpart to national industrial action. Half term holidays also resulted in reduced activity within month.

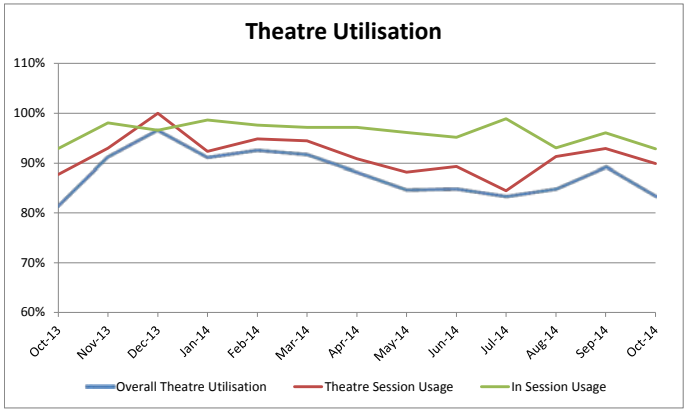
A decreased day case activity trend is being monitored and may reflect the profilng of A/L rather than any change to clinical workforce.

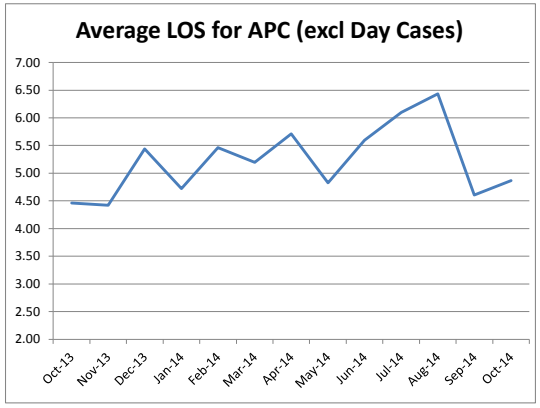
Quarterly Detailed Report
Efficiency Indicators as at October 2014

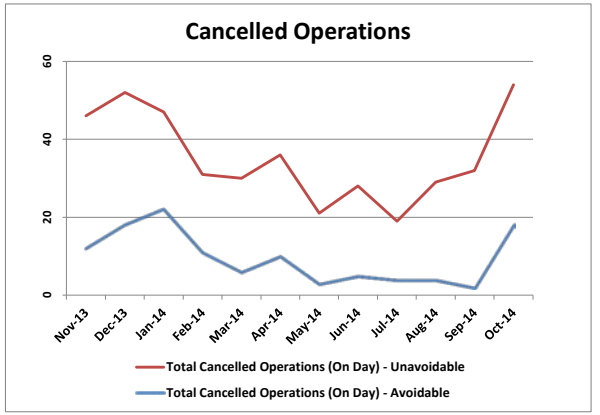
Headlines

- Overall cancelled operations remains red rated, and is the highest it has been in over a year.
- AVLOS is red rated, down from amber last month.
- There were 50 unused theatre sessions in month, an increase from September, and has resulted in an amber rating.

	Monitor	National	CQC Standard		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	14/15 Full Year Position
Efficiency			4	Overall Theatre Utilisation	81.51%	91.23%	96.58%	91.13%	92.59%	91.74%	88.30%	84.76%	84.98%	83.48%	84.97%	89.30%	83.47%	85.61%
			4	Theatre Session Usage	87.73%	93.02%	100.00%	92.37%	94.88%	94.44%	90.88%	88.17%	89.30%	84.42%	91.29%	92.94%	89.88%	89.55%
			4	In Session Usage	92.92%	98.07%	96.58%	98.66%	97.59%	97.14%	97.16%	96.14%	95.16%	98.88%	93.07%	96.09%	92.87%	95.62%
			4	Unused Theatre Sessions	61	30	0	36	21	25	33	51	46	74	33	32	50	319
			4	Number of Cases per Theatre Session	2.67	3.09	2.97	2.83	3.10	3.11	3.31	2.98	2.98	2.97	3.15	3.25	2.80	3.05
			4	Total Cancelled Operations (On Day or Day Before)	82	120	84	78	71	58	67	53	61	54	56	39	54	384
			4	Total Cancelled Operations (On Day) - Avoidable		12	18	22	11	6	10	3	5	4	4	2	18	46
			4	Total Cancelled Operations (On Day) - Unavoidable		34	34	25	20	24	26	18	23	15	25	30	36	173
			4	Total Cancelled Operations by Hospital (On Day)	2	11	10	9	3	5	5	8	6	8	8	11	15	9
			4	% Cancelled Operations by Hospital	0.17%	0.89%	0.94%	0.73%	0.25%	0.38%	0.46%	0.71%	0.52%	0.67%	0.73%	0.80%	1.21%	0.74%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.33	2.35	2.30	2.58	2.44	2.50	2.76	2.78	2.49	2.43	2.53	2.40	2.48	2.55
			4	Pain Review-To-New Ratio	3.59	2.70	3.38	3.72	3.85	3.64	4.74	4.26	4.07	2.63	4.29	3.52	3.33	3.83
			4	Outpatient DNAs	8.46%	8.51%	8.61%	9.59%	8.18%	8.65%	8.42%	8.40%	8.48%	8.78%	9.21%	8.13%	8.26%	8.53%
			4	Bed Occupancy - Adults	83.58%	86.36%	79.80%	83.60%	88.61%	80.72%	80.32%	81.21%	86.15%	86.40%	80.63%	84.25%	83.17%	83.15%
			4	Bed Occupancy - Paediatrics	58.60%	59.72%	53.18%	63.80%	65.87%	82.80%	69.26%	50.87%	54.44%	89.96%	88.17%	50.00%	44.44%	63.91%
			4	Bed Occupancy - HDU	90.67%	85.92%	84.62%	87.45%	86.89%	91.40%	69.88%	75.10%	77.05%	69.85%	63.64%	73.39%	68.15%	70.95%
			4	Bed Occupancy - Private Patients	71.89%	77.62%	64.94%	80.28%	68.88%	78.80%	65.52%	81.57%	83.25%	84.33%	76.04%	82.86%	80.65%	79.25%
			4	Admissions on the Day of Surgery	417	405	386	421	415	445	358	383	396	392	393	473	489	2884
			4	AVLOS for APC (excl day cases)	4.46	4.42	5.44	4.72	5.47	5.20	5.71	4.83	5.60	6.10	6.43	4.61	4.87	5.45







Efficiency Commentary

Theatre cancellation data has been partially affected by in month industrial action, although there are other impacting factors, which will be reported verbally to the Board.

The low paediatric bed occupancy rate reflects both half term and consultant leave. New appointments may develop for BCH/ROH bed usage.

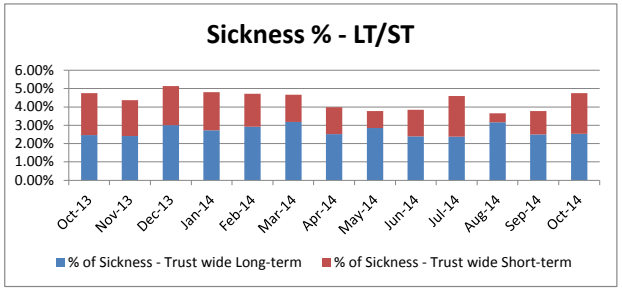
In month the decision was taken to pospone private patients. Private patient bed occupancy is now anticipated to reduce to zero from December.

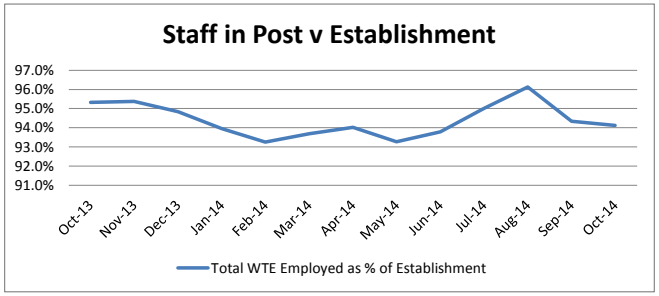
Monthly Report
Workforce Indicators as at September 14

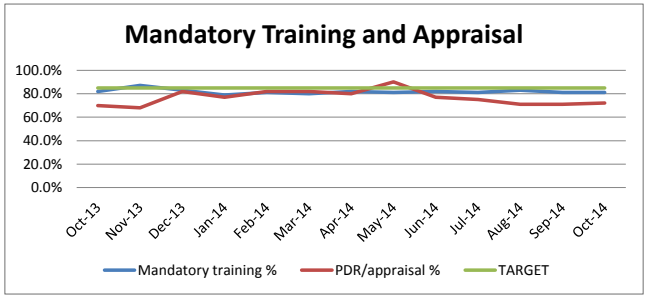
Headlines

- Turnover measures remain within acceptable limits and are green.
- PDR remains red, although it has improved slightly from last month.
- Sickness absence increased due to a seasonal short term spike.

	Monitor	Contract	CQC Standard		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	14/15 Full Year Position
Workforce				Total WTE Employed as % of Establishment	95.3%	95.4%	94.8%	94.0%	93.3%	93.7%	94.0%	93.3%	93.8%	95.0%	96.1%	94.3%	94.1%	94.4%
				Staff Turnover (%) - Unadjusted	12.8%	12.9%	13.1%	12.2%	11.8%	11.3%	11.6%	11.3%	11.9%	12.7%	12.8%	10.8%	11.4%	11.8%
				Staff Turnover (%) - Adjusted	8.7%	8.4%	8.6%	8.0%	7.4%	7.1%	7.7%	7.7%	9.5%	8.4%	8.4%	7.1%	8.9%	8.2%
				% of Sickness - Trust wide	4.8%	4.4%	5.1%	4.8%	4.7%	4.7%	4.0%	3.8%	3.8%	4.6%	3.7%	3.8%	4.8%	4.1%
				% Staff received mandatory training last 12 months	82%	87%	83%	79%	81%	80%	82%	81%	82%	81%	83%	81%	81%	81.6%
				% Staff received formal PDR/appraisal last 12 months	70%	68%	82%	77%	82%	82%	80%	90%	77%	75%	71%	71%	72%	76.6%
				Staff Friends & Family Test - Care & Treatment														
				Staff Friends & Family Test - Great Place to Work														







Workforce Commentary

Sickness absence has increased overall due to a higher level of short term sickness in October. The October monthly figure is identical to October 2013 and is therefore in line with a seasonal fluctuation.

The vacancy position taken from the ledger shows a vacancy level of almost 6%. To ensure consistency of calculation with previous months (which has historically included each month an overestablishment in R&D , the September figure has been recalculated retrospectively and is now green.

The turnover figure increased slightly from September's position but is still green. The adjusted turnover figure remains green and is similar to the October 2013 position. It has now been green since August 2013.

The mandatory training position held steady at amber for the 9th consecutive month.

Monthly Report

Finance Dashboard as at 31st October 2014

	Surplus £'000	Cash £'000	Capital spend £'000
Plan	931	19,775	2,787
Actual	742	16,393	2,317
Forecast for next month (YTD)	905	16,193	3,019

	Year to date		
	Actual	Plan	Risk Rating
Capital Servicing Capacity	2.8	3.0	4
Liquidity Ratio	66.5	62.0	4
Overall Continuity of services ratio			4

	Plan	Actual
Surplus before imp.	931k	742k
Impairments	(485k)	(485k)
Surplus after imp.	446k	257k

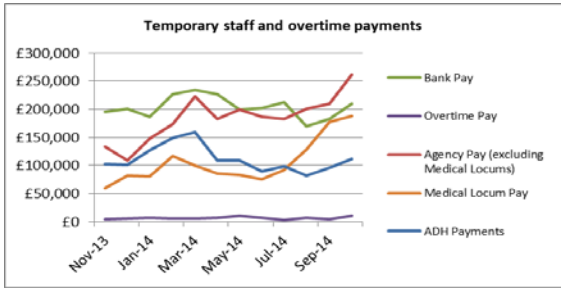
The planned and actual results include the first and second quarter's element of the expected impairment (£485k).

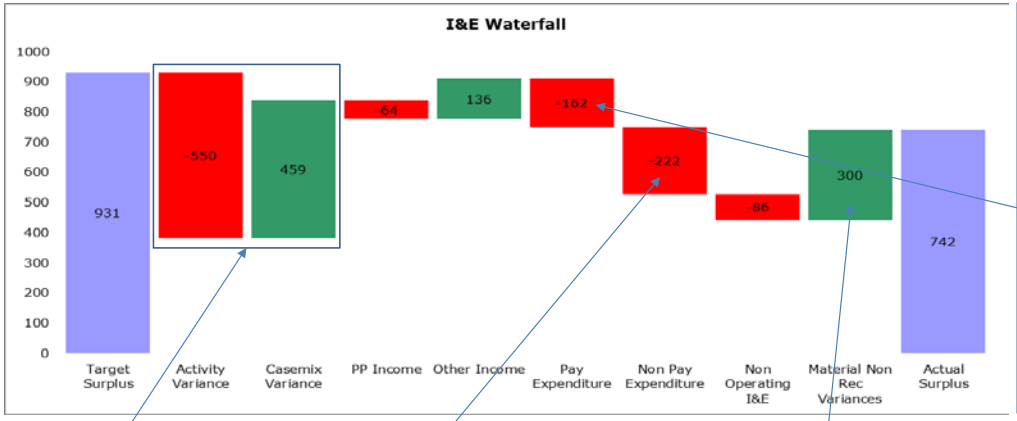
The underlying plan was therefore a surplus of £931k, compared to an actual of £742k.

Both the Trust's Capital Servicing Capacity and Liquidity Ratio are 4 for the month.

Whilst bank, overtime and ADH payments have been relatively stable, there is a significant increase in the use of agency and locums in the last 12 months.

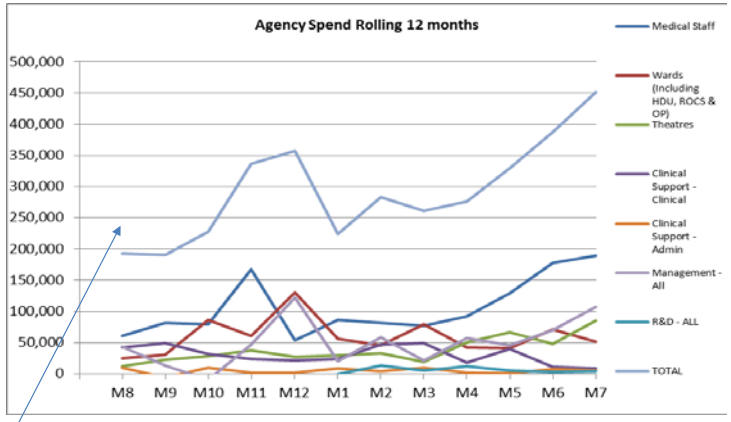
This is particular worrying when compared against overall APC activity, which shows that despite current activity being at similar level to November last year, temporary and overtime staffing pay is nearly £300k higher.





The pay expenditure is significantly higher than Monitor plan.

Significant overspends against budget and plan are becoming a trend and as such, further analysis has been performed to show the extent of the issue.



Activity was largely in line with plan for electives, but non-elective and day case procedures met only 94% of plan. The activity variance is therefore slightly higher this month.

In addition, overall case mix has been richer than expected.

This month however, this has not been sufficient to match the shortfall in activity, and the Trust has fallen behind Monitor plan.

There has been an overspend in non-pay costs against plan.

Orthotics, implants and drugs have been higher than expected partly linked to income performance, in addition to overspends in areas such as postage.

In addition, there remains included within non-pay costs is an accrual for £50k of patient fees in relation to the emergency care of a overseas private patient.

The position has been significantly helped this month through a number of non recurring variances.

A donated asset of £80k for Project Playroom has been recognised as additional income this month.

In addition, £100k of overperformance relating to 2013/14 CCG activity has been agreed and reflected in the position.

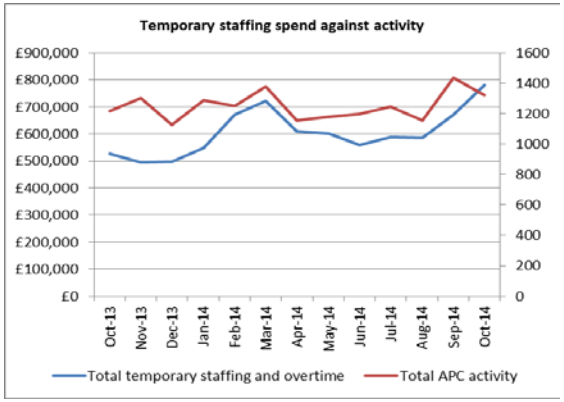
These additions have been offset by a £83k adjustment relating to theatres consumables. These had been included within theatres stock in the prior year incorrectly, and have now been reflected accurately in the I&E position as an expense.

Particular increases in agency spend have been seen in medical staff (locums), management (due to changes in board and implementing the transformational strategy). and in theatres were there have been significant vacancies, and increased activity.

Locum spend is a particular worry. 15 locums were used in October, with 11 being full time.

The number of locums being used has been climbing steadily over the past 6 months, with 7 being used in May.

4 of these locums have been in post for 12 months or over.



Monthly Report

CIP Dashboard as at 31st October 2014

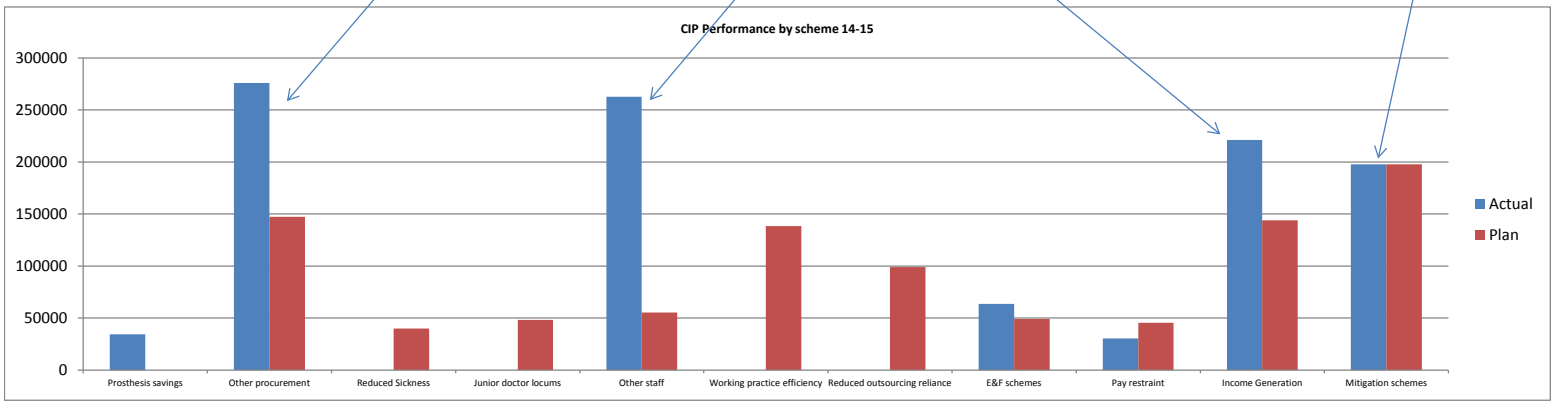
Plan for YTD	£950k
Actual for YTD	£1070k
Difference	£120k

Negotiation of better rates on SLAs accounts for the majority of this performance, with £58k relating to agreeing a lower PACs service contract, and £47k relating to the Orthotics contract.

A significant scheme relates to a non-recurrent vacancy saving on a consultant in spinal of £80k, in addition to review of job plans in Oncology and reduction in NED costs under management.

A significant proportion of the performance in this area is as a result of the increase in car parking and catering charges, in addition to income generation from the ROCs contract.

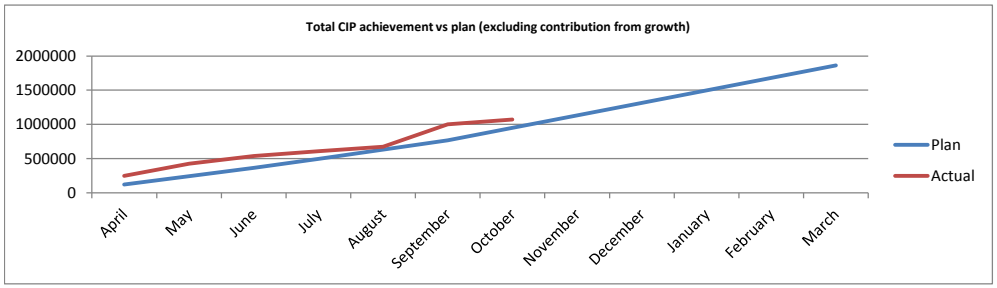
The mitigation CIP recognised to date relates to improvements in cancellations, in addition to pay restraint savings.



Overall performance against plan has remained positive in M7.

The strongest performance to date has been in 'other procurement', 'income generation', 'other staff' and the 'mitigation schemes'.

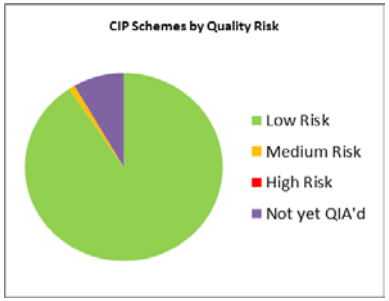
Directorates and management will need to keep a strong focus on CIP performance to ensure it continues to meet plan over the remainder of the year.



Overall performance by category

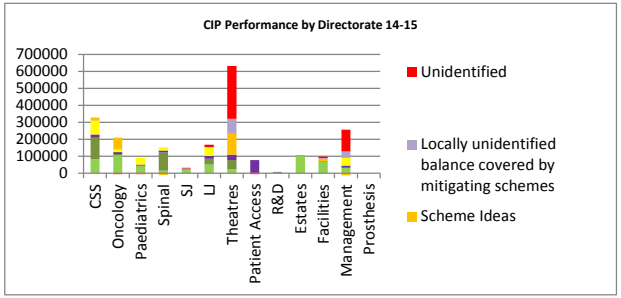
	£'000
Completed recurrent	536
Completed non-recurrent	336
Completed mitigation scheme	198
Planning/Implementation	244
Scheme Ideas	191
Mitigating Schemes	135
Unidentified	379
Total CIP target	**2019**

CSS continues to have the strongest performance to date in terms of completed schemes, with theatres still having the largest unidentified balance.



91% of schemes have been QIA assessed, with all those in the 'completed' categories having been QIA'd.

A process has now been agreed at CIP board for review of existing and new QIAs, and the Internal Audit report on QIAs iis still in the process of being finalised.



There is a gap between the CIP target for the year, and those schemes currently identified locally, or felt to be achievable as a mitigating scheme.

The CIP Board on 1st October and 5th November has challenged individual directorates on their schemes and plans, and the board will continue to monitor progress and challenge those schemes which are either unidentified or not yet implemented.

It is important to note that the income targets for the year to date have been met, despite activity targets being missed, and so the income CIP target for the year to date has been recognised.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Board:26th November 2014 **ENCLOSURE NUMBER: 6**

SUMMARY REPORT TO Trust Board

DIRECTOR LEAD:	Helen Shoker, Director of Nursing & Governance
AUTHORS:	Lisa Pim, Deputy Director of Nursing & Governance Alison Braham, Governance Manager
SUBJECT:	**Patient Quality Report – October 2014**

SUMMARY

This paper provides an update on patient quality, safety and experience activity during October 2014 and sets out the 2014/15 national, regional contractual and ROH NHSFT quality standards.

The quality of care we deliver, our patient's safety and their experience remains a high priority for the organisation and it is anticipated this report will assist the Board in bringing together key quality issues for debate, assurance and information.

It is proposed that from January 2015 this paper will continue to be received by EMT and Clinical Governance Committee in full, with an abbreviated version providing assurance to the Board following review by the aforementioned.

Key areas of note this month:-

- 12% decrease in incident reporting compared to the previous month. Incident reporting continues to be monitored and the importance of this remains a key priority for the Trust.
- 12 unavoidable (adult) inpatient falls, 9 of which resulted in no patient harm and the remaining 3 resulted in patient injuries of a minor nature.
- Falls prevention: 6 new ultra-low beds are now on-site with a further 4 arriving during November 2014; planning for a patient focused falls prevention day next year has also commenced ("April Falls Day" running on 1st April 2015).
- 2 avoidable Grade 3 pressure ulcers during October.
- The Trust is compliant with current Ebola guidance and all front of house staff have been asked to ensure every patient presenting at the Trust is screened by asking the appropriate questions advised by Public Health England.
- The WHO checklist compliance figure for October was 97.96% against a target of 99%. Further work is being undertaken to review and modify the WHO checklist document, to ensure its practical application.
- The percentage of complaints resolved (within timeline) did not meet the KPI target of 80% with only 25% achieved this month. This is due to concerted efforts to complete longstanding complaints that had yet to be resolved.

RECOMMENDATIONS

Trust Board are asked to:

- **Approve** the proposed change to reporting from January 2015
- **Note and seek clarity** on specific points of interest

1 PATIENT SAFETY

1.1 Serious Incidents - October 2014

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There were 6 Serious Incidents reported during October 2014 and Appendix 1 outlines details of all current open Serious Incident Investigations.

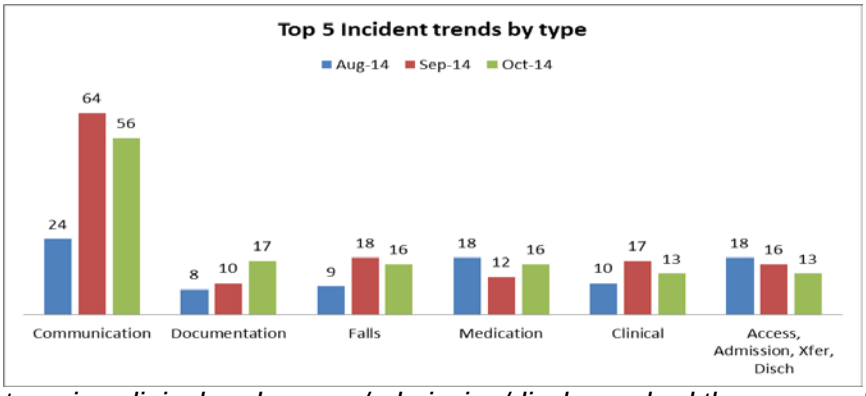
1.2 All other incidents requiring an investigation

5 additional incidents were reported that subsequently required an RCA investigation to be undertaken (See Appendix 2)

A total of 223 incidents were reported during October, compared to 249 incidents reported during September and represents a 12% decrease in reporting in-month. This continues to be monitored and the importance of incident reporting remains a priority for the Trust.

Appendices 3a and 3b provide a breakdown of the types of incidents reported by ward/hospital department.

The graph below indicates the top five incident trends by incident type:



(Please note that categories clinical and access/admission/discharge had the same volumes of incidents reported and as such have both been reflected in the graph above)

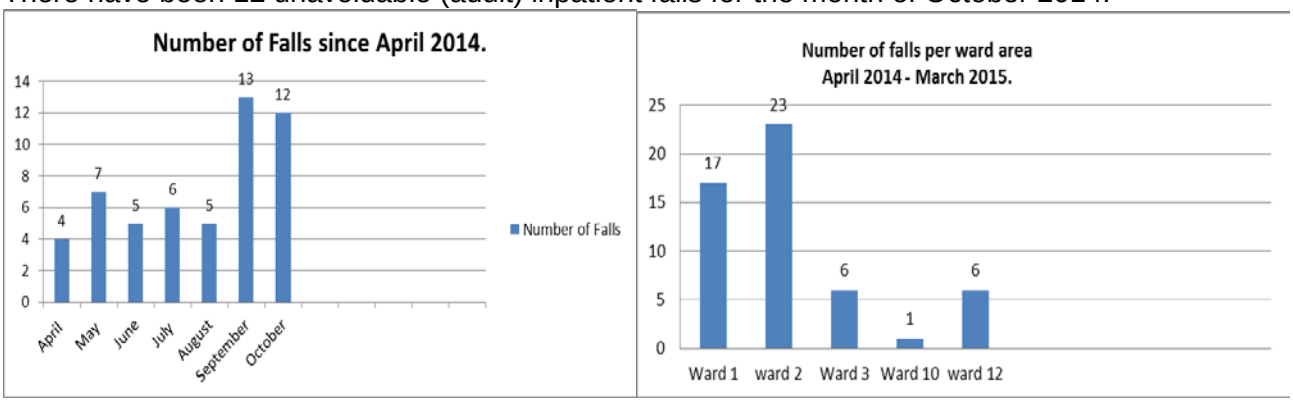
1.3 Deaths

There were no deaths reported this month.

1.4 Falls

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There have been 12 unavoidable (adult) inpatient falls for the month of October 2014.



All reportable falls have been individually reviewed and all 10 were unwitnessed by staff.

Two separate falls were reported for one patient, meaning there were 12 falls incidents surrounding 11 patients.

Harm suffered as a result of inpatient falls

As an organisation, we continue to see the majority of falls resulting in none to minor physical harm. Of the 12 falls reported during October, 9 falls resulted in no patient harm and the 3 other patient injuries were of a minor nature.

Actions for Improvement

The following are additional organisational actions that are now in place to support falls prevention and care of patients:

- 6 of our new ultra-low beds are now onsite with the remaining 4 arriving on November 28th. Beds are arriving in stages to minimise any disruption to patients or estates staff.
- Work is commencing for next years "April Falls Day" running on April 1st 2015. This day is targeted at our patient population rather than staff and will be based in the outpatient arena.
- Staff have been asked to prepare for November's Falls meeting. Individual areas have been tasked with showcasing one thing they could each do to help reduce harm from falls in their area.
- In order to showcase Falls further and to help the Falls lead with implementation of findings from projects, a voluntary learning opportunity exists for a band 6 member of staff to work alongside the lead. An advert for expressions of interest has been released.

Falls Risk Assessments & Care Planning - Quality indicator requirements

Qu1.	Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	October 2014	100%
Qu2.	If the patient is identified as high risk is a care plan in place? Yes/ N/A	October 2014	100%
Target = 91% compliance per ward			

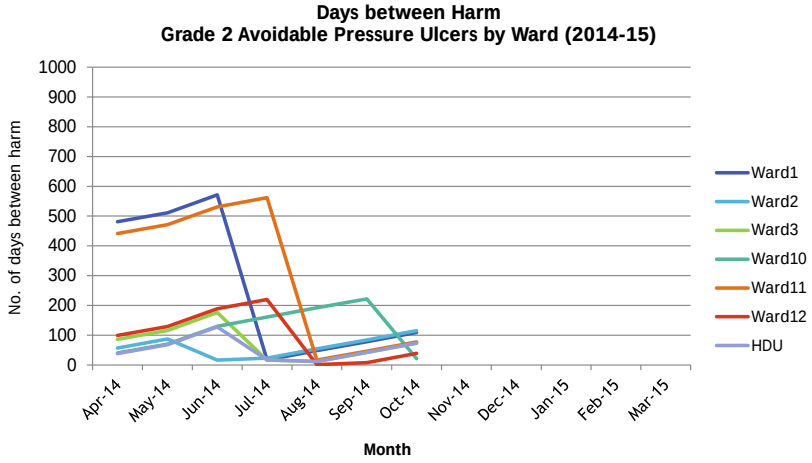
1.5 Infection Prevention and Control and Tissue Viability

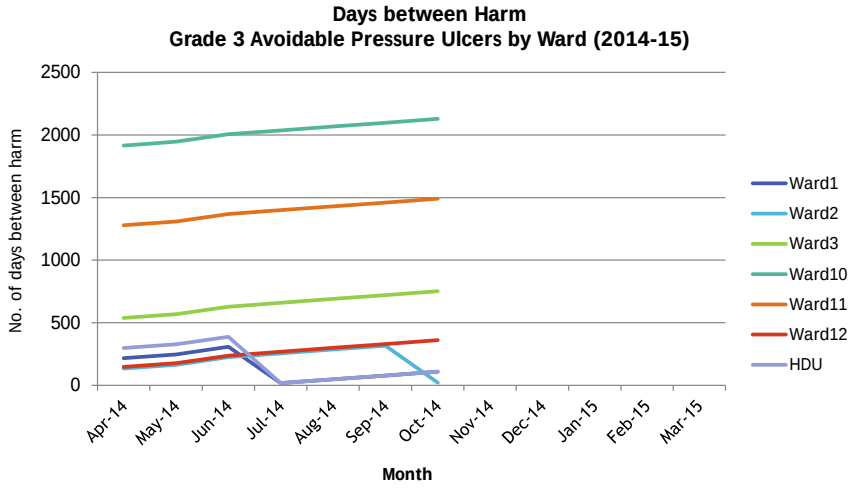
REPORTING REQUIREMENT: Contractual Quality KPI requirement, National Safety Thermometer CQUIN and National Reporting requirement

There have been no MRSA bacteraemias, apportioned cases of *Clostridium difficile* or any other cases of reportable organisms this month.

1.6 CQUIN Scheme: Safety Thermometer

Days between harm are reported in the following format, an upward trend demonstrates increasing days between harm.





This information along with the root cause analysis are utilised to ensure practice is scrutinised and improved wherever possible.

The team expect to meet both IPC and TV related CQUIN schemes and the Trust is compliant with the Hygiene code.

1.7 Tissue Viability

There were 2 avoidable pressure ulcer (grade 3) during October. These affected one patient and are under investigation. There was also an unavoidable grade 2 pressure ulcer.
During the first six months of this financial year there have been a total of 12 Avoidable Grade 2 Hospital Acquired Pressure Ulcers reported across the trust.

The table below shows the number of pressure ulcers by ward. It details the avoidable and unavoidable cases as defined by the Tissue Viability team after route cause analysis. Please note that there are incidences where there are apportioned cases across more than one clinical area and these are highlighted in yellow. These figures are not to be used for total incidence reporting and are to illustrate the clinical areas where hospital acquired pressure ulcers have occurred within the trust.

Pressure Ulcers by Ward (2014-15)

Table 1: Grade 2 Hospital Acquired Pressure Ulcers by Ward

Grade 2	Apr'14				May'14				Jun'14				Jul'14				Aug'14				Sep'14				Oct'14			
	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S
Ward1														1	1													
Ward2									3				1						2				1					
Ward3			1											2		1		1										
Ward10																							2				1	
Ward11																	1											
Ward12															1		1				1							
HDU														2		1		2					1					

Table 2: Grade 3 Hospital Acquired Pressure Ulcers by Ward

Grade 2	Apr'14				May'14				Jun'14				Jul'14				Aug'14				Sep'14				Oct'14			
	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S	A	S	U	S
Ward1														1														
Ward2																									2			
Ward3																												
Ward10																												
Ward11																												
Ward12																												
HDU														1														

The Grade 3 pressure ulcers identified on ward 2 were deemed avoidable as a result of gaps in the documentation which mean it was not possible to evidence that all appropriate interventions were put in place at the correct time.

1.8 Surgical Site Infection

The timing for submission of this report is ahead the provision of complete activity data for October, the number of patients readmitted with infection cannot be reported this month. Surveillance for arthroplasty patients has been expanded to 1 year post operatively.

Surgical Site Infection data is reported to Public Health England quarterly with the next submission being due at the end of December 2014 (for July – September 2014 is the period due to be submitted).

1.8.1 Bone Infection Unit

Activity within the unit continues to be high with 53 patients under the care of the team, 16 of whom are inpatients. Patients are widespread and monitoring can be a challenge – one of the patients is currently residing in South America.

1.8.2 Flu vaccination

The flu vaccinations have been undertaken by Occupational Health this year, supported by HR and IPC. So far uptake is 23.7% of frontline staff. The national target is to vaccinate 75% of all frontline staff. The detail is in the table below:

	Total No of staff	October	% Uptake
Add Prof Scientific and Technic			
Allied Health Professionals			
Healthcare Scientists	**103**	34	33%
Additional Clinical Services	**139**	23	16.50%
Medical and Dental	**108**	17	15.70%
Nursing and Midwifery Registered	**226**	63	27.80%
Estates and Ancillary	**114**		
Administrative and Clerical	**277**	115	41.50%
Total	**967**	**252**	
total frontline staff	**576**	137	**23.7**
all staff	967	252	**26**

1.8.3 Ebola

The Trust is compliant with the current Ebola guidance and has a plan in place with a quick reference guide and an 'infection control grab bag' containing all the personal protective equipment (PPE) recommended by Public health England (PHE) on Ward 10, which is where any potential case will be isolated should they present here. All front of house staff have been asked to ensure that every patient presenting at the Trust is screened by asking the appropriate questions advised by PHE.

The guidance for Ebola changes often and further changes are anticipated as the crisis continues. It is expected the Trust will have made appropriate preperations to manage a potential case. Work is underway to identify a core of around 55 clinical staff to undertake thorough training in the application and removal of PPE. Once the staff have agreed to join, the Ebola team training will be undertaken with a plan to refresh the training monthly. Health and Safety have kindly offered to assist IPC with this piece of work.

1.9 Safeguarding Adults and Children
REPORTING REQUIREMENT: Contractual Quality KPI requirement and National Reporting requirement

The information outlined below provides an update of Adult and Children Safeguarding Training for October 2014:

Adult Safeguarding Training

- Adults Level 1 (Basic Awareness) – 94.57%
- Level 1 Safeguarding Adults (includes SG, MCA, DoLs, Learning Disabilities) MCA 88.48%, DOLS 89.19%
- Level 2 – Enhanced (External provider) – 85.54%
- Level 3/4 – For Leads = 100%

Concerns reported and possible alerts reported to team: 9
Incidents reported: 2
Deprivation of Liberties application submitted: 0

Staff attended Birmingham Safeguarding practitioner workshop with very positive feedback. There was also good sharing of practice and application of patient at the centre of safeguarding care and outcome of interventions.

Children Safeguarding Training

- Children's Level 1 (Basic Awareness): 94.57%
- Level 2- Enhanced Child Protection: 85%
- Level 3/4 – For Lead and Named Nurse/Doctor: 100%
- Concerns reported and possible alerts to team: 10

1.10 Patient Safety Alerts
REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

A total of 10 Patient Safety alerts were closed during October 2014, 9 of which required no further action by the ROH.

The Trust is currently assessing the relevance of the following alerts:

Reference	Alert Title	Issue Date	Response	Deadline
EFN/2014/48	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDeR) - FKI - Eclipse - Circuit Breaker	30-Oct-14	Assessing Relevance	27-Nov-14
EFN/2014/45	Low Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - MEM - R338FY37/AP/D1 - Isolator	22-Oct-14	Assessing Relevance	19-Nov-14
DH/2014/003	Reminder for the testing of fire & smoke dampers and ensuring the integrity of fire stopping	21-Oct-14	Assessing Relevance	30-Apr-15
EFN/2014/42	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Merlin Gerin - CE2 - Circuit Breaker	16-Oct-14	Assessing Relevance	13-Nov-14

Status of open alerts:

Reference	Alert Title	Issue Date	Response	Deadline
NHS/PSA/W/2014/009	Risk of using vacuum and suction drains when not clinically indicated.	06-Jun-14	Action Required: Ongoing	04-Jul-14
NHS/PSA/D/2014/006	Improving medical device incident reporting and learning	20-Mar-14	Action Required: Ongoing	19-Sep-14

Actions taken (open alerts):
NHS/PSA/W2014/009: Whilst appropriate equipment has now been ordered with an expected delivery date of 11th November 2014 the alert remains open due to the following 2 areas;

Part 2 - Consider if immediate action needs to be taken locally and develop an action plan, if required, to decrease the risk of the occurrence of a similar incident. *This is not yet complete as it has not been established if the proposed change has been disseminated across the spinal teams and alternative drains are not on site or in use yet.*

Part 4 - Share any learning from local investigations or locally developed good practice resources by emailing: patientsafety.enquiries@nhs.net*. Not complete*

NHS/PSA/D/2014/006: Awaiting feedback from Trust Medical Director.

1.11 WHO compliance

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

The total number of WHO Checklists that met the 100% Standard continues to be monitored. The target has not been met, resulting in a contract variation being served on the trust by our Commissioning partners, alongside an agreed action plan and trajectory for improvement in compliance. The Director of Nursing has direct oversight of this piece of work to esure the safety and quality of patients remain a priority. Further work has been undertaken by the Theatre Manger to review and modify the WHO Checklist Document, to ensure its practical application.

The compliance figure for October was 97.96% against a target of 99%.

1.12 Blood Safety

REPORTING REQUIREMENT: Legal requirement and ROH NHSFT Good Practice

Traceability of blood/ blood products is a legal requirement, to ensure 100% compliance with the 30 year traceability guidelines as stated in the European Directive and UK Blood Safety and Quality Regulations (2005). Historically this has been problematic due to the paper trail of providing evidence of traceability, and lack of compliance and assurance from the clinical areas to follow process. To highlight the problem, between August 2013 – March 2014 17 incidents were reported regarding untraced blood / blood products.

By implementing a zero tolerance approach to this, monitoring areas monthly and introducing a new process in theatres, currently there are no outstanding units for quarters 1 and 2, and therefore no incidents have been raised in 6 months. As we move into q3 October has 100% traceability.

The pilot to send evidence electronically to strengthen compliance and ensure an electronic audit trail is in place, commenced the 3rd November. An update on this will be given in next month's report. Raising awareness of blood safety in general across the organisation remains a focus to maintain the improvements seen this year.

1.13 CQUIN Schemes

REPORTING REQUIREMENT: National and Local CQUIN Requirement

Evidence for Q2 is due to be submitted to Commissioners within agreed deadlines. To date all CQUIN's are on target for achievement. The financial value of the schemes have been previously reported.

Our Specialised Commissioners have formally confirmed we have met Q2 milestones. Please see below table indicating Specialised CQUIN Milestone Requirements;

1	Specialised Dashboards	10%	Targets for end Q2: The Provider must: • Submit data for Q2 against all the required dashboards in line with the dashboards reporting arrangements • Confirm that data have been submitted within the specified deadline against all relevant dashboards • Provide a summary of how the dashboard products are being used within the Trust • Identify any key issues that have been identified Where the Provider does not provide satisfactory evidence in the specified areas a penalty up to a maximum of the level specified in brackets will apply against the quarterly value of this indicator
2	Highly Specialised Collaborative Audit Workshop	20%	Please provide for Q2: Progress report against the highly specialised CQUIN
3	Specialised Orthopaedics Network MDT	50%	Please provide for Q2 an report outlining Q2 and YTD progress in relation to: Network referral guidelines, operational protocols and mechanisms decided and instituted. Agreed by each network partner. Monitoring mechanisms, particularly with regard to RTT in place. 100% by Q4 of all cases meeting network protocol discussed and considered by virtual MDT.

2 PATIENT EXPERIENCE

2.1 PALs contacts, Complaints and Compliments

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

2.1.1 PALS

Number of contacts this month was 148 – down by 5 on last month's volume of 153.

Of the 148 contacts, 80 were general enquiries (54%) and 68 were concerns (46%) which is around 10 percentage points different to last month's split of general enquiries 45% and concerns 55%.

Greatest areas of concern continue to be:

- Spinal –what's happening with care and treatment plans; lack of info/clarity; chasing update and progress; no follow up booked post-surgery etc.
- Waiting lists long for injections and only one person able to book appointments which compounds patient frustration in not getting answer/update. Directorate taking action on this.
- What is happening with treatment or care?
- Changes to appointments

Highest volumes of general enquiries were:

- What is happening/what happens next?
- Work Experience
- Telephone number enquiries

2.1.2 COMPLAINTS

Number of complaints received this month is 10, up from 8 last month.

Areas of concern:

- Communication and Administrative barriers to progress x 3
- Approach of individuals x 2
- Outcome/Care and treatment x 3
- Incident caused harm x 1
- Access to services x 1

The percentage of complaints resolved within timeline was 25% against KPI of 80% which is closely linked to the average length of time to close complaints due – which in October was 109 days slightly down on last month's average of 134. There have been concerted efforts to complete longstanding complaints awaiting resolution. There is currently 1 long standing complaint still to complete however this will be completed within the next reporting period.

The complaint management process have been enhanced and is being piloted in Oncology and Outpatients, with the support of the directorate teams.

2.1.3 COMPLIMENTS

Number of compliments received this month is 465 which is comparable to last month's total of 476.

2.1.4 Friends and Family Test

The Friends and Family Test for October is 83 with a 50% return rate and meets the CQUIN requirements for the month. The detractor rate for the month is 2.1% which remains low.
The Public and Patient Services Team are monitoring distribution of the test questions by volunteers and staff. 63% of questionnaires filled in this month were handed out by volunteers. This may present a challenge in the next few months if volunteers are absent in the winter months for any reason and this information is being shared with Directorate Leads.

2.1.5 Child Patient Experience

The October FFT Score for Ward 11 (under 16) is 84 which is a point higher than the Trust average. Collections still remain fairly low which does impact significantly on the scoring.

The ward is still experiencing technical difficulty with the IT implementation of Fabio Frog data collection. The Public and Patient Services Manager and the acting Senior Sister are meeting with the supplier this month to resolve the issues that have been ongoing for some time.

2.2 Litigation

REPORTING REQUIREMENT: ROH NHSFT Good Practice

Two new potential clinical negligence cases were received in October 2014.

Ref	Description	Directorate
T467	No details currently – at disclosure stage	Oncology

T465	Hip replacement July 2010. Revision October 2011. Implant failure.	Large Joints

Following disclosure of the patient's notes to solicitors, a formal letter of claim was received in the following case:

Ref	Description	Directorate
T426	Outcome of THR Jan 2012: intra-op fracture	Large Joints

1 proceeding 'liability to third parties' claim was received

Ref	Description	Directorate
T466	Patient attending OPD appointment fell on car park	Corporate

Closed Cases

The following cases were robustly defended by the Trust and NHSLA. Liability was denied and no costs were incurred by the Trust:

- **Staff claim** (T419) – details withheld for reasons of confidentiality
- **Third party claim** (T441) – injury to hand cutting overgrown bushes in garden adjoining Trust grounds

2 potential claims were closed: these did not proceed beyond disclosure of the patients' notes to their solicitors.

Ref	Date of incident	Directorate	Details
T373	Sept 2012 onwards	oncology/ x-ray	Failure to identify gastric adenocarcinoma
T285	2009 onwards	Oncology	Surgical outcome below knee amputation

5 proceeding claims were closed

Ref	Date of incident	Directorate	Details	Outcome/ Settlement
T358	Aug 2007	Large Joints	Hip replacement, nerve cemented to hip joint.	Liability Denied. Damages: £0 Claimant Costs: £0 Defence Costs: C.£1.4k
T266	2007	Spinal	Informed consent - alternative treatment to surgery not offered	Liability Denied. Claim withdrawn by claimant.
T385	Feb 2012	Large Joints and OPD&CSS	Failure to diagnose and treat hip fracture following THR; reduced mobility, pain and ossification of hip. Also a SIRI and complaint	Liability Admitted; Damages £3k; Claimant Costs £5.2k; Defence Costs £2k
T319	Oct 2011	Spinal	Damage to windpipe from intubation during decompression surgery leading to infection. Also a complaint.	Liability Denied Damages £0; Claimant Costs £0; Defence Costs £1,400
T326	July 2010	OPD&CSS	Phlebotomy - potential HCAI (needle re-used). Also a SIRI and complaint	Liability Admitted Damages £12k; Claimant Costs 24.5k; Defence Costs £2.9k

Coroner's Inquests: None

2.2.1 Medico-legal Advisory Forum

The Medico-legal Advisory Forum has held the inaugural meeting in early November and have agreed Committee Membership, Terms of Reference and Chair/Deputy Chair roles. The Forum is supported by Non-Executive Director Frances Kirham and facilitated by the Deputy Director of Nursing and the Trusts Litgation Officer. An update on the forums work will be provided to EMT and CGC quarterly.

2.3 Single Sex Compliance

REPORTING REQUIREMENT: National Reporting Requirement & Contractual Reporting Requirement

There were no single sex compliance breaches during October.

3. EFFECTIVENESS OF CARE

3.1 National Joint Registry (NJR) Update

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

Monthly NJR Compliance:

	Jan 14	Feb 14	March 14	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14
% Compliance	100%	96%	96%	93%	95%	85%	95%	89%	93%	88%

Current 2014 overall compliance: 93% average, against the target of 90%

Monthly NJR Consent Compliance:

	Jan-14	Feb-14	Mar-14	April 14	May 14	June 14	July 14	Aug 14	Sept-14	Oct-14
% NJR Consent compliance	75%	82%	81%	80%	91%	94%	95%	95%	91%	92%

Current 2014 Consent compliance: 91% average, against the target of 95%

3.2 Patient Reported Outcome Measures (PROMs)

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

During October the 90% target compliance rate for completed questionnaires for both hip (98.4%) and knee (97.8%) replacement surgery was achieved.

3.3 Safety Thermometer

REPORTING REQUIREMENT: National Reporting Requirement

2014-15		Oct-14
Pressure Ulcers	All	2.04%
	New	1.02%
Falls with harm		0%
CAUTI		0%
New VTE		0%
Total Harm Free		97.96%

3.4 Matron KPI
REPORTING REQUIREMENT: ROH NHSFT Good Practice

The following is a brief summary of the Ward KPI's.

Paedeatric Directorate – Overall Amber. Decreased performance in workforce metric due to high levels of sickness, improvement noted in safety metric moving to green.

Spinal Directorate – Overall Amber. Sustained performance generally with improved workforce metrics. 4 falls noted this month, all reviewed as unavoidable. Increasing levels of low/no harm noted.

Support Services – Overall Green. The KPI's for Support Services are split into OPD (Amber rating), Pain Team (Green rating), and ROCS (Green rating). POAC are sustaining progress (Amber) with slow steady improvements noticed against all metrics. Excellent performance against KPI's in the Pain Team and ROCS, of note for OPD are safety checks and sickness.

Large/Small Joints Directorate – Overall Amber. The KPI's for Large/Small Joints are split into Ward 2 (Amber rating), and Ward 10/12 (Overall Amber) who have now ben amalgamated. Of note for ward 2 is falls (4, 3 patients and 1 member of staff – all reviewed as unavoidable),and an increase in formal complaints plus a Grade 3 Pressure sore which is under investigation . For Ward 12, there has been an improvement in metrics related to training and patient experience and Discharge Lounge Utilisation has shown improvement on last month.

Theatre/Anaesthetics/Critical Care Directorate – Overall Amber. The KPI's for Theatre/Anaesthetics/Critical Care Directorate are split into HDU, KPI not completed at time of report, ADCU (Amber rating), CCO (Amber rating), and Theatres (Amber Rating) 2 Theatres KPI's incomplete at time of report Theatre 6 and Theatre 10. Of note for Theatres is high levels of sickness in most theatre teams. Additional work is also being undertaken on the WHO Safety Checklist. Continued high focus remains on training with most team members booked into essential training if not already complete. There are elevated levels of sickness within ADCU noted. For CCO training remains a required focus for 1 key member of staff.

Oncology Directorate – Overall Amber. There has been 2 patient falls on ward 3 this month (unavoidable). Sickness levels are noted as increasing for this month also.

APPENDIX 1a – Ongoing Serious Incidents Requiring Investigation (SIRI) - October 2014

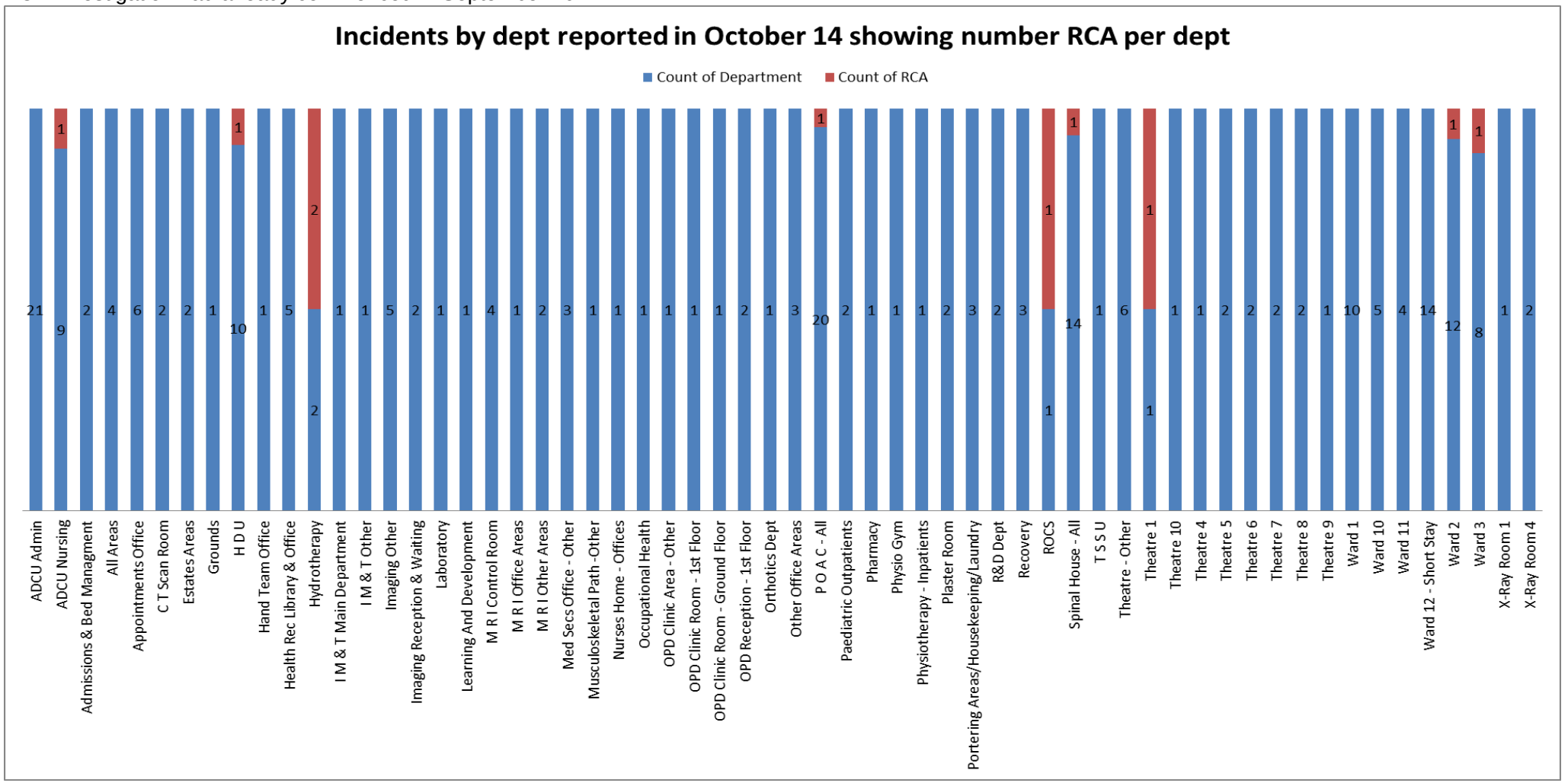
Ref	Incident date	Date raised to CCG	Type of incident	Level of harm (Prior to completion of RCA investigation)	Directorate	Status	Final RCA due
13903 STEIS 2014/32488	03/10/14	07/10/14	VTE	Near Miss	Large Joints	Downgrade requested	N/a
13912 STEIS 2014/33034	07/10/14	09/10/14	VTE	Near Miss	Oncology	Investigation underway	11/12/14
13837 STEIS 2014/33461	10/09/14	14/10/14	Surgical error	Low harm	Spinal	Investigation underway	16/12/14
13982 STEIS 2014/33836	15/10/14	16/10/14	Grade 3 pressure ulcer	Moderate harm	Paediatrics	Investigation underway	19/12/14
13944 STEIS 2014/34206	20/10/14	21/10/14	Grade 3 pressure ulcer	Low harm	Large Joints	Investigation underway	23/12/14
14048 STEIS 2014/35097	23/10/14	28/10/14	Drug incident	No harm	Theatres & Anaesthetics	Investigation underway	02/01/15
13634 STEIS 2014/29006	29/08/14	05/09/14	Suboptimal patient care	Near Miss	Large Joints	Report under review, due for submission on time.	07/11/14
13678 STEIS 2014/29080	06/09/14	08/09/14	Attempted suicide	Catastrophic	Large Joints	Investigation underway, on target.	10/11/14 (amended from 8/11/14)
13717 STEIS 2014/29738	11/09/14	12/09/14	VTE	Near Miss	Oncology	Investigation under review.	14/11/14
13795 STEIS 2014/30724	22/09/14	22/09/14	Transfer/ death	Catastrophic	Large Joints	Investigation underway. Extension requested.	24/11/14
13853 STEIS 2014/31822	29/09/14	30/09/14	VTE	Moderate	Large Joints	Investigation underway	02/12/14
13856 STEIS 2014/31828	29/09/14	30/09/14	VTE	Near Miss	Small Joints	Investigation underway	02/12/14
13568 STEIS 2014/27185	19/8/14	20/8/14	Treatment delay	Reported as minor harm	Theatres, Anaesthetics & Critical Care	Investigation underway	6/11/14 (Extended from 23/10/14)

APPENDIX 1b - Closed Serious Incident investigations

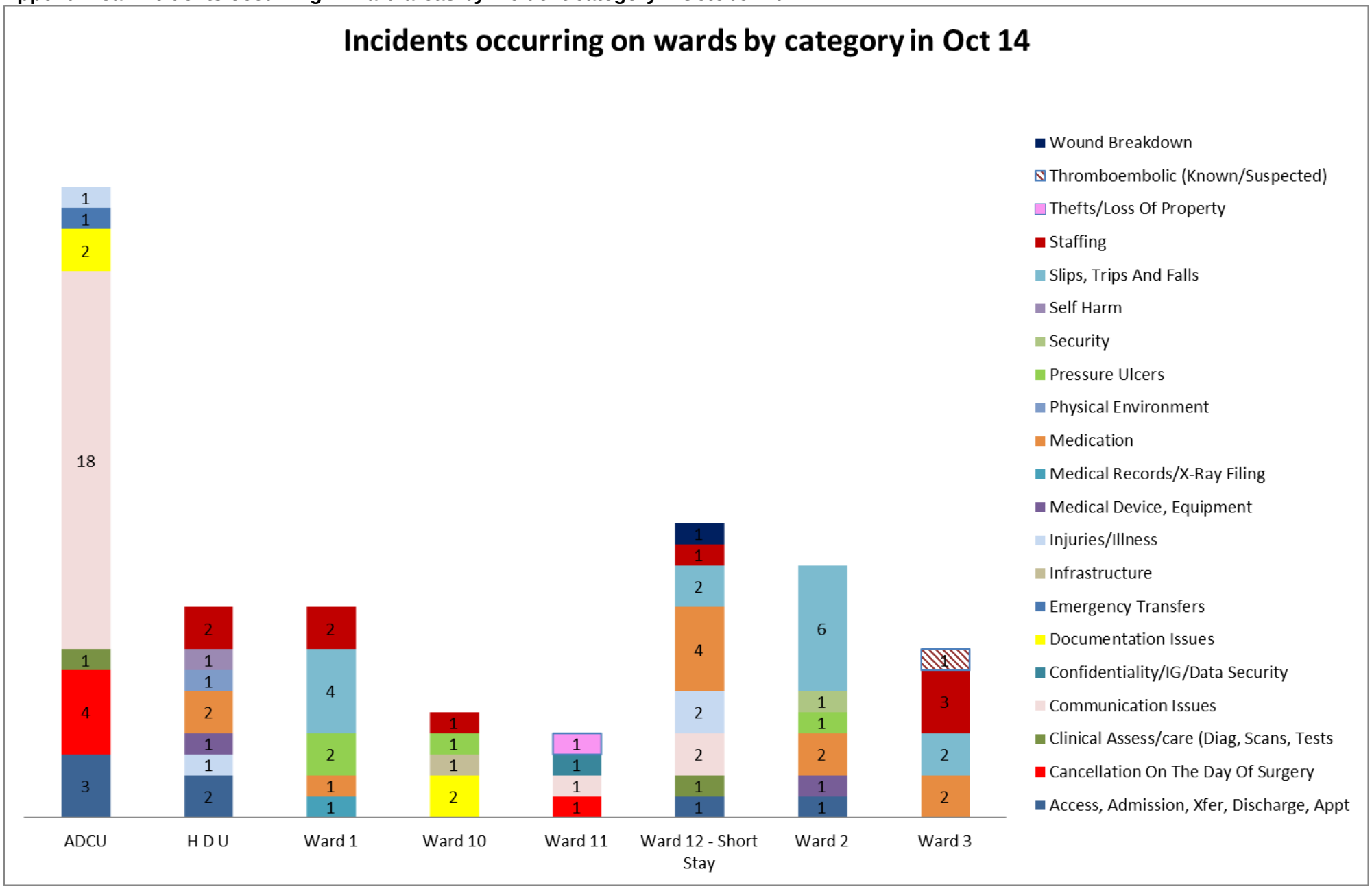
NB. Summary of learning from incidents requiring investigation is provided each quarter (next due in December 2014 report).

Ref	Incident date	Description	Directorate	Deadline for submission of RCA investigation report	Progress/ Date submitted
13520 STEIS 2014/26461	13/8/14	VTE	Oncology	17/10/14	Report submitted 10/10/14.
13523 STEIS 2014/26463	9/8/14 (reported 14/8/14)	VTE	Oncology	17/10/14	Report submitted 17/10/14.
13205 STEIS 2014/24850	03/07/14	VTE	Spinal	03/10/14	Report submitted 07/10/14.
13652 STEIS 2014/28834	03/09/14	Grade 3 pressure ulcer	Oncology	06/11/14	Downgraded.

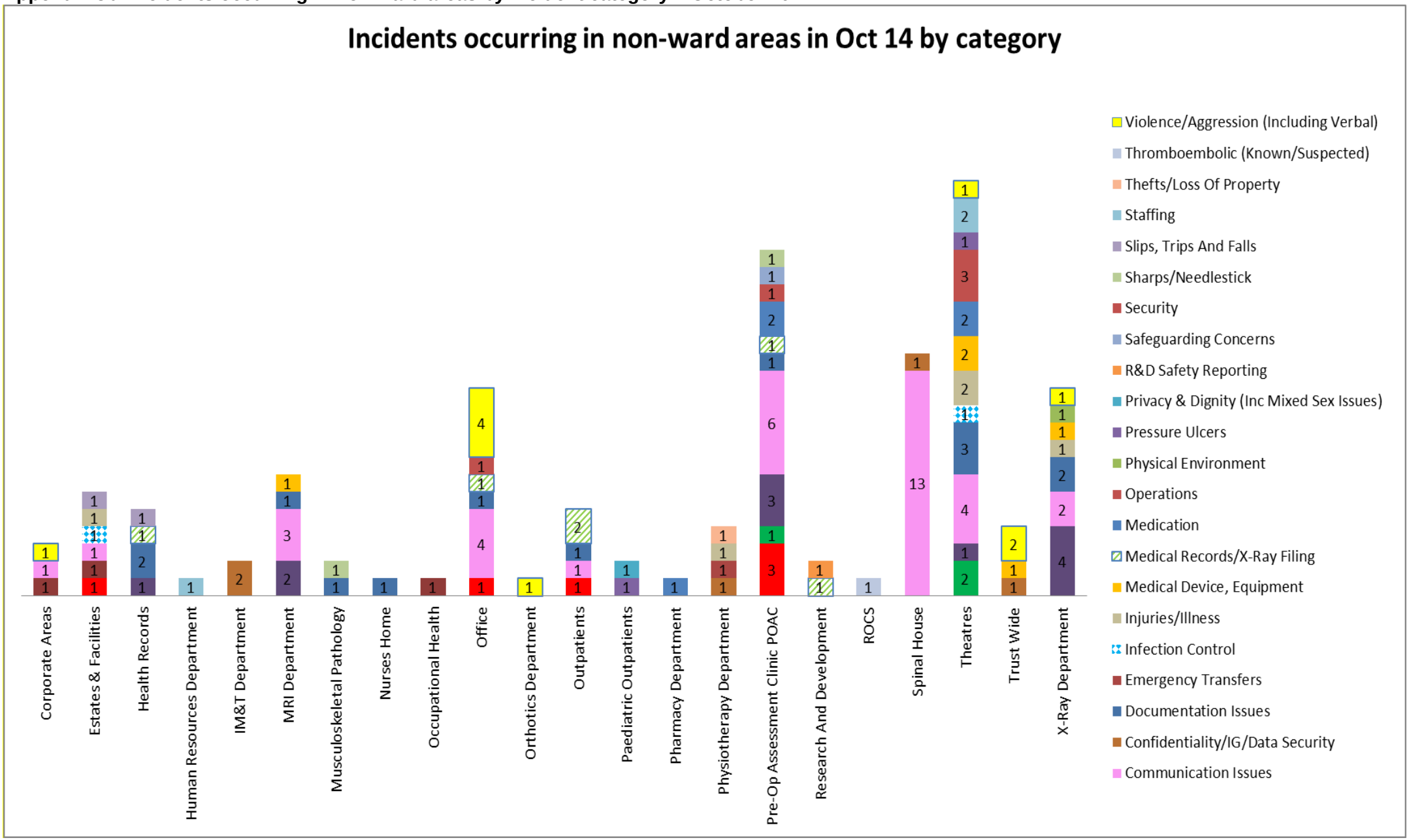
Appendix 2: No. of Incidents requiring an RCA investigation by department – October 2014
***NB:** A total of 11 incidents required an investigation, however Incident 13837(Surgical error) was initially reported internally at the end of September and included on the September report. This was escalated to a Serious Incident in October 2014 (and subsequently reported to commissioners) and is not reflected in the graph below as the RCA investigation had already commenced in September 2014.



Appendix 3a: Incidents occurring in ward areas by incident category – October 2014



Appendix 3b: Incidents occurring in non-ward areas by incident category – October 2014



Appendix 4 – Year to date breakdown by Directorate (PALs, Complaints, Compliments, Concerns and Enquiries)

Directorate	PALS	General Enquiry	Concern	YTD Enquiry	YTD Concern	Complaints	YTD Complaints	Compliments	YTD Compliments
Clinical Support	24	15	9	59	109	0	9	32	214
Corporate	25	21	4	125	46	1	5	18	173
Large Joint	26	18	8	63	102	6	23	162	963
Oncology	14	8	6	22	34	0	3	29	183
Paediatrics	6	0	6	4	38	0	1	45	242
Small Joint	6	2	4	21	29	0	4	3	31
Spinal	35	10	25	29	147	2	14	73	581
Theatres	12	3	9	8	30	1	5	103	739
TOTAL	148	80	68	331	535	10	64	465	3126

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26th November2014 **ENCLOSURE NUMBER: 7**

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**Safe Staffing – October 2014**

Safe staffing of our wards continues to be closely monitored and consistent performance has been achieved against the National Quality Board (NQB) and NHS England guidance.
The Trust Board are asked to agree that monthly reporting continues to Clinical Governance Committee as there is a direct correlation between nurse staffing ratios and the quality of care experienced by our patients. It is proposed that CGC will provide a six monthly update to the Board as recommended by the NQB.

In October there were FIVE incidents reported relating to safe staffing. Proactive use of incident reporting continues to require focus to improve awareness and accurate reporting. No breaches of minimal safe staffing standards. Matrons are confident that safe staffing is maintained and have reviewed all incidents.

Directorate teams are asked to observe emerging patterns within incidents, such as short notice sickness absence, un-planned HDU admissions and clinical site co-ordinator role, and act accordingly.

Twice weekly Matron/Senior Nurse Quality Debriefs continue. Monthly Safe Staffing Briefings continue to develop knowledge and awareness across the nursing team.

The Safe Staffing action plan demonstrates good progress for the organisation against the national recommendations and ward specific public display boards are now populated.

Monthly Bank and Agency request and fill rates report now includes filled shifts that are cancelled at short notice (DNAs), for the month of September 814 shifts were requested of which 19 did not fill and 5 DNA'd.

ROH NHSFT completed the NHS England Safe Staffing UNIFY data uplift on for the month of October on time. For a sixth month ROH NHSFT has received a GREEN rating. This demonstrates the planned nursing levels versus the actual nursing levels.

IM&T are supporting the transfer of paper based, labour intensive mechanism to an electronic solution which is slightly delayed and envisaged to be in place across all wards in Spring 2015 and there is continued learning from the pilot sites of Wards 1 & 2.

The tool has been enhanced in October to recognise the use of 'specialing' shifts for high dependency patients, such as those at high risk/actual falls.

Summary data for October:-

Shift	Actual versus planned
Day Registered Nurses	99.6%
Day Health Care Assistants	103.7%
Night Registered Nurses	100%
Night Health Care Assistants	102.52%

Comparison to other Trusts is considered with available data showing:-

September RJAH	RN between 94.7% and 100.8%
September Royal National Orthopaedic	Overall 97.5%
September HEFT	RN between 70.5% and 300%
September SWBH	Data not available

IMPLICATIONS eg. Financial, operational, risk, etc

Patient safety and experience, Staff satisfaction, Organisational reputation

RECOMMENDATIONS

Trust Board is asked to:-

- Confirm that Safe Staffing be reported to CGC monthly and to Trust Board six monthly in the future
- Note the continued progress made by ward teams, Matrons and project lead
- Recognise and acknowledge the importance to ROH NHSFT of the national guidance in regards to our patient welfare and future strategy
- Be assured

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26th November 2014 **ENCLOSURE NUMBER: 8**

NAME OF DIRECTOR	Helen Shoker, Director of Nursing and Governance
SUBJECT	EMT Risk Register and BAF Report
AUTHORS	Lisa Pim, Deputy Director of Nursing and Governance Jane Moore, Litigation Assistant and Governance Facilitator

SUMMARY

This report covers the period September and October 2014

Trust Board are asked to:

Note EMT specific risks :

(a) increasing risks - risk i.d 27 'temporary and agency medical staffing' has increased

(b) decreasing risk - none

(c) new risks – none escalated by Directorate teams

(d) closed risks

35 'admin review'

8 'increasingly complex patients'

(e) risk i.d. 22, 'Marketing', executive director lead has been discussed at EMT this month and is pending agreement with the individual

Trust Board are asked to review the Trust risks as highlighted within the **BAF themes** document and note:

BAF theme 5 "contract with commissioners" updated and graded amber

a) increasing risks

b) decreasing risk

risk i.d. 32 "SSI within arthroplasty"

c) new risks - none

d) closed risks – none

Ulysses is being updated to reflect the new strategic objectives in the relevant column. Once complete risk leads will be asked to align specific risks to the new strategy initiatives and nominate operational leads for each risk.

The Executive Directors have developed the risks associated with implementing the new strategy and these will be included in next month's report.

IMPLICATIONS

Patient Safety, Contractual, Legal, Reputational

RECOMMENDATIONS

Trust Board is asked to:

- Note the paper
- Discuss

BOARD ASSURANCE FRAMEWORK 2013/14 (updated: 12.11.14) Appendix 1

This table maps all Trust-wide high level (red) risks against the 8 new 2013/14 BAF themes. Details of the 8 strategic BAF themes are given on the attached summary sheets.

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	9	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
				Leading Committee	CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
	Trust-wide risks with a red/amber risk rating		RAG status	Exec Lead								
I.D.	RISK	CONSEQUENCES										
32	Higher than expected rates of 30 day SSI within arthroplasty		12	Medical Director (As DIPC)	Lead Committee				Supporting Committee			
33	Insufficient assurance around robust implementation of infection prevention strategies in theatres.		16	Medical Director (as DIPC)	Lead Committee				Supporting Committee			
27	Inability to control the use of unfunded medical temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2	lack of continuity of patient care; On going locum and agency costs. potential successful banding claims Pre-monitoring exercise has highlighted potential breaches of national New Deal standards.	20	Medical Director	Supporting Committee			Lead Committee		Supporting Committee	Supporting Committee	Supporting Committee
7	Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays.	Risk to patients of deterioration in condition whilst waiting. Increased complaints & litigation. Risk of Financial penalties levied by Commissioners for breach of 52 weeks	12	Director of Operations				Lead Committee				
178	Poor completion of WHO safety procedure. Mitigation: Working partly in place, reviewing whole process. Daily WHO Audits undertaken and published. Poor Practice highlighted	Patient safety through their their experience of the operating department may be compromised, at the mosts severe a never event may occur.	12	Director of Nursing & Governance	Lead Committee							

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	9	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
669	Assurance that existing point of care testing (POCT) equipment is fit for purpose and compliant with regulations. Lack of unified procurement process, inventory, quality assurance, protocols and training.	Patient safety/care being compromised.	16	Director of Operations				Lead Committee				
666	There is a risk that the 18 week monitoring of patient cannot happen so effectively if information is not up to date.	Cannot manage 18 week pathway internally, failing 18 week target, breach of contract	12	Director of Operations				Lead Committee				
270	Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	The Trust will not be adequately recompensed for its work increasing the risk to the organisations long term financial viability	15	Director of Finance								Lead committee
New or Recently Upgraded Risks August 2014												
none												
Risks downgraded- to be monitored												
414	ROH shows low position for health improvement as measured by PROMs on national Information Centre figures	Patient experience Reputational damage	12	Medical Director	Lead committee			Supporting Committee	Supporting Committee			Supporting Committee

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	9	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
				Leading Committee	CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
	Trust-wide risks with a red/amber risk rating		RAG status	Exec Lead								
I.D.	RISK	CONSEQUENCES										
12	Contractual KPIs: Trust is required to sign up to SLA contracts with our material commissioners, including performance clauses in line with national and local requirements	Quality of care reduced leading to fines and financial loss. Reputational damage.	8	Director of Nursing & Governance (changed from Director of Finance)	Lead Committee	Supporting Committee	Supporting Committee		Supporting Committee			
269	Failure to deliver activity targets	creates a lower in year surplus and a lower base to contract from in 2013/14 thus shrinking the organisation. Lack of	8	Director of Operations (changed from Director of Finance)	Supporting Committee			Lead Committee				Supporting Committee
275	Inability to consistently demonstrate learning from serious events/ claims/ complaints is embedded in practice	poor quality patient experience	9	Director of Nursing & Governance	Lead Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee	Supporting Committee		Supporting Committee
625	Spinal database relating to outcomes and CQUINS held in R& T - data corrupted.	Adversely impacts upon delivery of quarter 4 CQUINS report and potential financial loss to Trust	12	Director of Finance	Supporting Committee				Lead Committee			Supporting Committee

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
				Current risk rating	6	3	4	6	9	12	16	10
					ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term
Leading Committee					CGC	EMT	CGC	EMT	EMT	EMT	EMT	EMT
Trust-wide risks with a red/amber risk rating			**RAG status**	**Exec Lead**								
I.D.	**RISK**	**CONSEQUENCES**										
621	Delays in MRI imaging and reporting	potential delay in diagnosis and treatment. Ineffective outpatient consultations . Repeat visits. Potential complaints/claims	12	Director of Operations (changed from Director of Finance)	Lead Committee							
51	Medical Records: Non compliance with Information Governance/ data protection regulations.Retention of records unnecessarily. Insufficient destruction of medical records in line with policy. Mitigation: policy updated with justification for retention of records; policy to follow ratification process	Potential financial penalty due to data protection/IG breaches.	12	Director of Operations	Supporting Committee			Lead Committee				

	1. Standards of care	2. Monitor licence	3. CQC registration	4. Business continuity	5. Contract with Commissioners	6. Staff engagement	7. Organisational leadership	8. Long-term Viability
Ulysses risk register i.d.	643; 260	261	262	263	265	665	582	440
	Risks that could lead to unacceptable standards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence conditions	Risks that impact on the achievement of CQC standards	Risks that impact on the ability to maintain services in the short-term	Risks that impact on the ability to meet contractual terms and targets with our commissioners	Risks that impact on the delivery ofengagement across all staff groups	Risks linked to organisational leadership at all levels and across all staff groups	Risks that impact on the ability to maintain services in the long-term

643; 260	**261**	**262**	**263**	**265**	**665**	**582**	**440**

Appendix 2

Board Assurance Framework Update – November 2014

(updated: 20th November 2014)

BAF Theme 1: Standards of Care (i.d. 260)

Update on progress

Assurance on risk mitigation and current risk rating to be sought from Infection Prevention and Control Team regarding risk 32 "SSI within arthroplasty" and "infection control within theatres".

Trust-wide risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
March 2014	(i.d.178) Poor completion of WHO safety procedure. Mitigation: Working partly in place, reviewing whole process. Daily WHO Audits undertaken and published. Poor Practice highlighted	Potential compromise to patient safety, possible never event	DNG	• Safe • Effective	16	12	Weekly reports continue. Directorate, Theatres team and CD's aware of failure to meet 100% WHO checklist compliance	Revised action plan agreed with lead Commissioners.	CGC
Tbc	(id 32) SSI within arthroplasty		MD	• Safe • Effective	16	12	Current risk downgraded from 16 to 12 (Aug 2014)	Robust monitoring of SSI rates by BIU Adherence to best practice SOP to minimise SSI risk	CGC

Tbc	(id 33) infection prevention in theatres		MD	• Safe • Effective	16	16			EMT

BAF Theme 2 Monitor Licence (i.d. 261)

Update on progress
Awaiting update on risk i.d. 261

BAF Theme 3 CQC Registration (i.d. 262)

Update on progress
Awaiting update on risk i.d. 262

BAF Theme 4 Business continuity (i.d. 263)

Update on progress
Work on pad for MRI scanner is underway. Demolition of stores area and relocation of services and records in wards 5 and 7 underway to allow demolition of the north of site to allow for pad to be built for x 2 mobile theatres. Flu vac plans under consideration.

Trust-wide risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Director	Link to CQC domain(s)	Initial Risk	Current Risk*	Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
August 2014	(i.d.669) Assurance that point of care testing (POCT) equipment is fit for purpose and compliant with regulations.	Patient safety/care being compromised	Dir Ops	• Safe • effective	16	16		Lack of unified procurement process, inventory, quality assurance, protocols and training. Processes and training in place in relation to blood glucose meters. All incidents relating to POCT equipment reviewed by the Blood Safety Committee and escalated to quality/EMT committees Sub group of Blood safety committee being set up to focus on this specifically	EMT

June 2014	(i.d.7) Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays.	Risk to patients of deterioration in condition whilst waiting. Increased complaints & litigation. Risk of Financial penalties levied by Commissioners for breach of 52 weeks	Dir of Ops	• Safe • Effective	20	12	Managed via risk 12 on 'KPIs' until escalation and re-opened as single risk Retained on BAF as 'high' Amber until update on mitigation received..	Whilst no patients have breached 52 weeks since Feb 14, there remains an ongoing risk. Discussions with theatres indicate that spinal skill mix has reduced currently due to vac fac and sickness. Private sector options for adult patients are being explored and a further mitigating plan from theatres team is expected at end of August.	EMT
August 2014	(i.d.666) There is a risk that the 18 week monitoring of patient cannot happen so effectively if information is not up to date.	Cannot manage 18 week pathway internally, failing 18 week target, breach of contract	Dir of Ops	• effective	16	12		Technical staff fix issues as they arise. Informatics Manager is covering technical issues when short staffed. Longer term - infrastructure needs reviewing. Medium term - upgrade SQL. Investigation and amendment to 18 week tracker to improve robustness and performance. Review Extra Manager. Extra member of staff (fix term) to enable additional actions to be completed	EMT
April 2014	(id 27) Inability to control the use of unfunded medical temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either	Increasing locum and agency costs and potential successful banding claims. Following EMT discussion, awaiting further update from Medical Director.	MD	• Well led • Safe • Effective	20	20	Current risk rating increased November 2014	**Completed Actions:** • immediate action to avoid further unplanned expenditure • ensure consultants do not insist junior doctors work beyond rota time complete. **New Planned Assurances** • Opportunities being explored to engage and train other workers to provide care e.g. Physicians Assistants, Fellows. • Exploring taking Physicans Assistants from Autumn 2015 (DWF&OD and MD)	EMT

	GP trainees or FY2							• Expressed interest in additional posts from HEWM (Rachel Ingham-Jones progressing) Following discussion at EMT on 19.11.14, it was agreed by the Committee that the risk rating should be increased. This is following a significant increase in temporary medical staff and associated costs.	

BAF Theme 5 Contract with Commissioners (i.d. 665)

Update on progress

Regular communication with commissioning leads around potential 18 week breaches as a result of Trust decision to target reductions in backlog during October and November. Mitigation plan introduced to ensure breaches are appropriately managed and financial impact of breaches are offset by additional contribution.

BAF Theme 6 Management of Change (i.d. 265)

Update on progress

Awaiting update on risk i.d. 265

BAF Theme 7 Organisational Leadership (i.d. 582)

Update on progress

See detailed risk below

Trust-wide risk(s) aligned to this theme									
Date added to BAF	**Risk**	**Consequence**	**Lead Director**	**Link to CQC domain(s)**	**Initial Risk**	**Current Risk***	**Reason & evidence for risk rating change***	**Update to include gaps in control and assurance**	**Lead Committee**
March 2014	(i.d. 582) management of change	Care for patients that is less than the best; Lack of organisational sustainability	WFOD	• Well led • Safe • Effective	16	16		EMT decision to engage external partner to review barriers and enablers to engagement of doctors in leadership roles and activities. 3 providers bid for work. Decision taken on 17th September to proceed with Kings Fund. Substantive appointments made to Director of Strategy and Transformation and Director of Operations posts. Postholder for transformation to take up post in November	EMT
BAF Theme 8 Long term viability (i.d. 440)									
Update on progress Awaiting update on risk i.d. 440									

Trust-wide risk(s) aligned to this theme									
Date added to BAF	**Risk**	**Consequence**	**Lead Director**	**Link to CQC domain(s)**	**Initial Risk**	**Current Risk***	**Reason & evidence for risk rating change***	**Update to include gaps in control and assurance**	**Lead Committee**
Sept 2014	(i.d. 270) Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	The Trust will not be adequately recompensed for its work increasing the risk to the organisations long term financial viability	Dir of Fin	• Effective	15	15		NEW: escalated to BAF Sept 2014 CEOs & DoFs met with Monitor and NHS England on 2nd September to discuss proposed tariff impact. Little confidence received that Monitor understood or acknowledged issues. Efforts around lobbying and evidence gathering for required changes has been intensified Following a further submission of evidence, a subsequent meeting with Monitor and NHS England on 23rd September was more productive. Agreement to review evidence provided and work with SOA on revised draft prices prior to formal consultation	EMT

RISKS DE-ESCALATED FROM THE BAF

The following risks have been down-graded from the BAF and will continue to be monitored through relevant Committees

Risk ID	Description	Monitoring Committee
621	Delays in MRI imaging and reporting	CGC
636	PAS system contract expires July 2016 - successor arrangements. Removed from BAF Aug 2014 - to be monitored via IM&T Committee	IM&T
30	Non-compliance with CQC outcome 9 “management of medicines”	DTC
13	Failure to deliver contractual CQUINS	QC / EMT
31	Absence of risk assessments on which to base a Health surveillance programme:	WFOD
29	CQC outcome 4 “care and welfare of people who use services”. Inadequate documentation. Concerns over the environment on Ward 11. Additional psychology support services required	QC
28	Accuracy and timeliness of prescribing of medications on admission and reduction of missed doses of critical medicines	DTC

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: November 2014 **ENCLOSURE NUMBER: 9**

NAME OF DIRECTOR:	**Helen Shoker**
SUBJECT:	**CQC action plan**

The CQC Inspection report was published on 17th October 2014, the report specified the actions the Trust must take which are regulated activities, these are known as compliance actions and are as follows:-

- Medicines are managed at all times in line with legal requirements
- Equipment is properly checked and maintained in accordance with electrical safety requirements
- A chaperone policy is developed and chaperones made available to support patients privacy and dignity
- Confidential patient information and records are not left unsupervised in unrestricted public areas of the outpatient department
- Appointments are organised for all clinics to reduce waiting times for patients and improve their experience in the outpatient department
- Letters to GPs and other referring bodies are sent out within set timescales to ensure effective communication

A number of specified actions which the Trust should take, and which are non-regulated activities, were also highlighted. The risks associated with not taking action on these points are of patient experience, safety and the quality of care being compromised, further compliance actions being served at the next inspection and a deterioration of the rating for the Trust.
These actions are:-

- Resuscitation equipment is routinely checked in accordance with the Trusts procedures and records of checks are kept in outpatients
- There is managerial oversight of all outpatients services to ensure the efficient and effective operation of the department and to ensure patient experiences of care are improved
- Discharge arrangement to facilitate early identification and availability of beds for patients admitted on the day of surgery are improved
- The implementation of Enhanced Recovery Programmes to reduce patient length of stay in hospital and promote greater patient involvement in their care
- When the reception desk is closed there is clear, visible signage to direct patients and visitors form the main entrance to other departments

The CQC standard action plan template has been completed for all of the above; these have been developed in collaboration with key staff groups and have an identified responsible Director. This was submitted to the CQC on time.

The specific risk of failing to meet the CQC specified regulated activities has been developed by the Director of Nursing and Governance and will be reviewed by the Clinical Governance Committee.

The Board approved the circulation of the action plan in October, with approval by the CEO and Chairman, and a monthly update is planned from December onwards. The update will be co-produced by the Directors of Nursing and Operations, the majority of actions sit within their respective portfolios.

To date progress has been made against all actions, for example:-
Additional signage around the Hospital site and the welcome desk staffed in routine hospital hours,
HDU and ward staff awareness sessions relating to medicine management,
Trial of appropriate medical records storage solutions in OPD,
Commencement of Outpatient Matron and Outpatient Improvement Manager,
Chaperone policy drafted, improved signage highlighting to visitors the offer of a chaperone and greater OPD staff awareness,
Daily bed management processes have been designed and implemented and the use of 'expected date of discharge' across the wards has improved,
Random checks of resuscitation equipment and controlled drug management take place each week and results are positive.

IMPLICATIONS

Patient safety and experience, Staff satisfaction, Organisational reputation and sustainability

RECOMMENDATIONS

The Trust Board is asked to:-

- Confirm the intention to provide a monthly Trust Board update

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26 November 2014 **ENCLOSURE NUMBER: 10**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	Update on Five Year Strategic Plan

SUMMARY

To update Board on the current position and future actions with regards to the Five Year Strategic Plan and initiation of the Transformation Programme designed to deliver the Trust's strategic initiatives

IMPLICATIONS

To deliver the 5 year strategic plan the Trust must reorganise its resources and bring new capacity and capability into the organisation. Additionally, new information systems will be required. Commissioners continue to develop a longer-term view of the local health system and new national proposals are developing which may impact upon the Trust's strategy.

RECOMMENDATIONS

To note the progress to date and actions planned for the next period.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update Board on current position and future actions with regards to the Five Year Strategic Plan and initiation of the Transformation Programme designed to deliver the Trust's strategic initiatives
Recommendation	To note the progress to date and actions planned for the next period.

1.0	**Summary/Background** Following the agreement of the Trust's 5 Year Strategic Plan in June 2014 this report is intended to update the Board on implementation of the plan and transition from existing activities. The new CEO of NHS England has published a Five Year Forward View in partnership with other leaders of national organisations. An overview of the most relevant aspects have been set out in my CEO's report, and the full document can be viewed at www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf The emerging picture is still taking shape and will be impacted by any changes in policy post general election in May 2015.
2.0	**Progress Made to Date** The strategic plan was submitted to Monitor on 30 June 2014 in line with national requirements. On 2 September 2014 an initial review meeting took place with Monitor and no major concerns were identified based on the assumptions in the plan. It was noted, however, that the proposed tariff changes for 2015/16 introduced new risks which would need to be reviewed as the tariff is finalised. Formal feedback from Monitor has now been received and the letter explains that an in-depth review of the Trust's strategies and plans has not been undertaken. Instead, Monitor has tested the robustness of the financial projections which describe the plans; this has involved applying a limited number of sensitivities to counterbalance variations in the Trust's assumptions. A copy of the letter will be made available to Board members. The Board will continue to review planning assumptions and the more recent issue regarding tariff is still a 'live' issue; our representations to Monitor along with colleague organisations in the Specialist Orthopaedic Alliance(SAO) has resulted in changes to the original proposals, a delay in issuing the new tariff for formal consultation and a commitment to further work during 2015/16 in partnership with the SOA to further develop the pricing model for 2016/17 onwards.

Monitor has issued new guidance for Boards 'Developing strategy: What every trust board member should know', which can be found at www.gov.uk/government/uploads/system/uploads/attachment_data/file/363273/Monitor_-_Developing_Strategy_-_a_guide_for_board_members.pdf
(Please note the gaps are 'underscores' _). A leaflet will be available for Board members.

Additional internal and external engagement has continued over the last couple of months to prepare the organisation to 'launch' the transformation programme.

- **Strategic Engagement and System Planning**

The Trust continues to work with its strategic partners such as Birmingham Children's Hospital and through the Specialist Orthopaedic Alliance on issues relevant to our services and to explore opportunities for sustainable service improvement.

The Birmingham, Sandwell and Solihull 'Unit of Planning' meetings continue to explore the 15 year vision for the three health economies. As reported previously, a significant financial gap will exist in the local system if no change occurs in the pattern of commissioned services.

- **Trust Leadership and Governance**

Director of Strategy & Transformation
Professor Phil Begg took up post on 01 November 2014. His role has overall responsibility for the development of the Trust's strategy and for leading the strategic change required. Phil has had an extremely busy first couple of weeks meeting with key people from across the Trust and is working closely with Karen Yates, the Interim Programme Director to begin to move the programme structure forward as well as determining how to frame the programme to ensure the inclusion of all levels of staff across the Trust in the delivery of the ROH Strategy. Karen Yates has agreed to remain with the Trust and move into the Programme Manager role in support of Phil pending a substantive appointment to the post.

Transformation Committee
Terms of Reference for the Transformation Committee were approved by the Board during its October meeting.

With the Director of Strategy & Transformation now in post dates are now being sought for the first formal Transformation Committee meeting to take place. It is proposed that the first formal meeting be held sometime in January 2015, with a half day workshop to be held in December and we are currently forming an opinion about where in the Trust's committee schedule the routine meeting should take place; once agreed the calendar schedule for the year will be set .

The half day workshop will enable Transformation Committee members to receive details of plans / tools and templates to be used in support of the programme of work and to think through in more detail how the Committee will fulfil its responsibilities to the Board of Directors.

Transformation / Improvement Team
Work is on-going to draw up an implementation plan outlining how we can harness the current project / programme management skills and experience that already lie within the Trust and how we can populate the new structure. This work is linked closely to the work currently in train with regards to wider structural changes at ROH.

Since the report in September we have begun to draw up our 'Master Plan' to support delivery of the strategy.

During October Karen Yates ran two workshop sessions with the Executive Team to flesh out the details of the major projects or programmes of work that lie within the seven strategic initiatives. This work has provided us with a giant 'Gantt chart' to help us plot our progress and identify areas of extreme pressure (where multiple work-streams need to be driven forward concurrently) or where one work-stream has interdependency with another. Using this as our guide we will then have to prioritise our activities and/ or flex our improvement team capacity to support delivery.

Since the creation of the 'master plan' Karen has been meeting with colleagues to populate the levels of detail below this and fully understand the interdependencies and timelines in more detail. This work will conclude in December.

Priority - Patient Pathway
In October a *'Lunch & Listen'* event was held – open to staff from across all areas of the pathway for large and small joints. This structured session asked teams working around each element of the patient pathway to prepare in advance a flow chart of how patients moved through their section of the service and to think through what they felt worked well currently in the pathway and what they felt did not work well.
The event saw an excellent turnout of staff from across the Trust (c30 people) and some fantastic preparation work had been done to present to colleagues during their allotted 10 minute slot.

During the session a number of key common themes came out, and attendees felt that it had been a very useful and thought provoking meeting. Not surprisingly a number of people pointed out that similar exercises had been carried out over previous years but had not really generated any significant action.

Unlike the previous attempts at this we have therefore moved quickly forward in designing a highly functional tool (based initially in MS Excel – for speed of delivery). This tool shows an overview of a typical timeline for a patient to move through from referral into the Trust through relevant departments and back out into the community. Using the functionality of Excel then allows users to click on a button to drill down further in to the detail of a particular part of the pathway.

These additional worksheets also display the 'Things that work well' and 'Things that don't work so well' elements highlighted by the teams themselves on the day. These latter elements can be easily pulled together by running a simple one button enquiry, allowing us to quickly review the good and the not so good; to pick out common themes across directorates / divisions; to share good practice and help us over time reduce duplication in the system and tackle known hot-spots.

Work will be on-going through December and January to bring further detail to the pathways included in the tool (working closely with each team) and then also to include Oncology, Spinal and Paediatrics pathways.

This work is seen as an excellent mechanism both to work on the patients' pathway directly and also to engage wider groups of staff on the ground in the overall work of the Transformation Programme.

In addition to this, a software tool has been purchased which was made operational on 10 November 2014, to assist with the scheduling of out-patient clinics and when the next update takes place this will start to identify areas for management attention and should start to bring immediate improvement capability to the department.

Whilst work is on-going to finalise the programme structure current meetings across the Trust are being reviewed and where possible these will be mapped across into the new meetings structure. This work will continue through December – with migration taking place in January 2015.

Progress on Work Streams:
Whilst the overall programme structure is still evolving work is continuing on a number of projects aligned to our strategy.

Some key activities in the next two months include:

Work Stream 1 – Creating a culture of excellence, innovation and service

- Restructure
  - Final structures agreed
  - Engagement with staff and stakeholders
  - Begin selection process
- Change Leadership Capability
  - Agree model
  - Executive Team change leadership skills training
- Medical Leadership Strategy
  - Diagnostic exercise (Kings Fund)
- Board Development
  - Define scope and purpose
  - Start baseline assessment
- Values work
  - Planning and implementation of awareness session with Senior Managers – then roll out
  - New Appraisal Policy
  - Recruitment - Brand and project resources
  - Design clinical roles
- Learning Strategy
  - Scoping & Definition
  - Baseline Assessment

Work Stream 2 – Exceptional patient experience every step of the way

- Outpatients
  - Phase 1 start
  - Rapid diagnostic exercise
- Patient access reviews
  - Mapping and process re-sequencing
  - Dashboard development
- Business Intelligence
  - Continuation of assessment of operational need
  - Outcomes work
  - Development of patient experience

Work Stream 3 – Safe and Efficient Processes

- Enhanced recovery
  - Finalising protocol
- 7 Day working
  - Contract negotiations
- Medical Workforce Review
  - Identify project resources
  - Consult stakeholders
- EPMA
  - Agree final specifications
- Organisational Governance
  - Developing sub-committee structure and TORs

Work Stream 4 – Fully engaged patients and staff

- Head of Communications has now been appointed (Sally Xerri-Brooks)
- Will start work 08 December 2014 and become workstream lead
- Progress work around the internal messages and 'branding' of programme management

Work Stream 5 – Developing Clinical Services

- Growth of Spinal capacity
  - Scoping exercise
- Develop Orthopaedic Network
  - Engagement period
  - Development of MDT
  - Contracting review re: cohorting
- Direct Access Ultrasound
  - Scope service
- Collaborative Service Delivery
  - Agree internal ceiling capacity

Work Stream 6 – Information for Excellence

- This work-stream has a good project management basis already in place for delivery of its programmes of work, having an existing project board that will in effect migrate to become the programme Board for this work stream.
- The IM&T Strategy was passed by the Board earlier this summer and the supporting delivery plans will form the detail of this element of our Master Plan.
- ESR

	o Phased roll-out • PAS / ORMI – Scoping • IT Infrastructure o Continued rollout of thin client IM&T also have project management skills and capabilities which will need to be aligned closely with the Transformation / improvement Team when it is formed in order for us to use all our capacity most effectively across the Trust. **Work Stream 7 – ROH: Knowledge Leader** • Denise McLellan is back 2 days per week until Christmas to work in support of the Medical Director to develop and refine our thinking around this work stream, to identify interim steps towards an integrated approach, to assess short term transitional risks with recommended mitigating actions and deliver an implementation strategy • On 11 November 2014 workshop was held with the objectives of: o Familiarising people with ROH Corporate Strategy 2014 – 2019 o Considering in more detail "ROH: The Knowledge Leader" o Reviewing the current position and applying critical thinking o Identifying Key Milestones – short, medium and long term o Obtaining feedback and giving staff an opportunity to 'shape the supporting strategies' • The session was extremely well attended and has identified many intermediate steps that need to be taken to drive this element of our plan forward. The details are currently being written up • It will also lead to the early establishment of an internet forum to allow on-going interaction and debate about this element of our strategy.
3.0	**Next Steps** • Further work to develop and define the migration of existing relevant improvement initiatives. • Development of new projects within the 7 workstreams. • Transformation Committee ½ day workshop – 17 December 2014 • Implementation of practical improvement tools, such as the out-patient scheduling tool
4.0	**Conclusion and Recommendations** The Board is asked to note this update and discuss key points.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26 November 2014 **ENCLOSURE NUMBER: 11**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Approval of amendments to the Constitution/ Standing Orders including notice of a motion to amend the Standing Orders received from Frances Kirkham and Rod Anthony**

For formal approval and adoption of further proposed amendments to the Constitution reflected in Appendix 1 which update the Council of Governors' and Board of Directors' Standing Orders as well as making a number of more minor changes to the rest of the Constitution.

IMPLICATIONS

The Trust Board approved in principle various revisions to the standing orders of both the Council of Governors and Trust Board at its September 2014 and October 2014 meetings, as well as a number of more minor amendments to the rest of the Constitution. These changes were also given formal approval by the Council of Governors at their October 2014 meeting and these changes are reflected in the amended Constitution provided as Appendix 1.

Mills and Reeve, solicitors to the Trust, advise that the changes referred to above must be approved by the Council of Governors and the Board of Directors but will not require the approval of members at an Annual Members Meeting since they are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust. Under the Health and Social Care Act 2012, Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act. Mills and Reeve have been responsible for final review of the amended constitution prior to the September meetings of the Board and Council and have assumed responsibility for assuring the Trust of such compliance.

Since the meetings of the Council and Trust Board in October there have been no further changes to the document provided as Appendix 1. The Audit Committee have reviewed the document at their November meeting and are content with what is proposed.

APPROVAL PROCESS

The Trust's current Constitution provides that:

45.1 The trust may make amendments of its constitution only if –

45.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

45.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

It further provides in relation to the Trust Board that the Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.16 *(this should refer to 3.5)* has been given; and
- no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
- at least two-thirds of the Board members are present; and
- the variation proposed does not contravene the requirements of Monitor.

A notice of motion proposed by Frances Kirkham and Rod Anthony, Non-Executive Directors has been given to Jo Chambers, CEO, in accordance with the above provisions.

RECOMMENDATIONS

The Board is asked to approve the amended constitution (including the amended standing orders) provided as Appendix 1 and to adopt the amended constitution from 26 November 2014.

CONSTITUTION OF THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

(Updated as per the Health and Social Care Act 2012)

www.roh.nhs.uk

29 October 2014

Constitution of The Royal Orthopaedic Hospital NHS Foundation Trust

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Paragraph

1. **Interpretation and definitions**

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph 11 of the constitution

constitution means this constitution and all annexes to it.

Monitor is the body corporate known as Monitor, as provided by Section 61of the 2012 Act.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. **Name**

The name of the foundation trust is The Royal Orthopaedic Hospital NHS Foundation Trust (the Trust).

3. **Principal purpose**

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income

available in order to better to carry on its principal purpose.

4. **Powers**

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. **Membership and constituencies**

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency

5.1.2 the staff constituency

6. **Application for membership**

An individual who is eligible to become a member of the Trust may do so on application to the trust.

7. **Public Constituency**

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. **Staff Constituency**

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

10 Restriction on membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9 – Further Provisions.

11. **Annual Members' Meeting**

The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

12. **Council of Governors – composition**

12.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13. **Council of Governors – election of governors**

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the Trust's Authorisation are attached at Annex 5.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 45 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

13.5 In order to assist prospective governors in deciding whether to nominate themselves for election the Trust shall publish a description of the requirements of the role, which shall be reviewed by the Council of Governors from time to time.

14. **Council of Governors - tenure**

14.1 An elected governor may hold office for a period of up to 3 years.

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.3 An elected governor shall be eligible for re-election at the end of his term.

14.4 An appointed governor may hold office for a period of up to 3 years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

14.6 An appointed governor shall be eligible for re-appointment at the end of his term.

15. Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

15.4 Annex 6 makes provision for the removal of Governors.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

17.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26) or, in his absence, the Vice Chairman (appointed in accordance with the provisions of paragraph 27 below), shall preside at meetings of the Council of Governors unless they have a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 7.

19 Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the Trust has failed or is failing—

19.1.1 to act in accordance with its constitution, or

19.1.2 to act in accordance with provision made by or under

Chapter 5 of the 2006 Act.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22 Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

23. Board of Directors – composition

23.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chairman

23.2.2 up to 7 other non-executive directors; and

23.2.3 up to 7 executive directors.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer

23.5 One of the executive directors shall be the finance director

23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the executive directors is to be a registered nurse or a registered midwife.

24. Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors – qualification for appointment as a non-executive director.

A person may be appointed as a non-executive director only if –

25.1 he is a member of a Public Constituency, or

25.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university , and

25.3 he is not disqualified by virtue of paragraph 29 below.

26. Board of Directors – appointment and removal of chairman and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the Trust and the other non-executive directors.

26.2 Removal of the chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

27. Board of Directors – appointment of vice chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a vice chairman.

28. Board of Directors - appointment and removal of the Chief Executive and other executive directors

28.1 The non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chairman, the Chief Executive and the

other non-executive directors shall appoint or remove the other executive directors.

29. **Board of Directors – disqualification**

The following may not become or continue as a member of the Board of Directors:

29.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person in relation to whom a moratorium under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

29.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

30. **Board of Directors – meetings**

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

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. **Board of Directors – standing orders**

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8.

32. **Board of Directors - conflicts of interest of directors**

32.1 The duties that a director of the Trust has by virtue of being a director include in particular –

32.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

32.1.2 A duty not to accept a benefit from a third party by reason

of being a director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2 The matter has been authorised in accordance with the constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than –

32.4.1 The trust, or

32.4.2 A person acting on its behalf.

32.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered –

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the directors appointed for the purpose under the constitution.

32.10 A matter shall have been authorised for the purposes of paragraph 32.2.2 above if:

32.10.1 The Board of Directors, in accordance with the requirements set out in this paragraph 32.10, authorise any matter or situation proposed to them by any director which would, if not authorised, involve a director (an "Interested Director") breaching his duty under paragraph 32.1.1 above to avoid Conflicts;

32.10.2 The matter in question shall have been proposed by any director for consideration in the same way that any other matter may be proposed to the Board of Directors under the provisions of this Constitution;

32.10.3 Any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interested Director; and

32.10.4 The matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

33. Board of Directors – remuneration and terms of office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

33.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34. Registers

The Trust shall have:

34.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of governors;

34.4 a register of directors; and

34.5 a register of interests of the directors.

35 Admission to and removal from the registers

35.1 Any person entitled to be a Member who, as appropriate, applies or is entitled to become a Member, shall have their name and the constituency or class to which they belong added to the register of Members.

35.2 The register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted (which may be the Secretary), their date of becoming a member of the Council of Governors, the anticipated length of their term and the date of their ceasing to be a member of the Council of Governors.

35.3 The Register of Directors shall list the names of Directors, their capacity on the Board of Directors and an address through which they may be contacted (which may be the Secretary)

36 Registers – inspection and copies

36.1 The Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37 Transition

37.1 With effect from the end of the 30th July 2014 (Effective Date) the following provisions of this paragraph 37 shall take effect:

37.1.1 Public members who on the Effective Date live in an electoral area comprised in a Birmingham public

constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of Annex 1 shall become members of the Birmingham and Solihull public constituency as described in Part B of Annex 1;

37.1.2 Public members who on the Effective Date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become members of the Rest of England public constituency as described in Part B of Annex 1;

37.1.3 Public governors who on the Effective Date live in an electoral area comprised in a Birmingham public constituency or in the Solihull electoral area of the Other West Midlands public constituency as described in Part A of Annex 1 shall become governors in the Birmingham and Solihull public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.4 Public governors who on the Effective Date live in an electoral area comprised in the Rest of England and Wales public constituency or in the Other West Midlands public constituency (excluding Solihull) as described in Part A of Annex 1 shall become governors in the Rest of England public constituency as described in Part B of Annex 1, unless they have indicated to the Trust that they do not wish to do so;

37.1.5 If the number of governors for any public constituency following implementation of the preceding provisions of this paragraph would exceed the number of governors allowed for that constituency, then the governors in that constituency shall draw lots to determine which of their number shall retire

38. **Documents available for public inspection**

38.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current constitution,

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The Trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40. Audit committee

The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the Trust's auditor.

41.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. Annual report, forward plans and non-NHS work

42.1 The Trust shall prepare an Annual Report and send it to Monitor.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

42.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about –

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must –

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the directors of the Trust of its determination.

42.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the governors and members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the annual accounts;

43.1.2 any report of the auditor on them;

43.1.3 the annual report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Instruments

44.1 The Trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The Trust may make amendments of its constitution only if –

45.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

45.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

45.2 Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

45.4 Amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and significant transactions

46.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

46.2 The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

PART A (until the Effective Date – see paragraph 37)

There are five public constituencies reflecting the populations the Trust serves:

- South Birmingham
- Heart of Birmingham
- Eastern and Northern Birmingham
- Other West Midlands
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

South Birmingham Public Constituency:

Bartley Green
Billesley
Bournville
Brandwood
Edgbaston
Hall Green
Harborne
King's Norton
Longbridge
Moseley
Northfield
Quinton
Selly Oak
Weoley

Heart of Birmingham

Aston
Bordesley Green
Handsworth Wood
East Handsworth
Ladywood
Lozells
Nechells

Small Heath
Soho
Sparkbrook
Sparkhill
Springfield

Eastern and Northern Birmingham

Northern Birmingham:
Kingstanding
Perry Barr
Oscott
Sutton Four Oaks
Sutton New Hall
Sutton Vesey

Eastern Birmingham:
Acocks Green
Erdington
Hodge Hill
Kingsbury
Shard End
Sheldon
Stockland Green
Washwood Heath
Yardley.

Other West Midlands - comprising the metropolitan boroughs of:

Coventry
Dudley
Sandwell
Solihull
Walsall
Wolverhampton

Rest of England and Wales

Initially the Trust will utilise the details of patients from the Patient Administration System as information to support membership recruitment within the Public Constituency in addition to other recruitment efforts.

The Trust intends to develop membership numbers in the Public Constituency over time; however the minimum number of members in the public constituency described above is to be 100 persons split across the 5 constituencies as follows:

Public Constituency	Minimum Number
South Birmingham	41
Heart of Birmingham	9
Eastern and Northern Birmingham	13
Other West Midlands	31
Rest of England and Wales	6
Total	100

PART B (with effect from the Effective Date– see paragraph 37)

Two public constituencies reflecting the populations the Trust serves:

- **Birmingham and Solihull**
- Rest of England and Wales

The Public Constituency will comprise members of the public, including patients, in the following local government electoral areas:

Birmingham and Solihull

The electoral areas listed in Part A of this Annex for the three former Birmingham constituencies plus Solihull.

Rest of England and Wales

The electoral areas in England and Wales not comprised in the Birmingham and Solihull constituency. The minimum number of members for each Public Constituency is as follows:

Public Constituency	**Minimum Number**
Birmingham and Solihull	67
Rest of England and Wales	33
Total	100

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

All Staff eligible for membership as described in paragraph 0 of the constitution will automatically become members of the Staff Membership Constituency upon Authorisation. Staff will have the right to opt out of automatic membership if they so wish.

There will be two classes of Staff Membership which will be determined based on Whitley Staff Groups:

- Clinical–comprising Medical, Nursing, Allied Health Professionals and Scientists

- Non-Clinical – comprising all staff not included in the clinical class.

There will be a minimum of 25% of total staff within each class, as specified below:

Staff Membership Class	Number of Staff in Post	Minimum Number in Constituency
Clinical	**468**	**117**
Non-Clinical	**339**	**85**

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust will not have a Patient Constituency; patients of the Trust may become members within the Public Constituency providing they fulfil the membership criteria.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 12.2 and 12.3)

PART A (until the Effective Date)

The Council of Governors is to comprise:

Elected Members

13 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
South Birmingham	5
Heart of Birmingham	1
Eastern and Northern Birmingham	2
Other West Midlands	4
Rest of England and Wales	1
Total	**13**

3 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	1
Total	**3**

In order to take into account the changing nature of the local health economy at the commissioning level, the Trust intends to retain the flexibility to increase the staff Members of Council and the Nominated Members of Council. Any increases in Staff Members of Council will require an increase in Public Members of Council in order to ensure that the relative proportion of Staff members to other Constituencies remain constant.

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
South Birmingham PCT	1
Heart of Birmingham (Teaching) PCT	1
Birmingham City Council	1
University of Birmingham	1
University of Central England	1
Patient Support Group Representative	1
Birmingham Council of Faiths Representative	1
Local Member of Parliament Representative	1
Bournville Village Trust	1
Total	**9**

PART B (with effect from the Effective Date – see paragraph 37

Elected Members

9 elected Members from the Public Constituency as follows:

Public Constituency	**Elected Members**
Birmingham and Solihull	5
Rest of England and Wales	4
Total	9

4 elected Members from the Staff Constituency as follows:

Staff Constituency Class	**Elected Members**
Clinical	2
Non-Clinical	2
Total	**4**

Appointed Members

Nominating Organisation (Including partnership organisations)	**Appointed Members**
Birmingham City Council	1
Birmingham City University	1
Local Member of Parliament Representative	1
University of Birmingham	1
Bournville Village Trust	1
Total	**5**

ANNEX 5 –THE MODEL ELECTION RULES

(Paragraph13)

Part 1-Interpretation

1. Interpretation

Part 2-Timetable for election

2. Timetable
3. Computation of time

Part 3-Returning officer

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4-Stages Common to Contested and Uncontested Elections

8. Notice of election
9. Nomination of candidates
10. Candidate's consent and particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination papers
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination papers
17. Withdrawal of candidates
18. Method of election

Part 5–Contested elections

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting documents
25. Ballot paper envelope and covering envelope

The poll

Procedure for receipt of envelopes

Part 6 – Counting the votes

Part 7–Final proceedings in contested and uncontested elections

Part 8–Disposal of documents

Part 9–Death of a candidate during a contested election

Part 10 – Election expenses and publicity

Expenses

Publicity

Part 11 – Questioning elections and irregularities

Part 12 – Miscellaneous

Part 1 - Interpretation

1. Interpretation

(1) In these rules, unless the context otherwise requires:

"the Trust"	Means the Royal Orthopaedic Hospital NHS Foundation Trust;
"election"	Means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;
"Monitor"	Means the Independent Regulator for NHS foundation trusts; and
"the2006Act"	Means the National Health Service Act 2006.

(2) Other expressions used in these rules and in Schedule 7 of the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

(1) The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

(1) In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday; or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

(1) Subject to rule 64, the returning officer for an election is to be appointed by the Trust.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

(1) Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

(1) The Trust is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules; and

(b) such remuneration and other expenses as the Trust may determine.

7. Duty of co-operation

(1) The Trust is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

(1) The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held;

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(c) the details of any nomination committee that has been established by the Trust;

(d) the address and times at which nomination papers may be obtained;

(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer;

(f) the date and time by which any notice of withdrawal must be received by the returning officer;

(g) the contact details of the returning officer; and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

(1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer:

(a) is to supply any member of the Trust with a nomination paper; and

(b) is to prepare a nomination paper for signature at the request of any member of the Trust,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

(1) The nomination paper must state the candidate's:

(a) full name;

(b) contact address in full; and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

(1) The nomination paper must state:

(a) any financial interest that the candidate has in the Trust; and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

(1) The nomination paper must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

(1) The nomination paper must be signed and dated by the candidate, indicating that:

(a) they wish to stand as a candidate;

(b) their declaration of interests as required under rule 11, is true and correct; and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

(1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand;

(b) decides that the nomination paper is invalid;

(c) receives satisfactory proof that the candidate has died; or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election;

(b) that the paper does not contain the candidate's particulars, as

required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11;

(d) that the paper does not include a declaration of eligibility as required by rule 12; or

(e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

(1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show:

(a) the name, contact address, and constituency or class within a constituency of each candidate standing; and

(b) the declared interests of each candidate standing, as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the Trust as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

(1) The Trust is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the Trust is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

(1) A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

(1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the Trust.

Part 5 – Contested elections

19. Poll to be taken by ballot

(1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper

(1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify:

(a) the name of the Trust;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency;

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) instructions on how to vote;

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll; and

(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter is the person to whom the ballot paper was addressed;

(b) that the voter has not marked or returned any other voting paper in the election; and

(c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter;

(b) the address of the voter;

(c) the voter's signature; and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(1) The Trust is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll

(1) The returning officer is to publish a notice of the poll stating:

(a) the name of the Trust;

(b) the constituency, or class within a constituency, for which the election is being held;

(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency;

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post;

(f) the address for return of the ballot papers, and the date and time of the close of the poll;

(g) the address and final dates for applications for replacement ballot papers; and

(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer

(1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the Trust named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope;

(b) a declaration of identity (if required);

(c) information about each candidate standing for election, pursuant to rule 59 of these rules; and

(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

(3) The returning officer shall have the right to edit or not publish any election statement if it exceeds the permitted number of words or because it contains statements which he reasonably believes are factually inaccurate, offensive or libellous.

25. Ballot paper envelope and covering envelope

(1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have:

(a) the address for return of the ballot paper printed on it; and

(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed declaration of identity if required; and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote

(1) An individual who becomes a member of the Trust on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

(1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers

(1) If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it); and

(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers

(1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she:

(a) is satisfied as to the voter's identity;

(b) has no reason to doubt that the voter did not receive the original ballot paper; and

(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper

(1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers"):

(a) the name of the voter; and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (public and patient constituencies)

(1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration:

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration; and

(b) of the particulars of that member's qualification to vote as a member of the public or patient constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for:

(a) the name of the voter;

(b) the address of the voter;

(c) the voter's signature; and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents

(1) Where the returning officer receives a:

(a) covering envelope; or

(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted; or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper

(1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) put the declaration of identity if required in a separate packet; and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”;

(b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it to the ballot paper;

(c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (public and patient constituency)

(1) Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to:

(a) mark the declaration of identity “disqualified”;

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the declaration of identity in a separate packet.

35. Sealing of packets

(1) As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it;

(b) the declarations of identity if required;

(c) the list of spoilt ballot papers;

(d) the list of lost ballot papers;

(e) the list of eligible voters; and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

36. Interpretation of Part 6

(1) In Part 6 of these rules:

"continuing candidate"	Means any candidate not deemed to be elected, and not excluded;
"count"	Means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates;
"deemed to be elected"	Means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll;
"mark"	Means a figure, an identifiable written word, or a mark such as "X";
"non- transferable vote"	Means a ballot paper– (a) on which no second or subsequent preference is recorded for a continuing candidate, or (b) which is excluded by the returning officer under rule44(4)below;
"preference"	As used in the following contexts has the meaning assigned below– (a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference, (b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and (c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on;
"quota"	Means the number calculated in accordance with rule 41 below;

“surplus”	Means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both)exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value)of all transferable papers from the candidate who has the surplus;
“stage of the count”	means– (a) the determination of the first preference vote of each candidate, (b) the transfer of a surplus of a candidate deemed to be elected, or (c) the exclusion of one or more candidates at any given time;
“transferable paper”	Means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate;
“transferred vote”	means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred; and
“transfer value”	Means the value of a transferred vote calculated in accordance with paragraph(4) or (7) of rule 42 below.

37. Arrangements for counting of the votes

(1) The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count

(1) The returning officer is to:

(a) count and record the number of ballot papers that have been returned; and

(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

39. Rejected ballot papers

(1) Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;
(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate;
(c) on which anything is written or marked by which the voter can be identified except the unique identifier; or
(d) which is unmarked or rejected because of uncertainty,

Shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and soon, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

40. First stage

(1) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

41. The quota

(1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 44 has been

complied with.

42. Transfer of votes

(1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those papers for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1) (a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall beat a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus; and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those papers for any continuing candidate; or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5) (a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at:

(a) a transfer value calculated as set out in paragraph (4)(b) above; or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote; or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

43. Supplementary provisions on transfer

(1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first; and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule 42 above:

(a) record the total value of the votes transferred to each candidate;

(b) add that value to the previous total of votes recorded for each candidate and record the new total;

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes; and

(d) compare

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule 42 or 44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be ,all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule 42 or 44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non- transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

44. Exclusion of candidates

(1) If:

(a) all transferable papers which under the provisions of rule 42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred; and
(b) subject to rule 45 below, one or more vacancies remain to be filled,

The returning officer shall exclude from the election at that stage the candidate with the lowest vote (or, where paragraph (12) below applies, the candidates with the lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels so that they are grouped as:

(a) ballot papers on which a next available preference is given; and

(b) ballot papers on which no such preference is given (thereby including

ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule 43 above, transfer each sub-parcel of ballot papers referred to in paragraph(2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule 45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and soon until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes; or

(ii) the total transfer value of votes transferred to each candidate;

(b) add that total to the previous total of votes recorded for each candidate and record the new total;

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total; and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes; with

(ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule 42 and rule 43.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded; and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

45. Filling of last vacancies

(1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall there upon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of anyone continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall there upon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

46. Order of election of candidates

(1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which the respective surpluses were transferred, or would have been transferred but for rule 42 (10) above.

(2) A candidate credited with a number of votes equal to, and not greater

than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

47. Declaration of result for contested elections

(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected;

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the North Staffordshire Combined Healthcare NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust; or
(ii) in any other case, to the chairman of the Trust; and

(c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make a list including:

(a) the number of first preference votes for each candidate whether elected or not;

(b) any transfer of votes;

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place;

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 39(1), available on request.

48. Declaration of result for uncontested elections

(1) In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected;

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the Trust; and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

49. Sealing up of documents relating to the poll

(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers;

(b) the ballot papers endorsed with “rejected in part”;

(c) the rejected ballot papers; and

(d) the statement of rejected ballot papers.

(2) The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it;

(b) the declarations of identity;

(c) the list of spoilt ballot papers;

(d) the list of lost ballot papers;

(e) the list of eligible voters; and

(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

(a) its contents;

(b) the date of the publication of notice of the election;

(c) the name of the Trust to which the election relates; and

(d) the constituency, or class within a constituency, to which the election relates.

50. Delivery of documents

(1) Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, the returning officer is to forward them to the chairman of the Trust.

51. Forwarding of documents received after close of the poll

(1) Where:

(a) any voting documents are received by the returning officer after the close of the poll; or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent; or

(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

The returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the Trust.

52. Retention and public inspection of documents

(1)The Trust is to retain the documents relating to an election that are forwarded to the chairman by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the Trust shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the Trust, and the Trust is to provide it, and may impose a reasonable charge for doing so.

53. Application for inspection of certain documents relating to an election

(1) The Trust may not allow the inspection of, or the opening of any sealed packet containing:

(a) any rejected ballot papers, including ballot papers rejected in part;

(b) any disqualified documents, or the list of disqualified documents,

(c) any counted ballot papers;

(d) any declarations of identity; or

(e) the list of eligible voters,

By any person without the consent of the regulator.

(2) A person may apply to the regulator to inspect any of the documents listed in (1), and there regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons;

(b) time;

(c) place and mode of inspection;

(d) production or opening,

and the Trust must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1):

(a) in giving its consent, the regulator;

(b) and in making the documents available for inspection, the Trust,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given; and

(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

54. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to the returning officer's

satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died; and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted; and

(ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49(1)(a).

Part 10 – Election expenses and publicity

Election expenses

55. Election expenses

(1) Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part 11 of these rules.

56. Expenses and payments by candidates

(1) A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

57. Election expenses incurred by other persons

(1) No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise; or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58. Publicity about election by the Trust

(1) The Trust may:

(a) compile and distribute such information about the candidates; and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the Trust about the candidates, including information compiled by the Trust under rule 59, must be:

(a) objective, balanced and fair;

(b) (as far as the information provided by the candidates so allows)equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election; and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the Trust proposes to hold a meeting to enable the candidates to speak, the Trust must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the Trust must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59. Information about candidates for inclusion with voting documents

(1) The Trust must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of

these rules.

(2) The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words (if supplied by the candidate); and

(b) a photograph of the candidate (if supplied by the candidate).

60. Meaning of "for the purposes of an election"

(1) In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

61. Application to question an election

(1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the regulator by:

(a) a person who voted at the election or who claimed to have had the right to vote; or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must:

(a) describe the alleged breach of the rules or electoral irregularity; and

(b) be in such a form as the regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(7) The regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.

(8) The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the Trust, the applicant and the members of the constituency (or class with in a constituency) including all the candidates for the election to which the application relates.

(9) The regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

62. Secrecy

(1) The following persons:

(a) the returning officer; and

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the Trust who has or has not been given a ballot paper or who has or has not voted;
(ii) the unique identifier on any ballot paper; and
(iii) the candidate(s)for who many member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63. Prohibition of disclosure of vote

(1) No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification

(1) A person may not be appointed as a returning officer, or as staff of the

returning officer pursuant to these rules, if that person is:

(a) a member of the Trust;

(b) an employee of the Trust;

(c) a director of the Trust; or

(d) employed by or on behalf of a person who has been nominated for election.

65. Delay in postal service through industrial action or unforeseen event

(1) If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24; or

(b) the return of the ballot papers and declarations of identity,

The returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the regulator.

66. Effect of administrative or clerical errors on election

(1) Elections shall not be invalidated by any administrative or clerical error on the part of the Trust or any acts or omissions of the returning officer acting in good faith on the basis of such error.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 22)

1. The Council of Governors will meet quarterly.

2. Any Member of Council judged by the Council of Governors to have acted in a manner which brings the Trust into disrepute will not be permitted to continue as a Member of Council.

3. NOT USED

4. The number of full terms of office for Elected Members of Council will be 3.

5. Under Paragraph 26.2 of the Constitution, 75% of all the Members of Council have to be in support in order to remove the Chairman or Non-Executive Directors

6. The following may not become or continue as a member of the Council of Governors:

   6.1 They are a Director of the Trust, or a Governor, Member of Council or Director of another NHS Body, or of an independent/private sector health care provider whose activities compete with those of the Trust. These restrictions do not apply to Appointed Partnership Members of Council;

   6.2 they are under sixteen years of age;

   6.3 being a member of a public constituency, they were or were entitled to be a member of one of the classes of the staff constituency at any point during the preceding two years;

   6.4 being a member of one of the public constituencies, they refuse to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

   6.5 they are currently on the sex offenders register.

   6.6 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, expiry of a fixed term contract, disability, ill health or age from any paid employment with a health service body. In other cases of dismissal, such as capability, an individual may be permitted to become a Member of Council, at the discretion of the Trust, and subject to full disclosure of the relevant circumstances and facts concerning that dismissal;

   6.7 they are a person whose tenure of office as the Chairman or as a

member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non- attendance at meetings, or for non-disclosure of a pecuniary interest;

6.8 they have had their name removed, by a direction under section 46 of the 1977 NHS Act from any list prepared under Part II of that Act or have otherwise been disqualified or suspended from any healthcare profession, and have not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable);

6.9 they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

6.10 they are an elected Member of Council and they cease to be a member of the constituency or class by which they were elected. This may include, but is not restricted to, the reasons for ceasing to be a member identified in Annex 9;

6.11 they are a Member of Council appointed by a partnership organisation and they cease to be sponsored by their partnership organisation;

6.12 they are a member of the Patient and Public Involvement Forum relating to this Foundation Trust or anybody succeeding it in this role;

6.13 they fail to or indicate that they are unwilling to act in the best interests of the Trust and in accordance with The Seven Principles of Public Life laid out by the Committee on Standards in Public Life in its First Report as amended from time to time;

6.14 they fail to agree (or, having agreed, fail) to abide by the values of the Trust set out in Annex 10.

7. A member of the Council of Governors shall immediately cease to be so if:

7.1 they resign in writing to the secretary;

7.2 they fail to attend at least half of the meetings of the Council of Governors in any financial year, unless the majority of the Council of Governors are satisfied that;

7.2.1 their absences were due to reasonable causes, and

7.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as the majority of Members of the Council of Governors consider reasonable.

7.2.3 if any of the provisions in paragraph 6 above apply.

7.2.4 without good reason they fail to undertake any training which the Council of Governors requires all members of the Council of Governors to undertake.

8. Members of the Council of Governors from elected staff who are subject to on-going formal disciplinary action in respect of their employment or engagement with the Trust, will be suspended from their membership of the Council of Governors pending the outcome of disciplinary action.

9. A Member of the Council of Governors may be removed from the Council of Governors by a resolution approved by not less than two-thirds of the remaining members of the Council of Governors present and voting at a general meeting of the Council of Governors on the grounds that:

9.1 they have committed a serious breach of the Trust Principles set out in Annex 10, or

9.2 they have acted in a manner detrimental to the interests of the Trust, and

9.3 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a member of the Council of Governors.

10. Where a vacancy arises from any reason (other than expiry of term of office) amongst the appointed member of the Council of Governors the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

11. Vacancies amongst the elected members of the Council of Governors will be dealt with under paragraph 9 of Annex 9.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 18)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Standing Orders
Council of Governors

CONTENTS

1. INTRODUCTION

1.1 Statutory Framework

1.1.1 The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act").

1.1.2 The principal places of business of the Trust is:

- The Royal Orthopaedic Hospital, Bristol Road South, Northfield, Birmingham B31 2AP.

1.1.3 NHS Foundation Trusts are governed by, the 2006 Act as amended by the 2012 Act, their constitutions and their NHS provider licences issued by Monitor (Regulatory Framework).

1.1.4 The functions of the Trust are conferred by the Regulatory Framework. As a body corporate it has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.1.5 The Regulatory Framework requires the Council of Governors to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Company Secretary).

2.2 Any expression to which a meaning is given in the 2006 Act (as amended by the Health and Social Care Act 2012 Act) or in the Regulations or Orders made under the 2006 Act shall have the same meaning in the interpretation and in addition:

"**TRUST**" means the Royal Orthopaedic Hospital NHS Foundation Trust.

"**COUNCIL OF GOVERNORS**" means the Council of Governors of the Trust as defined in the Constitution.

"**BOARD OF DIRECTORS**" means the Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.

"**CHAIRMAN OF THE BOARD**" or "Chairman of the Trust" is the person appointed by the Council of Governors to lead the Board of Directors and

to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions “the Chairman of the Board” and “the Chairman of the Trust” shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is so otherwise unavailable.

“**CHIEF EXECUTIVE**” means the chief executive officer of the Trust.

“**COMMITTEE**” means a committee of the Council of Governors

“**CONSTITUTION**” means the constitution of the Trust.

“**COMMITTEE MEMBERS**” means the Chairman and the Members of Council or Directors formally appointed by the Council of Governors or Board of Directors to sit on or to chair specific committees.

“**EXECUTIVE DIRECTOR**” means a Member of the Board of Directors who holds an executive office of the Trust.

“**FT CODE OF GOVERNANCE**” means the NHS Foundation Trust Code of Governance issued by Monitor from time to time.

“**LEAD GOVERNOR**” means a Member of the Council elected by the Council of Governors to hold that office for a term determined by the Council of Governors who may also be removed from office by a resolution of the Council of Governors.

“**MEMBER OF THE COUNCIL**” means a Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the Chairman).

“**MONITOR**” means the body corporate known AS Monitor, as provided by Section 61 of the 2012 Act.

“**NON-EXECUTIVE DIRECTOR**” means a member of the Board of Directors who does not hold an executive office with the Trust.

“**OFFICER**” means employee of the Trust or any other person holding a paid appointment or office with the Trust.

“**SOs**” means these Standing Orders.

“**SCHEME OF DELEGATION**” means the schedule of matters reserved to the Board of Directors and the Delegation of Powers, as approved by the Board of Directors and reviewed from time to time.

“**SECRETARY TO THE TRUST**” means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board Governors and the Chairman and monitor the Trust’s compliance with the Regulatory Framework and these standing orders.

"**VICE CHAIRMAN**" means the Non-Executive Director appointed from amongst the Non-Executive Directors as Vice Chairman by the Council of Governors to take on the Chairman's duties in his capacity as chairman of the Council of Governors if the Chairman is absent for any reason.

"**CLEAR DAYS**" means in any period the duration of which is determined by a starting and finishing event, all complete days in that period excluding the day when the event referred to as starting the period occurs (for example sending out an Agenda) and the day on which the event referred to as ending the period occurs (for example the date of the meeting). For the avoidance of doubt clear days include weekends and public holidays. As an example an Agenda sent out on a Friday for a meeting on a Wednesday represents four clear days: Friday and Wednesday are excluded so that Saturday, Sunday, Monday and Tuesday are the four clear days.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council of Governors

3.1.1 In accordance with the Constitution of the Foundation Trust, the composition of the Council of Governors after the Effective Date shall be:

- 9 Public representatives
- 4 Staff representatives
- 5 nominated representatives comprising
- 1 University of Birmingham representative
- 1 Birmingham City University representative
- 1 Birmingham City Council representative
- 1 Member of Parliament representative
- 1 representative of Bournville Village Trust

3.2 Role of the Chairman

3.2.1 The Chairman is not a member of the Council of Governors. However under the Regulatory Framework, he/she presides at meetings of the Council of Governors and has a casting vote.

3.2.2 Where the Chairman of the Trust has died or has ceased to hold office, or where he/she has been unable to perform his/her duties as Chairman owing to illness or any other cause, the Vice Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his/her duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include references to the Vice Chairman.

3.3 Role and Responsibilities of the Council of Governors

3.3.1 The role and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust Constitution, are:

- To appoint or remove the Chairman and other Non-Executive Directors of the Foundation Trust at a members' general meeting (except for the initial Chairman and Non-Executive Directors)
- To approve (by a majority of members of the Council of Governors) the appointment by the Non-Executive Directors of the Chief Executive (except for the initial Chief Executive)
- To appoint or remove the auditor at a general meeting of the Council of Governors.
- To be consulted by the Trust's Board of Directors on forward plans and to have the Council of Governors' views taken into account
- To be presented with at a general meeting of the Council of Governors, the Annual Report and Accounts and the report of the Trust's auditor

3.3.2 The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its Directors. The Council of Governors does not have the right to veto decisions made by the Board of Directors.

3.3.3 The Council of Governors, and individual Members of Council, are not empowered to speak on behalf of the Trust, and must seek the advice and views of the Chairman concerning any contact from the media or any invitation to speak publicly about the Trust or their role within it.

4. MEETINGS OF THE COUNCIL

4.1 Admission of the Public

4.1.1 The public shall be afforded facilities to attend all formal meetings of the Council of Governors except where the Council resolves:

(a) That members of the public be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; and/or

(b) That in the interests of the public order the meeting adjourn for a period to be specified in such resolution to enable the Council to complete business without the presence of the public.

4.1.2 Nothing in these Standing Orders shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of

proceedings as they take place, without the prior agreement of the Council.

4.2 Calling Meetings

4.2.1 Ordinary meetings of the Council shall be held at such times and places as the Council may determine and there shall be not less than 3 or more than 4 formal meetings in any year except in exceptional circumstances.

4.2.2 The Chairman of the Foundation Trust may call a meeting of the Council at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of Members of the Council, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at Trust's Headquarters, such one third or more Members of the Council may forthwith call a meeting.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his/her behalf shall be delivered to every Member of the Council, or sent by post to the usual place of residence of such Member of the Council, so as to be available to him at least three Clear Days before the meeting.

4.3.2 Want of service of the notice on any Member of the Council shall not affect the validity of a meeting.

4.3.3 In the case of a meeting called by Members of the Council in default of the Chairman, the notice shall be signed by those Members of the Council and no business shall be transacted at the meeting other than specified in the notice.

4.3.4 Agendas will be sent to Members of the Council before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three Clear Days before the meeting, save in emergency. Failure to despatch the agenda and supporting papers within the above timescales shall not affect the validity of a meeting unless the consequences of such failure were to reduce attendance at the meeting below a level at which the meeting was quorate.

4.3.5 Before each meeting of the Council a public notice of the time and place of the meeting shall be displayed at the Trust's offices and on the Trust's website and the public part of the agenda shall be displayed on the Trust's website at least three Clear Days before

the meeting, save in the case of emergencies.

4.4 **Setting the agenda**

4.4.1 The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2 A Member of the Council desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5 **Petitions**

4.5.1 Where a petition has been received by the Trust, the Chairman of the Council shall include the petition as an item for the agenda of the next Council meeting.

4.6 **Chairman of Meeting**

4.6.1 At any meeting of the Council, the Chairman of the Trust, if present, shall preside, unless he/she has a conflict of interest. If the Chairman is absent from the meeting or has a conflict of interest the Vice Chairman, if he/she is present, shall preside, unless he/she also has a conflict of interest. If the Chairman and Vice Chairman are absent or have conflicts of interest, such Non-Executive Director as the Members of the Council present shall choose shall preside unless he/she has a conflict of interest. Where the Chairman of the Trust, the Vice Chairman and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor (as defined in the Standing Orders of the Council of Governors) shall preside unless he/she is absent or has a conflict of interest in which case the Council of Governors shall select one of their number that does not have a conflict of interest to preside at the meeting. The person presiding at the meeting shall have a casting vote.

4.7 **Notices of Motion**

4.7.1 A Member of the Council desiring to move or amend a motion shall send a written notice thereof at least 10 Clear Days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting,

without notice on any business mentioned on the agenda.

4.8 Withdrawal of Motion or Amendments

4.8.1 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.9 Motion to Rescind a Resolution

4.9.1 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Member of the Council who gives it and also the signature of four other Council Members. When any such motion has been disposed of by the Council, it shall not be competent for any member other that the Chairman to propose a motion to the same effect within six months, however the Chairman may do so if he/she considers it appropriate.

4.10 Motions

4.10.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.10.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Council to move:

- An amendment to the motion
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business(*)
- The appointment of an adhoc committee to deal with a specific item of business
- That the motion be now put.(*)
- A motion resolving to exclude the public under SO4.1.1.

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Member of the Council who has not previously taken part in debate and who is eligible to vote.

No amendment to the motion shall be admitted, if in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.11 Chairman's Ruling

4.11.1 Statements of Members of the Council made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters

shall be final.

4.12 **Voting**

4.12.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Members of the Council present and voting on the question and, in the case of number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

4.12.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Council present so request.

4.12.3 If at least one-third of the Members of the Council present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Council present voted or abstained.

4.12.4 If a Member of the Council so requests, his/her vote shall be recorded by name upon any vote (other than paper ballot).

4.12.5 In no circumstances may an absent Member of the Council vote by proxy. A Member of the Council may only vote if present at the time of the vote on which the question is to be decided. A Member of the Council is considered to be present at a meeting in the circumstances outlined in Standing Orders 4.13 below.

4.13 Any Governor or member of a committee of the council of Governors may participate in a meeting of the council of Governors or such Committee by conference, telephone, computer or video link whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence, in person at such meeting and in the event of a vote count toward that vote..

4.14 **Minutes**

4.14.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

4.14.3 Minutes shall be circulated in accordance with the members' wishes.

4.15 Suspension of Standing Orders

4.15.1 Except where this would contravene any provision of the Regulatory Framework, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, including one public Member of Council and that a majority of those present vote in favour of suspension.

4.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Members of the Council.

4.15.4 No formal business may be transacted while Standing Orders are suspended.

4.16 Variation and Amendment of Standing Orders

4.16.1 These Standing Orders shall be amended only if the variation proposed does not contravene the Regulatory Framework any statutory provisions, guidance or best practice advice issued by Monitor and is approved in accordance with paragraph 45 of the Trust's Constitution.

4.17 Record of Attendance

4.17.1 The names of the Chairman and Members of the Council present at the meeting shall be recorded in the minutes.

4.18 Quorum

4.18.1 No business shall be transacted at a meeting unless at least six Members of Council are present of which at least two are public Members of Council.

4.18.2 If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned at the discretion of the Chairman and the Trust Secretary shall give or shall procure the giving of notice to all Members of the Council of the date, time and place of the adjourned meeting. Notwithstanding Standing Order 4.18.1 above, upon convening, those present shall constitute a quorum.

4.18.3 If a Member of the Council has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest (see

Standing Order 6, 7 or 8) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. COMMITTEES

5.1 Subject to the Regulatory Framework, the Council may appoint committees of the Council to assist the Council in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly of the Chairman and Members of the Council of Governors.

5.2 A committee appointed under this regulation may, subject to any restriction imposed by the Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chairman" is to be read as a reference to the Chairman of the Committee as the context permits, and the term "Member of the Council" is to be read as a reference to a member of the committee also as the context permits.

5.4 Subject to Standing Order 5.5, each sub-committee shall have such terms of reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance for Governors issued by Monitor. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Council may not delegate any decision-making or executive powers to any committee or sub-committee.

5.6 The Council shall approve the appointments to each of the committees which it has formally constituted.

5.7 The committees and sub-committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

5.8 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

5.9 A Governor or a member of a committee shall not disclose any matter reported to the Council or otherwise dealt with by the committee notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential.

5.10 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of members of the Council of Governors attending the meeting.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 The Regulatory Framework requires Council Members to declare interests which are relevant and material to the Council of which they are a Member. All existing Council Members should declare such interests. Any Council Members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as "relevant and material" are defined in the Trust's Constitution as follows:

any pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors.

6.1.3 At the time Council members' interests are declared, they should be recorded in the Council minutes. Any changes in interests should be declared at the next Council meeting following the change occurring.

6.1.4 Council members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.1.5 During the course of a Council Meeting, if a conflict of interest is established, the Member of the Council concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.1.6 There is no requirement for the interests of Council members' spouses or partners to be declared. However Standing Order 7, which is based on the regulations, requires that the interests of Members of the Council's spouses, if living together, in contracts should be declared. Therefore the interests of Council Members'

spouses and cohabiting partners should also be regarded as relevant.

6.1.7 If Council members have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.2 **Register of Interests**

6.2.1 The Company Secretary to the Trust will ensure that a Register of Interests is established to record formally declarations of interests of Council Members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by Council Members, as defined in Standing Order 6.1.2.

6.2.2 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared will be incorporated.

6.2.3 The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.2.4 In establishing, maintaining, updating and publicising the Register, the Trust shall comply with the Regulatory Framework.

7. DISABILITY OF CHAIRMAN AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chairman or another Member of the Council has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council may exclude the Chairman (or Member of the Council) from a meeting of the Council while any contract, proposed contract or other matter in which he/she has pecuniary interest, is under consideration.

7.3 For the purpose of this Standing Order the Chairman or Member of the Council shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she, is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.4 The Chairman or a member of the Council shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in a company, body or person with which he/she is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Member of the Council in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Member of Council:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

7.6 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Council and applies to a Member of the Council of any such committee or sub-committee as it applies to a Member of the Council.

8. STANDARDS OF BUSINESS CONDUCT POLICY

Members of Council should comply with the Trust Constitution, the NHS principles of conduct, the NHS Foundation Trust Code of Governance, published by Monitor, the requirements of the Regulatory Framework, and any guidance for Governors issued by Monitor.

8.1 Interest of Members of Council in Contracts

8.1.1 If it comes to the knowledge of a Member of Council that a contract in which he/she has any pecuniary interest not being a contract to which he/she is a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Company Secretary of the Trust of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.1.2 A Member of Council should also declare to the Company Secretary of the Trust any other employment or business or other relationship of his/hers, or of cohabitating spouse, which might reasonably be predicted could conflict with the interests of the Corporation.

8.2 Canvassing of and recommendations by Members of the Council in Relation to Appointments

8.2.1 Canvassing of Members of Council of the Trust or of any Committee of the Council of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment.

8.2.2 A Member of the Council shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Member of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.2.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.3 Relatives of Members of the Council or Officers

8.3.1 Candidates for any staff appointment under the Trust, shall when making application, disclose in writing to the Trust whether they are related to any Member of the Board of Directors or Council of Governors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.3.2 The Chairman and every Member of the Council and officer of the Trust shall disclose to the Chief Executive any relationship between him/herself and a candidate of whose candidature that Member of the Council or Officer is aware.

8.3.3 On appointment, Members of the Council (and prior to acceptance of an appointment in the case of officer members) should disclose to the Council whether they are related to any other Member of the Council or holder of any office in the Trust.

8.3.4 Where the relationship to a Member of the Council of the Trust is disclosed, the Standing Order headed Disability of Chairman and Members of the Board in proceedings on account of pecuniary interest (SO 7) shall apply.

9. MISCELLANEOUS

9.1 Interface between the Board of Directors and the Council of Governors

9.1.1 The Board of Directors will co-operate with the Council of Governors in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:

(i) The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to Monitor.

(ii) The Directors are to present to the Council of Governors at a general meeting the annual accounts, any report of the Auditor on them, and the annual report. This requirement may be satisfied by at least one Executive Director being present at the relevant meeting to discharge these responsibilities

9.2 Standing Orders to be given to Members of the Council

9.2.1 It is the duty of the Secretary to the Trust to ensure that existing Members of the Council and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

9.3 Review of Standing Orders

9.3.1 Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 31)

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Board of Directors

STANDING ORDERS

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, and subject to the Constitution at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Company Secretary to the Board of Directors, or in their absence the Chief Executive or Director of Finance

1.2 Any expression to which a meaning is given in the 2006 Act or in the Regulations and Orders made under the Act shall have the same meaning in these Standing Orders and Standing Financial Instructions, unless the context otherwise requires and in addition:

1.2.1 "**the 2006 Act**" is the National Health Service Act 2006 as amended by the 2012 Act.

1.2.2 "**the 2012 Act**" is the Health and Social Care Act 2012.

1.2.3 "**Accounting Officer**" means the person who from time to time discharges the Functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust it shall be the Chief Executive.

1.2.4 "**Board of Directors**" means the Board of Directors as constituted in accordance with the Constitution.

1.2.5 "**Chairman of the Board of Directors**" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions "the Chairman of the Board" and "the Chairman of the Trust" shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable. The Chairman is also the Chairman of the Council of Governors.

1.2.6 "**Chief Executive**" means the Chief Executive Officer of the Trust.

1.2.7 "**Clear Days**" means in any period the duration of which is determined by a starting and finishing event, all complete days in that period excluding the day when the event referred to as starting the period occurs (for example sending out an Agenda) and the day on which the event referred to as ending the period occurs (for example the date of the meeting). For the avoidance of doubt clear days include weekends and public holidays. As an example an Agenda sent out on a Friday for a meeting on a Wednesday represents four clear days: Friday and Wednesday are excluded so that Saturday, Sunday, Monday and Tuesday are the four clear days.

1.2.8 “**Clinical Governance** Committee" means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Trust has responsibility.

1.2.9 "**Committee**" means a formal committee or sub-committee created and appointed by the Board of Directors.

1.2.10 "**Committee members**" means members formally appointed by the Board of Directors to sit on or to chair specific committees.

1.2.11 “**Constitution**” means this constitution and all annexes to it.

1.2.12 " **Council of Governors**" means the Council of Governors of the Trust as constituted in accordance with Annex 4 of the Constitution.

1.2.13 "**Director of Finance**" means the chief financial officer of the Trust appointed to discharge the usual functions of its chief financial officer..

1.2.14 "**Executive Director**” means a member of the Board of Directors who holds an executive office of the Trust.

1.2.15 “**FT Code of Governance**” means the NHS Foundation Trust Code of Governance issued by Monitor from time to time.

1.2.16 “**Funds** held on trust” shall mean those funds which the Trust holds on incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under the Regulatory Framework. Such funds may or may not be charitable.

1.2.17 "**Member**" means Executive Director or Non-Executive Director of the Board of Directors as the context permits.

1.2.18 “**Monitor**” means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

1.2.19 “**Nominated Officer**" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.20 "**Non-Executive Director**" means a member of the Board of Directors who does not hold an executive office with the Trust and is appointed by the Council of Governors.

1.2.21 "**Staff**" means any employee of the Trust who is not a Director, or any other person who is the equivalent of an employee at the Trust and who in the discretion of senior management should be treated as an employee.

1.2.22 “**Regulatory Framework**” means the 2006 Act, the Trust’s NHS provider licence and the Trust’s constitution.

1.2.23 "**SFIs**" means Standing Financial Instructions approved by the Board of Directors and reviewed by it from time to time..

1.2.24 "**SOs**" means Standing Orders.

1.2.25 “**Scheme of Delegation**” means the schedule of matters reserved to the Board of Directors and the Delegation of Powers, as approved by the Board of Directors and reviewed from time to time.

1.2.26 "**Trust**" means the Royal Orthopaedic Hospital NHS Foundation Trust.

1.2.27 "**Trust Secretary**" means a person appointed by the Trust in accordance with the Constitution to be the Trust Secretary to act independently of the Board of Directors and the Council of Governors to provide advice relating to the governance of the Trust and monitor the Trust's compliance with the Regulatory Framework.

1.2.28 “**Vice Chairman**" means the Non-Executive Director appointed by the Council of Governors in general meeting from the Non- Executive Directors as Vice Chairman to take on the Chairman's duties in his capacity as Chairman if the Chairman is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

(1) The Royal Orthopaedic Hospital NHS Foundation Trust is a statutory body which became a public benefit corporation on1 February 2007 following approval by Monitor pursuant to the 2006 Act.

(2) The principal place of business of the Trust is Royal Orthopaedic Hospital NHS Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

(3) NHS Foundation Trusts are governed by the 2006 Act, their constitutions and their NHS provider licences issued by Monitor (the Regulatory Framework).

(4) The functions of the Trust are conferred by the Regulatory Framework.

(5) As a body corporate, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients property held by the Trust on behalf of patients

(6) The Regulatory Framework requires the Trust to adopt Standing Orders for the regulation of its proceedings and business.

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

(8) The Scheme of Delegation and the Standing Financial Instructions provide a comprehensive business framework for the administration of the Trust's affairs and need to be read in conjunction with the Constitution. All Directors and Nominated Officers should be aware of the existence of these documents and where necessary familiar with the detailed provisions contained in them.

1.2 Monitor and the NHS Framework

(1) In addition to the statutory requirements, Monitor's provider licence requires the Trust to comply with best practice in the NHS.

(2) The Regulatory Framework requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board of Directors, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The framework also requires the establishment of audit and remuneration and nominations committees with formally agreed terms of reference.

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers – Scheme of Delegation

The Trust has powers to delegate and make arrangements for delegation. Under SO5 (Arrangements for the Exercise of Trust Functions by Delegation) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Board of Directors of any of its functions by a committee of the Board of Directors or sub-committee appointed by virtue of SO 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit. Delegated Powers are covered in the Scheme of Delegation.

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERS AND TENURE

2.1 Composition of the Membership of the Board of Directors and principles for the appointment of members and role of the Nominations and Remuneration Committees

(1) In accordance with the Trust's constitution, the composition of the Board of Directors shall be:

(i) A non-executive Chairman who is also the Chairman of the Council of Governors;

(ii) Up to 7 Non-Executive Directors;

(iii) Up to 7 Executive Directors;

such that at least half the Board of Directors, (excluding the Chairman), shall be Non-Executive Directors.

(2) The Board will determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. Such factors will include whether the Director:

(i) has been an employee of the NHS Trust within the last five years;

(ii) has had within the last three years, a material business relationship with the Trust either directly, or as a partner shareholder, director or senior employee of a body that has such a relationship with the Trust;

(iii) has received or is receiving additional remuneration from the Trust apart from a director's fee, participates in the Trust's performance-related pay scheme, or is a member of the Trust's pension scheme;

(iv) has close family ties with any of the Trust's advisers, directors or senior employees;

(v) holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;

(vi) has served on the board of the Trust for more than six years from the date of their first appointment.

(3) One of the Executive Directors shall be:

(i) the Chief Executive (whose appointment is to be approved by the Council of Governors except the initial Chief Executive);

(ii) the Director of Finance;

(iii) a Medical Practitioner

(iv) a Registered Nurse

(4) In consultation with the Council of Governors, the Board will appoint one of the Non-Executive Directors who is deemed by the Board of Directors to be independent by reference to FT Code of Governance to be the Senior Independent Director. The term of office of the Senior Independent Director shall be specified by the Board of Directors on appointing him or her but shall not exceed the remainder of his or her term as a Non-Executive Director.

(5) The Senior Independent Director shall perform the role set out in the FT Code for senior independent directors and in SO10(2), and otherwise as summarised in a role description agreed between the Board of Directors and the Council of Governors which shall as a minimum include:

(i) providing a sounding board for the Chairman and serving as an intermediary for other Directors where necessary;

(ii) leading the Non-Executive Directors in the evaluation of the Chairman as part of process agreed with the Council of Governors;

(iii) Being available to governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Director of Finance has failed to resolve or for which such contact is inappropriate; and

(iv) Attending sufficient meetings with Governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of Governors.

The role description of the Senior Independent Director will be updated from time to time to reflect any changes to the role of Senior Independent Governor in the FT Code from time to time.

2.2 Appointment, re-appointment and removal of the Chairman and Non-Executive Directors

As provided by paragraph 26 of the Constitution, the Council of Governors at a general meeting of the Council of Governors shall appoint, re-appoint or remove the Chairman of the Trust and the other Non-Executive Directors.

2.3 Remuneration and terms of office of the Chairman and Non-Executive Directors

(1) The Chairman and the Non-Executive Directors are to be appointed by the Council of Governors at a general meeting at which the Council of Governors shall decide (taking into account the views of the Council of Governors' Nominations and Remuneration Committee);

(i) the period of office;

(ii) the remuneration and allowances; and

(iii) the other terms and conditions of office of the Chairman and other Non-Executive Directors.

2.4 Appointment and removal of Chief Executive and other Executive Directors

(1) As provided by paragraph 29 of the Constitution, the Non-Executive Directors shall appoint or remove the Chief Executive, save that the appointment of the Chief Executive (other than the initial Chief Executive) shall require the approval of a majority of the Governors present and voting at a general meeting of the Council of Governors.

(2) The Nominations Committee of the Board of Directors shall appoint or remove the other Executive Directors

2.5 Remuneration and terms of office of the Chief Executive and the Executive Directors

(1) The Remuneration Committee of the Board shall decide:

(i) The period of office;
(ii) The remuneration and allowances; and
(iii) The other terms and conditions of office of the Chief Executive and other Executive Directors.

(2) The Trust may reimburse Directors' travelling and other costs and

expenses incurred in carrying out their duties at rates determined by the Remuneration Committee of the Board above. These are to be disclosed in the annual report.

2.6 Appointment and Powers of Vice Chairman

(1) Subject to Standing Order 2.6(2) below, the Chairman and members of the Trust may appoint one of their number who is not also an Executive Director, to be Vice-Chairman, for such period, not exceeding the remainder of his/her term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman. The Chairman and members may there upon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.6 (1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where he/she have been unable to perform his her duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case maybe; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

2.7 ROLE OF THE BOARD

2.7.1 Role of Members

(1) The Board is collectively responsible for the performance of the Trust. The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public.

(2) The Board of Directors will:

(i) provide entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

(ii) be responsible for ensuring compliance by the Trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

(iii) develop and articulate a clear “vision” for the Trust which will

be a formally agreed statement of the organisation's purpose and intended outcomes which can be used as a basis for the organisation's overall strategy, planning and other decisions.

(iv) set the Trust's strategic aims at least annually taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.

(v) as a whole be responsible for ensuring the quality and safety of health care services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies.

(vi) ensure that the Trust functions effectively, efficiently and economically.

(vii) set the Trust's vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met

(3) All Directors:

(i) will take decisions objectively in the best interests of the Trust and avoid conflicts of interest.

(ii) have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.

(iii) have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

(4) Non-Executive Directors will scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They will satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. They are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing executive directors, and in succession

planning.

2.7.2 Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and the Standing Financial Instructions and the Scheme of Delegation.

2.7.3 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she shall be the Accounting Officer for the Trust and shall be responsible to Monitor under the NHS Foundation Trust Accounting Officer Memorandum.

2.7.4 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7.5 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

2.7.6 Chairman

(1) The Chairman shall be responsible for the operation of the Board of Directors and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with their terms of appointment and with these Standing Orders.

(2) The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the debate and ultimate resolutions.

(3) The Chairman will also be the Chairman of the Council of Governors.

2.8 Corporate Approach to Trust Business

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.9 Schedule of Matters Reserved to the Board of Directors and Scheme of Delegation

The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall be read in conjunction with these Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Board Members

The Chairman will ensure that the designation of Lead roles or appointments of Board members as set out in any statutory or other guidance binding on the Trust will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may determine.

(2) The Chairman of the Trust may call a meeting of the Board of Directors at any time.

(3) One third or more members of the Board of Directors may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forth with call a meeting.

(4) Ordinary meetings of the Board of Directors shall be held in public.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three Clear Days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any one member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

(5) Before each public meeting of the Board of Directors a notice of the time and place of the meeting shall be displayed at the Trust's principal offices and on the Trust's website; and the public part of the agenda shall be displayed on the Trust's website at least three Clear Days before the meeting.

3.3 Agenda and Supporting Papers

The Agenda and supporting papers, will be sent to Members no later than three Clear Days before the meeting, save in emergency. Failure to despatch the agenda and supporting papers within the above timescales shall not affect the validity of a meeting unless the consequences of such failure were to reduce attendance at the meeting below a level at which the meeting was quorate.

3.4 Petitions

Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

(1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board of Directors wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

(2) The notice shall be delivered at least 10 Clear Days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 ‘Motions: Procedure at and during a meeting’, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

(i) Who may propose

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

(ii) Contents of motions

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board of Directors;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

(iii) Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board of Directors.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(iv) Rights of reply to motions

(a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their

amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

(v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

(vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business (*);
- that the question should be now put (*);
- the appointment of an 'adhoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion resolving to exclude the public, including the press.

(*) In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Board of Directors it shall not be competent for any director other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or

recommendations of a Committee or the Chief Executive

3.9 Chairman of meeting

(1) At any meeting of the Board of Directors the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (if the Board of Directors has appointed one), if present, shall preside.

(2) If the Chairman and Vice-Chairman are absent, such member (who is not also an Executive Director of the Trust) as the members present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions)and their interpretation of the Standing Orders and Standing Financial Instructions ,at the meeting, shall be final.

3.11 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Members (including at least one Member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(2) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(3) If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, at the discretion of the Chairman the meeting shall stand adjourned and the Trust Secretary shall give or shall procure the giving of notice to all Members of the date, time and place of the adjourned meeting. Notwithstanding Standing Order 3.11(1) above, upon convening, those present shall constitute a quorum.

(4) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

(1) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.13 - Variation and Amendment of Standing Orders, every

question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chairman of the meeting shall have a second, and casting vote.

(2) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(3) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(4) If a member so requests, their vote shall be recorded by name.

(5) In no circumstances may an absent member vote by proxy. A Member may only vote if present at the time of the vote on which the question is to be decided. A Member is considered to be present at a meeting in the circumstances outlined in SO 3.16 below.

(6) A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

(7) A manager attending the Board of Directors meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or rules relating to the quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board of Directors are present (including at least one member who is an Executive Director of the Trust and one Non-Executive who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the decision to suspend Standing Orders shall be recorded in the Board's minutes.

(2) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

(3) Formal business can only be transacted while standing orders have been suspended with the written agreement of the Audit Committee.

(4) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall be amended only if the variation proposed does not contravene the Regulatory Framework any guidance or best practice advice issued by Monitor and is approved in accordance with paragraph 45 of the Trust's Constitution

3.15 Record of Attendance

(1) The names of the Chairman and Directors present at the meeting shall be recorded.

3.16 Participation in Meetings

(1) Any Director or Member of a Committee of the Board of Directors may participate in a meeting of the Board of Directors or such committee by telephone, computer or video link whereby all persons participating in the meeting can hear each other participate in the meeting in this manner shall be deemed to constitute presence, to count towards a quorum and in the event of a vote count toward that vote.

(2) All decisions taken in good faith at a meeting of the Board of Directors or at any Committee of the Board shall be valid and shall not be invalidated even if it is discovered subsequently that there was a defect in the calling of the meeting, or by any vacancy of its membership or defect in a Director's appointment.

3.17 Minutes

(1) The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

(2) No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

3.18 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all public meetings of the Trust, but shall be required to withdraw upon the Board of Directors deciding as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'-Guidance should be sought from the NHS Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

The Chairman (or Vice -Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board of Directors to complete its business without the presence of the public'.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed' Items Taken in Private 'outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **(Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon a resolution of the Board of the Trust.

3.19 Observers at Board of Directors meetings

The Board of Directors will decide what arrangements and terms and

conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board of Directors' meetings and may change, alter or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

(1) Subject to the Regulatory Framework, the Board of Directors may appoint committees consisting of Directors.

(2) The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committees as the context permits, and the term “member” is to be read as a reference to a member of other committees also as the context permits. (There is no requirement to hold meetings of committees established by the Board of Directors in public.)

4.3 Confidentiality

4.3.1 A Member of a Committee shall not disclose a matter dealt with, by, or brought before, the Committee without its permission until the Committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

4.3.2 A Director or a Member of a Committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or Committee shall resolve that it is confidential.

4.4 Terms of Reference

Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

4.6 Approval of Appointments to Committees

The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Regulatory Framework, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the relevant legislation.

4.8 Committees established by the Board of Directors

4.8.1 The committees and sub-committees established by the Board of Directors are:

(i) Remuneration Committee;

(ii) Nominations Committee;

(iiii) Clinical Governance Committee; and

(iv) Audit Committee.

4.8.2 The constitution and terms of reference of Committees referred to in SO 4.8.1 shall be as set out in terms of reference to be agreed by the Board of Directors.

4.8.3 Other Committees

The Board of Directors may also establish such other committees as required to discharge the Trust's responsibilities

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 The Board of Directors may make arrangements for the exercise, on

behalf of the Board of Directors, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board of Directors has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board of Directors for noting.

5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by other committees or sub-committees, which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees, or sub-committees and their specific executive powers shall be approved by the Board of Directors.

5.4 Delegation to Nominated Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board of Directors. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance to provide information and advise the Board of Directors in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board of Directors as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall be read in conjunction with these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non- compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Board of Directors for action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Board of Directors will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the Royal Orthopaedic Hospital NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Conflicts of Interest Policy for the Royal Orthopaedic Hospital NHS Foundation Trust staff

- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND STAFF UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to the Board of Directors

The Regulatory Framework requires members of the Board of Directors to declare interests which are relevant and material to the Board of Directors of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment. All interests should be "re-declared" at least annually

7.1.2 Interests which are relevant and material

(1) Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance and best practice advice issued by Monitor:

(i) Directorships, or equivalent held in private companies, public limited companies, (with the exception of those of dormant companies), NHS organisations, government departments, local authorities, charities or voluntary organisations. This includes positions of authority which are comparable to a director in a company, such as a trustee of a charity or voluntary organisation and partnerships (including membership of LLPs).

(ii) Subject to SO 7.3.(1) (iv) any pecuniary interest in a contract within the meaning of SO 7.3 (1) (iii) other than those pecuniary interests that are not regarded as such under SO7.3(1)(iv) (Exception to Pecuniary Interests).

(iii) Direct ownership or part-ownership of private companies, public limited companies, partnerships (including membership of LLPs) or sole trader businesses in the field of health and

social care, for example pharmaceuticals, medical devices, and some consultancy or IT. For the avoidance of doubt interests held via pooled investments such as investment trusts, unit trusts and pension funds managed by an independent manager should be excluded under this heading.

(iv) Direct ownership or part-ownership of private companies, public limited companies, partnerships (including membership of LLPs) or sole trader businesses likely to do business with the Trust. For the avoidance of doubt interests held via pooled investments such as investment trusts, unit trusts and pension funds managed by an independent manager should be excluded under this heading.

(v) Any employment, volunteer position or fee generating relationship with an organisation in the field of health or social care.

(vi) Research funding/ grants that may be received by an individual or their employer or organisation of which they are a director to fund work that they are directly involved or which any private or public company, business or consultancy which is owned in whole or part by them is directly involved in.

(2) If any member of the Board of Directors comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member should have declared their interest under 7.1.2 (1) (ii) but if they have not already done so, they should do so by giving notice in writing of such fact to the Trust as soon as practicable. In addition they should alert the Chairman of any such interest at the beginning of every Board meeting at which such contract is likely to be material to any Board discussion, notwithstanding that such interest has already been declared and recorded on the Register of Director's interests.

7.1.3 **Advice on Interests**

(1) If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Board of Directors or with the Trust's Company Secretary.

(2) Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

7.1.4 Recording of Interests in Board minutes

(1) At the time Board members' interests are declared, they should be recorded in the Board minutes.

(2) Any changes in interests should be declared at the next Board of Directors meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of declared interests in Annual Report

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of interest which arise during the course of a meeting

During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

(1) The Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Board members. The Register shall include the names of each Director, whether he has declared any interests and, if so, the interests declared and details of the business of the organisations declared.

(2) These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

(3) The Register will be available to the public and the Company Secretary will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Members in proceedings on account of Pecuniary Interest

(1) Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) “Pecuniary interest” subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

(a) they, or a nominee of theirs, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(b) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

(a) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or

(b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract, or

(c) those securities of any company in which they (or any person connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one percent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph(c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the Board of Directors

(1) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Board of Directors has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contractor other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question

with respect to it.

(2) The Board of Directors may exclude the Chairman or a member of the Board from a meeting of the Board of Directors while any contract, proposed contractor other matter in which they have a pecuniary interest is under consideration.

(3) Any remuneration, compensation or allowance payable to the Chairman or a Member in their capacity as Chairman or member of the Board of Directors as agreed by the Remuneration and Appointments Committee shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(4) This Standing Order applies to a committee or sub-committee as it applies to the Board.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and Guidance

Directors must comply with the Trust's Constitution, the requirements of the Regulatory Framework and any guidance and best practice advice issued by Monitor or any policies issued by the Trust.

7.4.2 Interests of Staff

(i) Any member of Staff of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the member of Staff shall declare their interest by giving notice in writing of such fact to the Company Secretary or Chief Executive as soon as practicable.

(ii) Any member of Staff should also declare to the Company Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. This could include any significant opportunity for personal gain, financial or otherwise associated with the member of Staff's status as an member of Staff of the Trust and access to the Trust's resources, for example relating to IP, wider know how, brand and reputation.

(iii) The Trust will require interests, employment or relationships of members of Staff so declared to be entered in a register of interests of Staff. All declarations across the Trust should be "re-declared" at least annually. Trust management shall have discretion regarding which members of Staff or which staff groups are required to add an entry in the register of interests of Staff. For example management may decide that it is not a proportionate approach to risk management to require junior staff with no budgetary responsibility

to add their entry to the register of interests of Staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

(i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust

7.4.4 Relationships of Directors or Officers

(i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Director or Officer of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(ii) The Chairman and every Executive and Non-Executive Director of the Trust shall disclose to the Board of Directors any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

(iii) On appointment, Non-Executive Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed "Disability of Chairman and members in proceedings on account of pecuniary interest" (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Company Secretary or a nominated manager by them in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 Register of Sealing

The Company Secretary shall keep a register in which they, or another manager of the Authority authorised by them, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

(1). The Board of Directors will co-operate with the Council of Governors in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:

(i) The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each financial year to be given to Monitor.

(ii) The Directors are to present to the Council of Governors at a general meeting the annual accounts, any reports of the Auditor on them, and the annual report. This requirement may be satisfied by at least one Executive Director being present at the relevant meeting to discharge these responsibilities

10. COMMUNICATION AND CONFLICT

(1) These Standing Orders describe the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasizes the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests

an approach to informal communications, and sets out the formal arrangements for resolving conflicts between the Council of Governors and the Board of Directors.

(2) Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides. The Senior Independent Director or Chairman will encourage informal methods of communication on behalf of the Board of Directors including: discussions between Governors and the Chairman, the Chief Executive or a Director, through the office of the Chief Executive or any other person appointed to perform the duties of the Chief Executive to the Board.

(3) Formal communications are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively. Communications initiated by the Council of Governors, and intended for the Board of Directors, will be conducted as follows:-

(i) Specific requests by the Council of Governors will be made through the Chairman, to the Board of Directors;

(ii) Any Governor has the right to raise specific issues at a duly constituted meeting of the Council of Governors through the Chairman. In the event of disagreement, two thirds of the Governors present must approve the request. The Chairman will raise the matter with the Board of Directors and provide the response to the Council of Governors.

(iii) Joint informal meetings will take place between the Council of Governors and the Board of Directors as and when necessary.

(4) The following formal methods of communication will also be used:-

(i) Provision of formal reports or presentations by Executive Directors to a meeting of the Council of Governors.

(ii) Reporting the views of the Council of Governors to the Board of Directors through the Chairman or Vice Chairman.

(5) The Council of Governors and the Board of Directors must be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

(6) If through informal efforts the Chairman cannot achieve resolution of a disagreement or conflict, the Chairman will follow the dispute resolution procedure as described in Annex 9.

11 MISCELLANEOUS (see overlap with SFI No.21.3)

11.1 Standing Orders to be given to Board of Directors

It is the duty of the Company Secretary to the Trust to ensure that existing Board of Directors and all new appointees are notified of and understand their responsibilities within these Standing Orders. New designated officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

11.2 Review of Standing Orders

Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph10.4)

1. Disqualification

1.1 A person may not become a member of the Trust if within the last five years they have been involved as a perpetrator in an incident of violence or abuse:

1.1.1 at any NHS hospitals or facilities;

1.1.2 against any NHS employees or other persons who exercise functions for the purposes of the NHS;

1.1.3 against registered volunteers;

1.1.4 against patients or the public on NHS premises.

2. Expulsion from membership of the Trust

2.1 A Member shall cease to be a Member if:

2.1.1 they resign by notice to the Company Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this Constitution;

2.1.4 they cease to be entitled under this Constitution to be a member of any of the Public Constituencies or of any of the classes of the Staff Constituency;

2.1.5 if after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a Member.

2.2 A Member may be expelled by a resolution approved by not less than two- thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors. The following procedure is to be adopted:

2.2.1 Any Member may complain to the Company Secretary that another Member has acted in away detrimental to the interests of the Trust, or is otherwise disqualified as set out in paragraph 2 above.

2.2.2 The Chairman of the Council of Governors, assisted by the Company Secretary, will judge the manner in which the

complaint should be managed.

2.2.3 If appropriate, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that the point of view of the Members involved is heard and may either:

2.2.3.1 dismiss the complaint and taken no further action; or

2.2.3.2 arrange for the complaint to be considered at the next meeting of the Council of Governors.

2.2.4 Details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the next meeting of the Council of Governors.

2.2.5 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

2.2.6 If the Member complained of fails to attend the meeting without reasonable cause the meeting may proceed in their absence.

2.2.7 The Council of Governors will take a view on the complaint and may decide to expel the Member from membership of the Foundation Trust. To effect expulsion from membership, the Council of Governors will adopt a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

2.2.8 A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel that person has been carried.

A member who is expelled may apply for re-admission to membership. This application is to be made in writing to the Chairman, who will arrange for the application to be considered by the next meeting of the Council of Governors. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

3. Trust Secretary

3.1 The Trust may have a Trust Secretary, who shall be appointed and removed by the Chairman and Chief Executive acting jointly.

4. Indemnity

4.1 The Trust Secretary and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly and the Trust may also take out and maintain for their benefit insurance against such risks. Any costs arising in this way will be met by the Trust.

5. **Vacancies**

The validity of any act of the Trust is not affected by any vacancy among the Directors or the Members of Council or by any defect in the appointment of any Director or Member of Council.

6. **Directors**

6.1 If:

6.1.1 an Executive Director is temporarily unable to perform their duties due to illness or some other reason(the "Absent Director");and

6.1.2 the Board of Directors agree that it is inappropriate to terminate the Absent Director's term of office and appoint a replacement director; and

6.1.2 the Board of Directors agree that the duties of the Absent Director need to be carried out;

then the Chairman (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting director as an additional director to carry out the Absent Director's duties temporarily.

6.2 For the purposes of paragraph 6.1 of this Annex, the maximum number of directors that may be appointed under paragraph 23 of the Constitution shall be relaxed accordingly.

6.3 The Acting director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint them under this paragraph notifies them that they are no longer to act as an Acting director.

6.4 An Acting director shall be an Executive Director for the purposes of the 2006 Act. He/she shall be responsible for their own acts and defaults and he/she shall not be deemed to be the agent of the Absent Director.

7. **Vacant Executive Director Positions**

7.1 If:

7.1.1 an Executive Director post is vacant ("Vacant Position");and

7.1.2 the Board of Directors agree that the Vacant Position needs to be filled by an interim post holder pending appointment of a permanent post holder,

then the Chairman (if the Vacant Position is the Chief Executive) or the Chief Executive (in any other case) may appoint a director as an interim director ("Interim Director") to fill the Vacant Position pending appointment of a permanent post holder.

7.2 The Interim Director will vacate office on the appointment of a permanent post holder or, if earlier, the date on which the persons entitled to appoint them under this paragraph notifies them that they no longer wish them to act as an Interim Director.

7.3 An Interim Director shall be an Executive Director for the purposes of the 2006 Act including purposes such as counting toward the quorum and voting rights.

8. **Vacant Council of Governor positions**

8.1 When a vacancy arises for one or more elected Members of Council, the Council of Governors shall have the option:

8.1.1 to take from the list of members who stood for election at the most recent election of Members of Council for the class or constituency in question whichever member who was not elected as a Member of Council at the recent election but had secured the next most votes at that time. This procedure, which shall be an uncontested election for the purposes of the Model Rules for Elections as they apply to the Trust, shall be available to the Members of Council on 2 occasions within 12 months of the previous election. Members of Council appointed in this way shall hold office for a minimum of 6 months from their appointment but, subject thereto, shall hold office until the earlier of the conclusion of the next election of Members of Council and (except where the vacancy arose through expiry of a term of office) the date on which would have expired the term of office of that Member of Council whose cessation of office gave rise to the vacancy;

8.1.2 to hold the post vacant until the next scheduled annual election of Members of Council; or

8.1.3 proceed to call an election for the vacant post.

ANNEX 10 – TRUST PRINCIPLES

Trust values

The Trust's values aim to create a culture of excellent patient care by ensuring all at the Trust:

- Respect and listen to everyone
- Have compassion for all
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Be open, honest and challenge ourselves to deliver the best
- Learn, innovate and improve to continually develop orthopaedic care

Members of Council

As to qualities of Members of Council:

- Honesty and integrity
- Demonstrates the Trust Values and is able to act and take decisions in accordance with the Trusts Equality and Diversity Policy and the Equality Act 2010 in particular to have due regard for factors in relation to the following protected characteristics as specified in the Equality Act of patients and staff:
- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.
- Representation of broad public constituency
- Awareness of community diversity and a willingness to be trained in that context

The Council of Governors may from time to time amend or vary such statement of principles as it thinks fit.

Enclosure 12

Royal Orthopaedic Hospital

Audit Committee

Informal Report from the Chair

Audit Committee met on the 11 November 2014, matters to brief the Board are:

1. The Committee was preceded by a routine private meeting between the Chair and NED with Internal Audit (Baker Tilly), Counter Fraud (Baker Tilly) and External Audit (Deloitte).

2. This pre meeting considered the aging of the outstanding audit recommendations. However, it was noted that there had been a perceptible improvement in the level of executive engagement within the audit and assurance process.

3. The pre meeting also discussed the developing modus operandi between the Audit Committee and Clinical Governance Committee. The AC Chair agreed to follow up progress with the Chair of CGC and the Director of Nursing and Governance.

   The committee then turned to the formal agenda

4. The committee received reports from Internal Audit (Baker Tilly), Counter Fraud (Baker Tilly) and Deloitte (external audit). Points to note are:

   a. A new International Auditing Standard (ISA 700), requires the external auditors to report an enhanced audit report within the Annual Report and Accounts. This report would provide a greater level of analysis and commentary on the risks facing the audit process and audit opinion.

   b. Deloitte summarised their audit planning report highlighting the key risks they had considered in planning their audit work. Of particular note Deloitte highlighted the sign off of Commissioning contracts prior to the year end. ROH had managed this process very well last year and that we should seek to achieve this again this year.

   c. The committee also received from Counter Fraud (Baker Tilly) an update on the counter fraud programme for 2014/15. There were no material matters to report.

   d. The committee received an update report from Internal Audit (Baker Tilly). The internal audit plan remains on schedule and a number of reports were in process. There were no material matters to report, although, as noted below, a detailed update on progress implementing the 18 week RTT internal audit recommendations was received from Jonathan Lofthouse.

   e. The committee received an update on the tracking of implementation of all internal and external audit recommendations. It was noted that there were no “high” risk items that were overdue. The committee reviewed a consolidated table that showed

the number of recommendations, those that had missed their due date and the rating of the recommendations- this regular report now allows the committee to track implementation performance over time to ensure that recommendations were being managed accordingly.

f. The Committee discussed the matter of the long standing outstanding audit recommendations and agreed that these should be reviewed and removed if appropriate.

5. The committee received a comprehensive update on the review of the Management of the Waiting Lists from Jonathan Lofthouse (Director of Operations) and Kashif Azim (Internal Audit). This update focused on the progress implementing the Internal Audit actions and recommendations and further improvements. The following were noted:
    a. Jonathan and his team, supported by Paul Athey, had worked closely with Internal Audit in completing the implementation plan and following-up on further improvement activities.
    b. Significant progress had been made.
    c. Following the transfer of responsibility from the previous Director of Operations, Jonathan Lofthouse was fully engaged in driving forward further improvements to the systems and processes in support of the week RTT targets.
    d. The Board is already familiar with the main risks and issues currently being managed, and the subsequent action plan being put in place, and the Committee will continue to support the executive team until resolution.
    e. It was noted that more recent actions had included implementation of new patient list management software and digital dictation software to improve turnaround times of outpatient letters. The impact of these were still being evaluated however early signs were positive.
    f. The RTT target information is being reviewed by the executive team on a daily basis.

6. The committee received an informative update on the BAF process from Helen Shoker. It was noted that progress continues to be made and the Committee offered its continued support to Helen, particularly in embedding the BAF process deeper into the organisation.

7. Subject to a couple of minor points to be checked, the Committee agreed the amended SFI's and Scheme of Delegation. The Committee also noted the changes to the Constitution and Standing Orders. No matters of concern were noted.

8. The Committee reviewed the losses and compensations report and noted that there was a worrying increase in over payments to staff as a result of HR not being notified of termination of employment.

9. The committee approved the revised Treasury Management policy, and the revisions to the accounting policies.

10. The Committee received a short presentation and report from Jayne Freemen, regarding Security Risk. Jayne agreed to return to a future Committee meeting with a further update and benchmarking information.

11. Gareth Hyland attended the Committee and presented the current position and controls around NHS commissioning contracts and the associated risks. The committee welcomed this update and noted the positive position for 2014/15.

12. Future proposed dates for the committee are:

    a. February 24th 2015- routine business
    b. April 21st 2015- routine business
    c. May 26th 2015- Annual Report and Accounts only
    d. September 17th 2015- routine business and workshop to review performance of the committee- self assessment
    e. November 24th 2015- routine business

Rod.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 26 November 2014 **ENCLOSURE NUMBER: 14**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Yve Buckland**
SUBJECT:	**Trust Board Dates 2015**

TITLE:

SUMMARY

This report provides the Trust Board meeting dates for 2015.

IMPLICATIONS

RECOMMENDATIONS

The Board is asked to note the Trust Board meeting dates for 2015.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Trust Board Meeting Dates for 2015

Wednesday 7 January 2015 - Trust Board Workshop

Wednesday 4 February 2015 – Public Trust Board Meeting

Wednesday 4 March 2015 - Trust Board Workshop

Wednesday 1 April 2015 – Public Trust Board Meeting

Wednesday 6 May 2015 – Public Trust Board Meeting

Wednesday 3 June 2015 – Trust Board Workshop

Wednesday 1 July 2015 – Public Trust Board Meeting

August 2015 – No meeting

Wednesday 2 September 2015 – Public Trust Board Meeting

Wednesday 7 October 2015 – Trust Board Workshop

Wednesday 7 October 2015 – Annual Members Meeting

Wednesday 4 November 2015 – Public Trust Board Meeting

Wednesday 2 December 2015 – Public Trust Board Meeting

Please reserve the whole day.

All meetings will be held in the Board Room (unless otherwise informed)

Enclosure 1

Minutes of the Trust Board Meeting
held in public on November 26th 2014 in the Boardroom

Present:
Trust Board
Dame Yve Buckland, Chairman
Mrs Jo Chambers, Chief Executive
Mr Jonathan Lofthouse, Director of Operations
Mr Paul Athey, Director of Finance
Mr Rod Anthony Non-Executive Director
Mr Tim Pile Non-Executive Director
HH Frances Kirkham, Non-Executive Director
Mrs Helen Shoker, Director of Nursing & Governance
Mr Andrew Pearson, Medical Director
Professor Tauny Southwood, Non-Executive Director (for item 11/14/154 onwards)

In attendance:
Mr Julian Denney, Interim Company Secretary
Mr Roger Tillman Deputy Medical Director
Professor Phil Begg Director of Strategy and Transformation
Ed Davies Director of Research (for part of meeting)

Apologies:
Ms Elizabeth Chignell, Non-Executive Director
Ms Anne Cholmondeley, Director of Workforce & Organisational Development

Agenda No.	Agenda Item	ACTION
11/14/146	**Apologies and welcomes** Apologies were received from Elizabeth Chignell and Anne Cholmondeley and from Tauny Southwood for the first part of the meeting. The Chairman welcomed Phil Begg to the Board as Director of Strategy and Transformation and Matron Stacey Keegan who was attending and observing the Board meeting as part of her professional development	
11/14/147	**Declarations of Interest** There were no new declarations of interest. It was noted that there was a requirement to re declare all interests annually and it was agreed that the interim Company Secretary should coordinate this activity working closely with the Director of Workforce & Organisational Development so that requirements under the "Fit and Proper" test could be re declared at the same time.	**JD/AC**

<table>
<tr><td>11/14/148</td><td><u>Patient Case – an illustration of the work we do</u>

It was noted that work was in progress to abridge a film covering important safeguarding issues in a form that could be brought to the February Board meeting. Safeguarding was particularly important given recent concerns about practice in the Birmingham area. The ROH had introduced a number of improvements for example stronger pre-operative assessment and refined polices to balance better any need for deprivation of liberty with the need to protect patients and the public.

A programme of patient cases is being planned for 2015.</td><td></td></tr>
<tr><td>11/14/149</td><td><u>Minutes of the Trust Board meeting held on 29th October 2014</u>

Resolved:
That the minutes of the above meeting be and are hereby approved as a true record.</td><td></td></tr>
<tr><td>11/14/150</td><td><u>Trust Board Action Points</u>
The action notes were updated (see separate sheet):

<table>
<tr><td>Action</td><td>Comment</td></tr>
<tr><td>05/14/88

Create Action Plan to address issues identified by the CGC</td><td>Draft has been circulated in the last week. Take off from actions list.</td></tr>
<tr><td>07/14/93

The Board requested that a further discussion be held about the pre-operative pathway.</td><td>It was agreed that this should be taken off the actions list and transferred to the Transformation Committee who are focussing on the whole of the patient pathway improvement as one of their key areas of improvement.</td></tr>
<tr><td>07/14/100

Additional metrics relevant to patient concerns (e.g. waiting</td><td>Completed</td></tr>
</table>
</td><td></td></tr>
</table>

	times in out patients) are expected to be brought together to understand those metrics most important to patients. HS to report further in September.			
	07/14/108 It was noted that a number of suggestions had been made for further amendments to the Constitution	Completed		
	09/14/121B NEDs wished to know the dates of clinical audit meetings - . Roger Tillman was asked to ensure that NEDs know the dates of the meetings.	Completed		
	09/14/124 The Board considers that, regarding the RTT backlog: •For adult patients the Trust should consider the reallocation of some theatre sessions to those clinicians with serious backlogs. Which could also free up some clinicians to support the Transformation agenda •For paediatric patients the Trust should seek PICU beds from any realistic source; it was acknowledged that we would also need to synchronise with the consultants timetable			

	•The Board supports the Director for Operations in pressing the Commissioners to have a Clinical Senate debate where there are clear clinical risks for particular patients			
	09/14/126 Regarding Safe Staffing an assessment will be made regarding how the level of incidents compares with other providers	Completed		
	10/14/142 A Board agreed action plan will be created and submitted to CQC (this will be circulated to Board members by email circulation). The action plan will be shared with Audit Committee	Completed Progress will be reported on every public board agenda until the CQC visit.		
11/14/151	**<u>Chairman and NEDs' update</u>** Dame Yve Buckland, Chairman updated the Board as follows: ***Governor election results*** The following have been elected to the Council of Governors: Public Governors: • Sue Arnott • Alan Last • Anthony Thomas Staff Governor: • Alison Braham will be the new Non-Clinical staff representative. ***NEDs objectives progress and sharing*** • It was agreed that all NEDs performance objectives would be shared with the other NEDs			

Recruitment of additional NED

- It was noted that a draft brief was being circulated to members of the Council of Governors nominations and remuneration committee based on comments made by Rod Anthony, Tauny Southwood and Jo Chambers and that support from an external head hunter would be sought
- The committee is comprised of Stella Noon, Karen Hughes, Yvonne Scott, Marion Thompson and Alan Last and Yve Buckland as Chair.

Attendance at Council meetings by NEDs

- Rod Anthony will be attending the Council this afternoon to talk about the work of the Audit Committee and Tim Pile will attend the February 2015 meeting of the Council to talk about the work of the Transformation Programme.
- Governors are currently considering how their observer role on Trust working groups and Committees can work most effectively; it is expected to be similar to their role as observers at Board meetings. The recording of Council actions is being considered as well as tailored training for Governors so that they understand better the wider context of Trust activity – for example the impact of national policy and the role of regulators.

FTN events for NEDs

- A list of forthcoming events relevant to NEDs has been circulated. It was noted that NED appraisals would consider which events were particularly appropriate for individual NEDs. The Chair and interim Company Secretary would coordinate attendances.

Minute of Appointments Committee meeting for the appointment of the Director of Operations

- It was noted that Minutes of the meeting of the Appointments Committee for Executive Directors had been received and it was agreed that they would be attached to the Board minute as follows:

Minutes of the meeting of the Appointments Committee for Executive Directors
held on 4th September 2014 in the Boardroom

Present:

Dame Yve Buckland, Chairman of the Trust and Chairman of

	the Committee Mrs Jo Chambers, Chief Executive HH Frances Kirkham, Non-Executive Director Professor Tauny Southwood, Non-Executive Director Ms Elizabeth Chignell, Non-Executive Director **In attendance:** Martin Hancock – NHS Leadership Academy **Apologies:** Mr Rod Anthony Non-Executive Director Mr Tim Pile Non-Executive Director The Chairman of the Committee said that the objective of the meeting was to make the appointment to the position of Director of Operations which was now vacant. Having completed the interview process and having regard to all of the information provided by and about the candidates the Appointments Committee for Executive Directors hereby appoints Jonathan Lofthouse to the post of Director of Operations subject to the usual pre-employment checks ***December Board development event – proposals and discussion*** The Chairman suggested that: • The December Board workshop should be used instead by the Transformation Committee as an orientation event • The January Board workshop should be used for a period of reflection regarding Board skills and competencies and that all Board members should complete a Board assessment questionnaire based on the "Healthy NHS Board" and aspects of the "Well Led" framework relating to Board leadership. The "Healthy NHS Board" model had been developed by the NHS Leadership Academy and was being used as a framework for NED development and appraisal. It was agreed that the questionnaire should be circulated after the Board meeting and returned to Yve Buckland cc Julian Denney by December 15th. ***Ratification of Tender for building work*** The Chairman reported that following a competitive process	**JD**

	she, in consultation with the CEO and Director of Operations, had approved a tender award for building work to Arthur M. Griffiths and Son Limited for the development of the old day case unit adjacent to main theatres. The area will be transformed into the new Central Appointments Booking Suite, with additional multidisciplinary break out educational space and meeting room. She requested Board ratification given the size of the contract. **Resolved:** The Board hereby ratifies the award of the contract for building work to the old day case facility to Arthur M. Griffiths and Son Limited. **Resolved:** That the Chairman and NEDs update be noted.	
11/14/152	**<u>Chief Executive's Report</u>** Jo Chambers introduced her report inviting a discussion. A number of points were highlighted as follows: ***100,000 Genome Project*** • It was noted that the first paragraph should have referred to: "The Trust has been moved from Phase 3 to Phase 2 of the West Midlands Plan". • The Board had delegated authority to submit information to the Chair and CEO and it was reported that this had now been submitted. • Some of the cancers that the ROH deal with are so rare that they were not even registered on the national template and this is being addressed nationally; this clearly supports the Trust's position as having an important contribution to make in the field of rare diseases and cancers, which are the focal point of the project in the first instance. ***Strategic Development of Organisational Capability*** • Sally Xerri-Brooks has been appointed to the Head of Communications role and will start with the Trust on 8 December 2014. • Mr Matthew Revell, Consultant Surgeon, has been appointed as Chief Clinical Information Officer. • The existing interim CIO has agreed to take on the role	

until the end of 2016; this followed an external recruitment exercise.
- The Trust's work with the King's Fund has now commenced which is designed to help the Trust better design its clinical leadership approaches and support clinical leaders to enable the transformation set out in the strategy.

National Policy and Context

- There is a high degree of concern across the health system and leaders are grappling with multiple issues and guidance,
- The national Five Year Forward View document has been published by NHS England, with shared support with other statutory bodies which aims to provide a strategic framework within which the NHS will operate and develop in future years. Board members are encouraged to read it. It sets out four 'pillars' for change:
    - A strong economic position to support funding of NHS and Social Care
    - Changing models of care
    - Embracing new technologies to support innovation
    - Culture change to secure real and lasting change.
- The 'Dalton Review' which is due to report soon on potential provider organisational forms.
- There is greater focus on partnerships with patients and communities with particular emphasis on prevention of ill-health as a central strand of future sustainability.
- Seven new care delivery models will be prioritised and promoted by NHS England of which two seem particularly relevant to the ROH:
    - Viable smaller hospitals
    - Specialised care – stronger concentration of a particular care service.
- Significant work will be done to develop new local partnerships to facilitate the introduction and development of these new approaches. It will be important for the ROH to consider opportunities to support the evolution of the systems it serves and to be aware of potential risks if it is not engaged in the wider system and able to adapt its offering.
- Information is also seen as a key enabler and new technology 'road maps' will be published before April 2015, and a range of strategies will be developed to accelerate health innovation.

- Additionally, a continued drive on efficiency and productivity is seen as essential through three approaches:
    - Demand – more prevention and greater support for patients and carers
    - Efficiency – accelerating efficiency programmes to increase the annual net efficiency gain from 0.8% per annum to 2% per annum until 2020.
    - Funding – the Forward View discusses options for closing the £30bn gap.
- The Forward View suggests that Foundation Trusts' surpluses and investment power could be used to support investment in new primary care models, or used to pump prime various new care models. The ROH has plans to invest its surpluses in much needed new information systems and organisational infrastructure to enable it to transform and therefore this potential national intervention would not be welcomed.
- Tariff changes are also a cause for concern where the impact of price changes may create unintended consequences particularly for specialist work that is only undertaken in a few hospitals but where tariff is insufficient to meet costs and commissioning budgets are in deficit but patients are still experiencing very long waits for access to specialist care.
- Whilst the ROH is putting much effort into implementing its 5 year strategic plan, all efforts must be considered in the context of the changing national and economic picture. A key principle to adopt will be to take action that is of benefit to patients irrespective of potential longer-term changes in commissioning intentions, tariff or organisational form within the local health economy.

National Performance Review

- As reported previously, there is national ambition to reduce the number of patients waiting for treatment beyond the NHS Constitution commitment of 18 weeks from referral to treatment. All providers are encouraged to ensure that the investment brings about the required reduction in waits, this highlights the importance of the ROH's work in providing assistance to a number of other Trusts as well as treating additional long waiting patients on its own lists; this activity builds credibility with the system as well as underpinning the ROH growth strategy.

	Executive Management Team EMT has met twice since the last Board meeting. Key matters include: ***October*** • An additional MSK Consultant was approved in principle to reduce waiting times and support growth in activity. • Theatre workforce challenges were discussed including review of a paper on overseas recruitment. • A report on the viability of the private patients unit was reviewed and it was agreed to suspend the unit for three months until further work could be done to ensure private work makes a contribution to NHS work. ***November*** • The EOS spinal imaging system was discussed; more work was required to determine if it was a viable system. • The major incident planning exercise was considered to be a helpful source of learning around how to respond internally; overall all aspects of the exercise were completed successfully. **Resolved:** That the CEO's report be noted. That the Chair and CEO approval of the submissions to the Genomics Project be noted as delegated at the previous meeting.	
11/14/153	**<u>Medical Director's Report</u>** Andy Pearson introduced his report inviting a discussion. A number of points were highlighted as follows: ***Outcomes*** • There is continuing work occurring around the development of an integrated outcome measurement and reporting capability in the Trust as part of a wider outcomes strategy. • The Trust has appointed Matthew Revell to the new	

post of Chief Clinical Informatics Officer

Infection Rates

- Monitoring of surgical site infection rates has been extended to 12 months for all arthroplasty patients (previously 30 days). There have been two instances where the downward trend has reversed; these have been investigated and it was concluded that there is no reason to believe that the existing reduction in SSI rates by 65% over the last two years will not be maintained.

Personal Databases

- A Caldicott Guardian concern has been the possible holding of patient sensitive information 'off-site' in a non-encrypted and/or password protected format.

- A questionnaire was sent to all doctors employed by the Trust requiring of them a statement that they either do not hold such data off-site or if they do that it is held in an encrypted format. It was agreed that it was essential to receive positive confirmation that the letters sent had been complied with.

Junior Doctor Forum

- A 'mid-term' meeting has been held with the GP trainee doctors. Generally they are very happy with their placement here. They find their workload reasonable and interesting. They find their teaching relevant and appropriate and it is provided in a distraction free environment.

The issues they have raised are:

1. Very slow response time from switchboard when phoning from an internal number forcing them to call from a mobile to speed the response time
2. Lack of access to library facilities after 7pm and at weekends
3. Delays in getting blood results especially INR results causing errors and delays in treatment decisions with increased length of stay

Proposed solutions:

1. Re-examine SLA with UHB for switchboard service
2. Library to explain why facilities are unavailable out of

	hours – it was noted that there was an expectation that these facilities would be available associated with SIFT funding. 3. Possibility of 'near' patient testing for INR –it was agreed that this should be looked at as part of a wider issue which had multiple consequences for patient quality and length of stay. ***Medical Workforce*** • The Trust remains vulnerable to the shortage of appropriate and available junior doctors to ensure a compliant on-call out of hours rota and this has resulted in a heavy reliance on agency locum staff with significant cost and variability of quality. A fundamental cause is the fact that the Trust is not eligible to take FY1 trainees and therefore has to rely on GP trainees only. • An experienced project manager will be appointed to develop options such as increasing the role of advanced nurse practitioners, physician associates and collaboration with other organisations. For example, if a consultant physician were appointed jointly with UHB in the future, the ROH could expect to access that individual's junior staff. ***Medical Engagement & Leadership*** • As well as being a crucially important issue for the 5 year strategy it was considered to be important for building the ROH's profile and was expected to be showcased by the Kings Fund. ***ROH as Knowledge Leader – strand 7 of the 5 year strategy*** • In order to fulfil the Trust strategy of becoming the 'Knowledge Leader' for Orthopaedics, strand 7, it is necessary for the organisation to have a co-ordinated research and innovation capability supported by a robust outcomes and clinical audit processes maintaining its renowned position for undergraduate and postgraduate teaching. It is considered that the Trust is a something of a watershed in making fundamental progress to address the current concerns. **Resolved:** That the Medical Director's report be noted.	**AP/HS/JL**

11/14/154	**<u>Corporate Performance report including report on action to improve referral to treatment times</u>**
	
	Paul Athey introduced his report inviting a discussion. A number of points were highlighted as follows:
	
	• The NHS provider sector is c £630M overspent with £271M of that overspend in the FT sector – this puts into context the ROH's financial results.
	• The ROH had reported a c£200k shortfall in budgeted surplus. This was associated with increased costs :
	  ○ Agency and medical locum spend had increased mainly associated with the on call rota – this was being addressed through Dir of Ops sign off, revise of current contractor/ procurement arrangements , and longer term , the medical workforce project
	  ○ Increased corporate spending associated with the Transformation programme and some vacancies linked to organisational restructuring
	  ○ Theatre recruitment difficulties – this is recognised as a national issue. An overseas recruitment business case is being developed.
	
	RTT – report on actions to reduce the number of long waiters
	
	Jonathan Lofthouse highlighted the following points:
	
	• Non admitted patients are below target – this is part of a national amnesty for backlog clearance
	• Admitted patients are above target – this will move below as backlog clearance progresses
	• One patient breached the 28 day cancelled operations target – this was due to an admin error
	• Two patients breached the 62 day cancer waits target – these were transfers from elsewhere where the cause of the breach was in the referring providers. This has been explained to Monitor who support the ROH and it is likely that the breach will be removed from the Trust's scorecard by its commissioners.
	• Of the backlog of 210 patients 200 have now been removed.
	• Spinal deformity still remains an area of risk; negotiations are in progress with the University Hospitals of North Midlands NHS Trust for access to theatre slots.
	• The Trust continues to support Walsall and has the	

	potential to support HEFT. ***General points :*** • The tolerances associated with CPR indicators will be reviewed for reasonableness e.g. Falls and the calculation of the avoidable pressure ulcers cumulative metric will be checked **Resolved:** That the Corporate Performance report be noted.	**PA/HS**
11/14/155	**<u>The Patient Quality Report</u>** Helen Shoker introduced her report and invited a discussion as follows: • There was a 12% decrease in incident reporting compared to the previous month. Incident reporting continues to be monitored and the importance of this remains a key priority for the Trust. • There were 12 unavoidable (adult) inpatient falls, 9 of which resulted in no patient harm and the remaining 3 resulted in patient injuries of a minor nature. There were younger patients falling. The Board were encourage that increased support was being given to patients and suggested that falls prevention was an area were clinical audit could help understand the effectiveness of different interventions • Regarding falls prevention: 6 new ultra-low beds are now on-site with a further 4 arriving during November 2014; planning for a patient focused falls prevention day next year has also commenced ("April Falls Day" running on 1st April 2015). Tim Pile volunteered to support this event. • There were 2 avoidable Grade 3 pressure ulcers during October. This will result in a breach of quality targets with commissioners. The Trust has set itself very testing targets regarding what is avoidable – in this case due to gaps in documentation rather than deficiencies in case. • The Trust is compliant with current Ebola guidance and all front of house staff have been asked to ensure every patient presenting at the Trust is screened by asking the appropriate questions advised by Public Health England. • The WHO checklist compliance figure for October was 97.96% against a target of 99%. Further work is being undertaken to review and modify the WHO checklist document, to ensure its practical application. It was noted that the target would be moved up progressively to reach 100% and that the non-compliance was	

	associated with minor non completion rather than failure to sue the checklist. • The percentage of complaints resolved (within timeline) did not meet the KPI target of 80% with only 25% achieved this month. This is due to concerted efforts to complete longstanding complaints that had yet to be resolved. • The Board urged that greater pressure be put on staff to undergo flu immunisation. • The CEO noted that the Board currently does not receive, in advance of external users, publically available information regarding the outcomes of its own medical staff and the Board strongly supported her efforts to change this; this should also improve the QGF self-assessment scores. **Resolved:** That the Patient Quality report be noted.	
11/14/156	**<u>Safe Staffing</u>** Helen Shoker introduced her report noting that: • In October there were five incidents reported relating to safe staffing but no breaches of minimal safe staffing standards. This is communicated to staff regularly to build their confidence. Directorate teams are asked to observe emerging patterns within incidents, such as short notice sickness absence, un-planned HDU admissions and clinical site co-ordinator role, and act accordingly. • Monthly Bank and Agency request and fill rates report now includes filled shifts that are cancelled at short notice (DNAs), for the month of September 814 shifts were requested of which 19 did not fill and 5 DNA'd. • ROH NHSFT completed the NHS England Safe Staffing UNIFY data uplift on for the month of October on time. For a sixth month ROH NHSFT has received a green rating. This demonstrates the planned nursing levels versus the actual nursing levels. • IM&T are supporting the transfer of paper based, labour intensive mechanism to an electronic solution which is slightly delayed and envisaged to be in place across all wards in Spring 2015 and there is continued learning from the pilot sites of Wards 1 & 2.	

	• The tool has been enhanced in October to recognise the use of 'specialing' shifts for high dependency patients, such as those at high risk/actual falls. • ROH safe staffing levels compare favourably with other specialist orthopaedic hospitals and other local hospitals **Resolved:** That the Safe Staffing report be noted and that the Safe Staffing be reported to CGC monthly and to Trust Board six monthly in the future.	
11/14/157	**Board Assurance framework (BAF)** Helen Shoker presented the BAF and highlighted the following: • The Ulysses system is being updated to reflect the new strategic objectives in the relevant column. Once complete risk leads will be asked to align specific risks to the new strategy initiatives and nominate operational leads for each risk. • The Executive Directors have developed the risks associated with implementing the new strategy and these will be included in next month's report. **Resolved:** That the Board Assurance Framework be noted.	
11/14/158	**CQC Action Plan** Helen Shoker presented the CQC Action Plan explaining that it responded to the CQC Inspection report published on 17th October 2014 and included both compliance actions and actions related to non-regulated activities. The CQC standard action plan template had been completed for all of the above and was submitted to the CQC on time. The Board approved the circulation of the action plan in October, with approval by the CEO and Chairman, and a monthly update is planned from December onwards. The update will be co-produced by the Directors of Nursing and Operations, the majority of actions sit within their respective portfolios. To date progress has been made against all actions, for example:- • Additional signage around the Hospital site and the welcome desk staffed in routine hospital hours,	

	• HDU and ward staff awareness sessions relating to medicine management, • Trial of appropriate medical records storage solutions in OPD, • Commencement of Outpatient Matron and Outpatient Improvement Manager, • Chaperone policy drafted, improved signage highlighting to visitors the offer of a chaperone and greater OPD staff awareness, • Daily bed management processes have been designed and implemented and the use of 'expected date of discharge' across the wards has improved, • Random checks of resuscitation equipment and controlled drug management take place each week and results are positive. The Chair invited a discussion as follows: • It was agreed that there should be a regular email update regarding the CQC action plan as there was only one full public Board meeting planned before the next CQC visit which was expected to be in week 2 of March • The CEO's view was that the level of progress was very encouraging. • Board members offered to provide support for example by providing a "mystery shopper" input against particular improvements. It was agreed that HS would identify opportunities for Board members to be involved and communicate these to JD to liaise with the Board. • Progress was being made in implementing enhanced recovery although it was noted that because the ROH had started from a position of good Length of Stay the potential for reduction was likely to be less than in some other hospitals. • The Chairman, CEO and Director of Nursing and Governance were planning to meet members of the Midlands CQC team just before Christmas. *(Post meeting note : CQC meeting rescheduled to 19 January 2015)* **Resolved:** That the CQC Action Plan be noted.	**HS/JD**
11/14/159	**<u>Update on Five Year Strategic Plan including update on the tariff</u>** The CEO presented her report highlighting the following points:	

- The strategic plan was submitted to Monitor on 30 June 2014 in line with national requirements. On 2 September 2014 an initial review meeting took place with Monitor and no major concerns were identified based on the assumptions in the plan. It was noted, however, that the proposed tariff changes for 2015/16 introduced new risks which would need to be reviewed as the tariff is finalised.

- Formal feedback from Monitor has now been received and the letter explains that an in-depth review of the Trust's strategies and plans has not been undertaken. Instead, Monitor has tested the robustness of the financial projections which describe the plans; this has involved applying a limited number of sensitivities to counterbalance variations in the Trust's assumptions. A copy of the letter was made available to Board members.

- The Board will continue to review planning assumptions and the more recent issue regarding tariff is still a 'live' issue; our representations to Monitor along with colleague organisations in the Specialist Orthopaedic Alliance (SAO) has resulted in changes to the original proposals, a delay in issuing the new tariff for formal consultation and a commitment to further work during 2015/16 in partnership with the SOA to further develop the pricing model for 2016/17 onwards.

- Professor Phil Begg took up post on 01 November 2014 and has been meeting with Tim Pile regarding the mobilisation of the Transformation Programme.

- In October a 'Lunch & Listen' event was held – open to staff from across all areas of the pathway for large and small joints. This structured session asked teams working around each element of the patient pathway to prepare in advance a flow chart of how patients moved through their section of the service and to think through what they felt worked well currently in the pathway and what they felt did not work well.

- The CEO also summarised progress in each of the workstreams which was explained in detail in her report

Key points raised in discussion:

	• It was agreed that the Board workshop planned for December 17th 2014 would be cancelled and replaced by a Transformation Committee workshop and that JD would provide support to the workshop. All Board members were invited even if they were not members of the Transformation Committee. • It was also noted that an external partner, Newton, would be carrying out some work quantifying opportunities relating to patient flow improvements. • The Chairman encouraged Board members to identify opportunities to learn from other centres, either in the UK or possibly internationally and to feed these back to Tim Pile. **Resolved:** That the Board note the Strategy Update.	
11/14/160	**Constitution/ Review of Standing Orders** The Chairman stated that the CEO had received a notice of a motion as required by the Standing Orders and it had been passed it to her by the CEO as follows: Dear Jo **Notice of motion to propose the amendment of Trust Board Standing Orders** We hereby give notice of a motion under Standing Order 3.5 as required by Standing Order 3.14, namely: *That the Standing Orders of the Board of Directors be amended in such manner as will be detailed in the relevant Trust Board paper (including appendices) to be provided for the Board meeting later this month.* Thank you. Frances Kirkham and Rod Anthony Non-executive directors She reminded Members of the Board that the Trust Board had approved in principle various revisions to the standing orders of both the Council of Governors and Trust Board at its September and October 2014 meetings, as well as a number of more minor amendments to the rest of the Constitution. These changes were also given formal approval by the Council of Governors at their October 2014 meeting and these changes are reflected in the amended Constitution provided as Appendix 1.	

	Mills and Reeve, solicitors to the Trust, have advised that the changes referred to above must be approved by the Council of Governors and the Board of Directors but will not require the approval of members at an Annual Members Meeting since they are not amendments in relation to the powers or duties of the Council of Governors or otherwise with respect to the role that the Council of Governors has as part of the Trust. Under the Health and Social Care Act 2012, Trusts may amend their constitutions without recourse to Monitor providing these changes remain compliant with requirements of the Act. Mills and Reeve have been responsible for final review of the amended constitution prior to the September meeting of the Board and Council and have assumed responsibility for assuring the Trust of such compliance. Since the October meetings of the Board and Council there have been no further changes to the amended Constitution and Standing Orders provided as Appendix 1. **Resolved:** That the Board hereby approves the further amended Constitution (including the revised Standing Orders) provided as Appendix 1 and agrees to adopt it from November 26th 2014. This was agreed by all present.	
11/14/161	It was agreed that minutes of all committee meetings should be received by a private meeting of the Board. **<u>Audit Committee</u>** Rod Anthony, Chair of the Audit Committee gave an update highlighting the following points: • The Committee discussed the matter of the long standing outstanding audit recommendations and agreed that these should be reviewed and removed if appropriate. • The committee received an informative update on the BAF process from Helen Shoker. It was noted that progress continues to be made and the Committee offered its continued support to Helen, particularly in embedding the BAF process deeper into the	

	organisation. • Subject to a couple of minor points to be checked, the Committee agreed the amended SFIs and Scheme of Delegation. The Committee also noted the changes to the Constitution and Standing Orders. No matters of concern were noted. • The Committee received a short presentation and report from Jayne Freemen, regarding Security Risk. Jayne agreed to return to a future Committee meeting with a further update and benchmarking information. • Gareth Hyland attended the Committee and presented the current position and controls around NHS commissioning contracts and the associated risks. The committee welcomed this update and noted the positive position for 2014/15. **Resolved:** That the Board : •Note the update of the Audit Committee	
11/14/162	**<u>Clinical Governance Committee</u>** Tauny Southwood, Chair of the Clinical Governance Committee gave an update and invited a discussion as follows : • A report from the Research and Development Committee had been received describing progress to date; further work had been requested on matters such as evidence for further integration, R & D strategy and further analysis of the Trust's performance against recruitment timelines and targets. • Further analysis had been requested on a number of issues relating to clinical audit. The Board requested that a date be provided when a robust clinical audit plan could be expected. • Consent was discussed and it was noted that further wok had been requested to provide better evidence that patient understanding of procedures being requested was recorded in the hospital notes. • It was noted that a robust clinical audit process could support the improvement work being done on falls described in the Patient Quality Report. **Resolved:** That the Board : •Note the update of the Clinical Governance Committee	**TS/RT**

11/14/163	**Charitable Funds committee** Frances Kirkham stated that there had been no meeting of the Committee since the last Board meeting.	
11/14/164	**Council of Governors** The Chairman gave a verbal update regarding the work of the Council of Governors. • The last meeting had included a number of important procedural matters such as the Council approval of the revised Constitution, a detailed update from the CEO and a report on Governor elections • The role of Governors on Trust working groups and Committees had been discussed • Frances Kirkham had given Governors an update regarding the work of the Charitable Funds Committee which had been very well received. **Resolved:** That the Board : Note the Chairman's update regarding the work of the Council of Governors.	
11/14/165	**Board Calendar 2015** This was noted by the Board	
11/14/166	**Any Other Business**	

Date and Time of Next Trust Board Meeting

Date of Next Meeting: Wednesday 4 February 2015 at a time to be advised.
There is also a private Board development event planned for Wednesday 7 January 2015

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 MEETING
TO BE HELD
ON
WEDNESDAY 26 NOVEMBER,
10.00AM IN THE BOARD ROOM

AGENDA

ITEM	TITLE	NOTES	BOARD ACTION	PAPER
11/14/146	**Apologies & Welcomes**		To Note	
11/14/147	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
11/14/148	**Patient Case – an illustration of the work we do** Director of Nursing and Governance			
11/14/149	**Minutes of Public Board Meeting held on the 29th October 2014** Chairman		For Approval	Enc. 1
11/14/150	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
11/14/151	**Chairman & NED update** **Including:** • Governor election results • NEDs objectives progress and sharing • Recruitment of additional NED • Attendance at Council meetings by NEDS • FTN events for NEDs • Minute of Appointment Committee meeting for the appointment of the Director of Operations • December Board development event – proposals and discussion • Ratification of Tender for building work Chairman & NEDs		For Information	

11/14/152	**Chief Executive's Report** **Including:** • AHSN genomics submission approval by CEO and Chair Chief Executive		For Information and Assurance	Enc. 3
11/14/153	**Medical Director's Update** Medical Director **Including:** • Update on research activities		For Information and Assurance	Enc. 4
	Performance Management / Assurance Reports			
11/14/154	**Corporate Performance Report including report on action to improve referral to treatment times** Director of Finance and Director of Operations		For Assurance	Enc. 5
11/14/155	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 6
11/14/156	**Safe Staffing** Director of Nursing & Governance		For Assurance	Enc. 7
11/14/157	**Board Assurance Framework** Director of Nursing & Governance		For Assurance	Enc. 8
11/14/158	**CQC Action Plan** Director of Nursing & Governance		For Assurance	Enc. 9
	Strategy			
11/14/159	**Update on Five Year Strategic Plan including update on the tariff** Chief Executive and Director of Finance		For Information	Enc. 10

11/14/160	**Approval of amendments to the Constitution/ Standing Orders including the following Notice** Dear Jo **Notice of motion to propose the amendment of Trust Board Standing Orders** We hereby give notice of a motion under Standing Order 3.5 as required by Standing Order 3.14, namely: *That the Standing Orders of the Board of Directors be amended in such manner as will be detailed in the relevant Trust Board paper (including appendices) to be provided for the Board meeting later this month.* Thank you. Frances Kirkham and Rod Anthony Non-executive directors **Company Secretary**		For final approval and adoption	Enc. 11
	Board Committees			
11/14/161	**Audit Committee**		For Assurance	Enc 12
11/14/162	**Clinical Governance Committee**		For Assurance	Enc 13
11/14/163	**Charitable Funds Committee**		For Assurance	Verbal
11/14/164	**Council of Governors** Chairman		For Information	Verbal
11/14/165	**Board Calendar 2015** Chairman			Enc 14
11/14/166	**Any Other Business**			
	Date of Next Meeting: Wednesday 4 February 2015 at a time to be advised. **There is also a private Board development event planned for Wednesday 7 January 2015.**			

Confidential Matters

To resolve:

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

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.